

# **Scrutiny review: Access to GPs**

## **Review of the Health Select Commission**

*September 2013 – March 2014*

### **Scrutiny Review Group:**

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## Executive summary

The review group comprised the following members:

- Cllr Emma Hoddinott (Chair)
- Cllr Chris Middleton
- Cllr Judy Dalton
- Cllr Peter Wootton

There were seven aims of the review, which were to:

1. establish the respective roles and responsibilities of NHS England and GP practices with regard to access to GPs
2. ascertain how NHS England oversees and monitors access to GPs
3. identify national and local pressures that impact on access to GPs – current and future
4. determine how GP practices manage appointments and promote access for all patients
5. identify how NHS England will be responding to changes nationally
6. consider patient satisfaction data on a practice by practice basis and to compare Rotherham with the national picture
7. identify areas for improvement in current access to GPs (locally and nationally)

The review was structured around these aims with evidence gathered through written information and discussions with NHS England and the Local Medical Committee; analysis of the GP Patient Survey data; written evidence from other health partners and one GP practice; desk research; and visits to talk with staff at four GP practices to explore the practicalities of managing appointments in more depth.

### Summary of findings and recommendations

It is essential that people in all parts of the borough have accessible and high quality primary care to help achieve improved health outcomes and reduced health inequalities for our community. GPs play a key role as the main source of initial contact with the NHS for the vast majority of patients when they are unwell.

People's health in Rotherham is generally worse than the average for England and with a growing and ageing population and high incidence of long term conditions and co-morbidities, demand for GP services is high and likely to increase further over time. To meet this demand it is vital to ensure adequate numbers of GPs and other health care professionals and that GP practices have effective appointment systems and the right skills mix in their staff teams.

Nationally the challenge for NHS England is to develop a strategic commissioning framework and new ways of working that will deliver sustainable high quality primary care for all patients and be sensitive and responsive to local pressures and local need. Supply side factors of funding and investment; workforce planning, recruitment and retention; and quality facilities will all need to be addressed to meet growing demand.

Personal Medical Services contracts are the predominant contract type held by GP practices in Rotherham. They offer local flexibility and were introduced for practices that wished to be innovative and do things differently, to improve the quality of care or to provide new services. These contracts are currently under review by NHS England and there is a real concern that this will result in lost resources, impacting on both practices and patients.

Local consultation has highlighted public confusion about where to go for what health problem. Patients need to be clear which is the right health service - GP, pharmacy, Out of Hours service, Walk in Centre or Accident and Emergency - to access for the most appropriate care and how to do so. More public awareness raising about services would be beneficial.

Results of the national GP Patient survey are useful for comparative purposes with results available nationally, by clinical commissioning group and by GP practice. Although sample sizes are small the information provides an indication of satisfaction levels with each practice, its services and their availability to patients. Rotherham generally mirrors the national pattern at clinical commissioning group level, with minor variations from the national average, but with some significant variations between the 36 individual practices in Rotherham. Overall 81% of respondents were very or fairly satisfied with the opening hours at their practice and 79% agreed their surgery was open at convenient times.

Local GPs offer a range of appointment booking systems and one size does not fit all given the differences in practice size and practice populations. The majority of practices offer additional appointments beyond core hours in order to increase capacity to meet patients' needs. The review recognised that some excellent work is taking place locally to improve communication and promote access for different groups and this good practice should be shared more widely.

Nevertheless patients' experiences of accessing GPs do vary from practice to practice with some long waiting times reported. It is also apparent that for various reasons some patients choose to go to the Walk in Centre or to the Accident and Emergency department at the hospital when they should have been seen by their GP.

Patient expectations and preferences are changing, and it a question of striking a balance between clinical need, patient expectations and convenient access, with practices needing to work with their patients to develop systems that work well for both. Patient Participation Groups are already helping to identify areas for improvement and there is scope to develop these groups further.

Some local services have been transferred from secondary to primary care and more are likely to follow in a planned funded transfer, but this will need to be well managed to avoid compounding existing access and capacity issues.

In light of the future challenges for Rotherham outlined in this report, a proactive approach is needed to mitigate risk in relation to the capacity to deliver sustainable and accessible primary care for all our community.

A number of recommendations have been made by the review group and these are summarised below, covering the following areas:

**Improving access** – ensuring patients' views on access and ways to improve are heard; maintaining access to professional interpretation services; and adopting hybrid and flexible approaches to appointment systems.

**Sharing good practice** – showcasing best practice and sharing successes on providing good access to patients.

**Improving information for patients** – maintaining up to date information about each GP practice; the importance of cancelling unneeded appointments; and accessing the right health care service and health care professional at the right time.

**Capacity to deliver primary care** – mitigating risk to primary care in Rotherham in light of future challenges; encouraging GPs to remain in Rotherham after training; and being proactive about future increases in demand.

## **1. Why Members wanted to undertake this review**

Following discussion in Health Select Commission meetings a scrutiny review of Access to GPs was viewed as a priority in the work programme for 2013-14, as Members had raised concerns about waiting times for appointments on the basis of anecdotal information from the public. The purpose of the review was to identify any anomalies, issues or barriers which impact on patients in Rotherham accessing their GP and in particular in respect of obtaining a convenient appointment within 48 hours.

There were seven aims of the review, which were to:

1. establish the respective roles and responsibilities of NHS England and GP practices with regard to access to GPs
2. ascertain how NHS England oversees and monitors access to GPs
3. identify national and local pressures that impact on access to GPs – current and future
4. determine how GP practices manage appointments and promote access for all patients
5. identify how NHS England Area Team will be responding to changes nationally
6. consider satisfaction data from the GP Patient Survey on a practice by practice basis and to compare Rotherham with the national picture
7. identify areas for improvement in current access to GPs (locally and nationally)

## **2. Method**

A full scrutiny review was carried out by a sub-group of the Health Select Commission consisting of Cllrs Dalton, Hoddinott (Chair), Middleton and Wootton. Vicky Farnsworth and Robert Parkin, co-optees from Speak Up, a local organisation working with people with a learning disability, each took part in one of the practice fact finding visits.

An initial report to the commission provided an introduction and set the national and local context, with evidence for the review gathered through the following means:

- Briefing session and written information submitted by NHS England Area Team
- Review of the National GP Patient Survey data
- Presentations and discussion with NHS England Area Team and representatives from the Local Medical Committee
- Round table discussions with staff during visits to four GP practices, which varied by geographical location, single/multiple site, contract type, practice population and results of the national GP patient survey
- Written information from a further GP practice, Care UK, HealthWatch, Rotherham Clinical Commissioning Group and Rotherham Foundation Trust
- Desk top research

Members would like to thank everyone who gave evidence for the review and in particular the GP practices who volunteered to take part in the review and provided a meaningful insight into the practical management of patient appointments.

## **3. Background**

It is essential that people in all parts of the borough have accessible and high quality primary care to help achieve improved health outcomes and reduced health inequalities for our community. General practice is often referred to as “the cornerstone of the NHS”, with roughly 1million people visiting their GP every day across the country. GPs play a key role as the main source of initial contact with the NHS for the vast majority of patients when they are ill.

According to the 2013 Health profile people's health in Rotherham is generally worse than the average for England. Due to the demographic profile of Rotherham with a growing and ageing population and high incidence of long term conditions and co-morbidities, demand for GP services is likely to increase further over time. High deprivation levels in some areas means the Borough is now ranked 53rd most deprived district and falls within the 20% most deprived districts in England. As patients in deprived areas often have higher levels of need this too indicates higher demand for GP services in Rotherham compared to other parts of the country.

In order to meet this anticipated demand it is vital to ensure that Rotherham has adequate numbers of GPs and other healthcare professionals and that practices have effective appointment systems and an apposite skills mix in their staff teams.

Local consultation has highlighted public confusion about where to go for what health problem. Patients need to be clear which is the right health service - GP, pharmacy, Out of Hours service, Walk in Centre or Accident and Emergency - to access for the most appropriate care and how to do so.

Communication barriers that may impact on access to GPs, such as language barriers, people with autism or learning disability, and/or people with a sensory impairment, should be minimised. Specific barriers that limit access for other disadvantaged groups should also be addressed.

Evidence provided for the Urgent Care scrutiny workshop included a survey of 166 patients who attended the Walk in Centre (WIC) in January 2013. The survey showed that before attending the WIC 35% of patients had tried to get a GP appointment, 26% had taken over the counter medicines and 21% had not accessed any services before attending. This indicates some patients faced difficulties in accessing their own GP. Others made a choice to go directly to the WIC, which could be related to past experiences of their own GP practice, or could be for reasons such as urgency for treatment, proximity to work, or being a visitor to Rotherham.

"It is hard to obtain a quick appointment at our GP surgery and they often refer us to the Walk in Centre. However, if it isn't an emergency, but you need to see a doctor within a week – what happens then?"

"GP appointment booking system for same day appointments has impact on patients seeking access to other services as a fall-back."

"Wide variation in time to wait for routine appointments – from very good to over 2 weeks."

*Source: Right care, first time - report on outcome of public consultation Rotherham CCG*

## **4. Context**

### **4.1 NHS England**

The NHS has undergone significant structural change with NHS England (NHSE) assuming responsibility for commissioning core general practice services since April 2013 through 27 Area Teams. Spending on these services is approximately £7 billion p.a. across England. NHS England South Yorkshire and Bassetlaw (NHSE SY&B) is the local Area Team for Rotherham.

Nationally NHSE has undertaken a large scale consultation "*Improving General Practice – a Call to Action*" to inform the future of general practice services in England, as part of its wider consultation '*The NHS belongs to the people: a call to action*' launched on 11 July 2013. Following the consultation NHSE will publish a national strategic framework for commissioning primary care in the autumn, including general practice services, which clinical commissioning groups (CCGs) and Area Teams will use to organise local primary care services, taking into account local issues and patient needs.

Through their recent engagement with general practice, CCGs and other partners, NHSE identified significant challenges and pressures that will necessitate changes in the future development of general practice services. These include:

- an ageing population, growing co-morbidities and increasing patient expectations, resulting in a large increase in consultations, especially for older patients;
- increasing pressure on NHS financial resources, which will intensify further from 2015/16;
- growing dissatisfaction with access to services, with the most recent GP Patient Survey showing further reductions in satisfaction with access, both for in-hours and out-of-hours services;
- persistent inequalities in access and quality of primary care, including twofold variation in GPs and nurses per head of population between more and less deprived areas; and
- growing reports of workforce pressures including recruitment and retention problems.

#### **4.2 Monitor**

Monitor, the health sector regulator, also carried out its own review and consultation regarding access to GPs during 2013. The regulator intends to undertake further work to develop a detailed picture of the nature and extent of supply and demand for GP services across England to understand reasons for variations in access.

#### **4.3 Rotherham**

The challenges and pressures identified at national level are also pertinent issues for Rotherham and were considered by the review group in the context of how they impact on patient access to GPs locally. It should be noted that quality of primary care services was not the focus of this review.

Commissioning and contract arrangements for primary care are very complex. The next section summarises the various GP contracts and the additional services practices may choose to provide, either through enhanced services or by meeting standards in the Quality and Outcomes Framework. There is limited reference to improving access for patients now some past indicators have been removed.

#### **4.4 GP contracts**

Core general practice services in Rotherham are commissioned by NHSE SY&B under three contract types: general medical services (GMS), personal medical services (PMS) or alternative provider medical services (APMS) contracts. In addition to the core essential services local commissioners are directed to provide some services by the Secretary of State and may also decide to purchase additional non-core services, such as contraceptive services. These additional services may be delivered directly by GPs themselves, by nurses and other practice staff, or by other community-based providers, such as community nurses or pharmacists.

##### **GMS contracts**

- traditional nationally negotiated contract held between the GP practice and commissioning body
- renegotiated each year by NHS Employers with the General Practitioners Committee
- less holistic approach as payments are related to pieces of work (payment by results)
- funding per patient based on the Carr-Hill weighting formula (see glossary) that takes account of demographic and socio-economic factors that may affect practice workloads
- the Statement of Financial Entitlements provides a degree of security
- “global sum” covers costs of running a general practice, including some essential GP services

### **PMS contracts**

- locally agreed contract negotiated between the GP and NHSE SY&B
- increased money for doing things differently and can apply for growth money
- contract value for agreed outcomes from a set of services specified in the actual contract
- “freer” than GMS and high trust as not monitored line by line
- the Statement of Financial Entitlements does not apply but is referenced
- tend to be larger practices
- contract content will be influenced by annual GMS contract changes

### **APMS contracts**

- non-traditional providers of primary care such as other companies or social enterprises
- employ salaried GPs and may be nurse-led e.g. The Gate surgery
- there is a contract value and a tendering process based on value for money
- clear key performance indicators and measures in contracts

PMS contracts offer greater local flexibility and were for practices that wished to be innovative and do things differently, to improve the quality of care or to provide new services. For example when they were introduced practices were unlikely to have triage or nurse prescribers. There was also money available for salaried doctors.

Nationally 40% of GPs are on PMS contracts and overall in SY&B contracts are split fairly evenly between GMS and PMS, with slightly more GMS. In contrast in Rotherham 24 practices (75%) hold PMS, eight hold GMS and four hold APMS contracts. Thus the major national review of PMS contracts, described in more detail on page 11, has far greater significance for general practice in Rotherham than for some of our neighbours in SY&B.



Kiveton Park Medical Centre - one of the five practices that participated in the review



#### **4.5 Enhanced services**

In addition to three types of contract for GP core services there are also three types of additional services which all practices, irrespective of contract type, may choose to provide. They entail increased money for additional services beyond the national core specification.

**Directed Enhanced Services (DES)** - Area Teams are obliged by the Government to provide these services for patients in their area, but individual GP practices can choose whether or not to provide them. Standards and prices are set nationally and the list of DES is revised annually. Examples include the extended hours access scheme, learning disability health checks and patient participation scheme.

**National Enhanced Services (NES)** - Area Teams may choose to commission these services depending on local needs, but in line with nationally set standards and prices. They include commonly needed services such as contraceptive services.

**Local Enhanced Services (LES)** - Area Teams and CCGs may design and commission other services in response to specific local need or to pilot innovations. In some cases NES standards are used but adjusted to reflect additional work, otherwise standards and prices are negotiated locally. Examples in Rotherham include the case management pilot (see page 21) and follow up services transferred from secondary to primary care, such as post-operative wound management. No LES is currently planned to improve access to GPs.

#### **4.6 Quality and Outcomes Framework (QOF)**

The QOF is a points-based system that sets targets with financial payments for achieving set levels of performance and the delivery of quality care. It covers both clinical and public health, is revised each year and practices choose to provide these services. The QOF was set up to facilitate change and once practices can demonstrate that a change is mainstreamed it then becomes a part of the core service. Savings released from removing an indicator go back into the global sum or into new enhanced services. For example the patient on-line access for booking appointments and repeat prescriptions was a DES that has been incorporated within the core GMS contract for 2014-15.

Patient experience indicators relating to access have been retired from the QOF. Prior to 2012/13 two indicators rewarded practices for patients being able to access a consultation with a GP within two working days and to be able to book more than two days ahead. The length of appointments indicator, with ten minutes being the optimum for booked appointments and eight for open surgery appointments, has been removed for 2014-15.

The issue of access within 48 hours has attracted extensive media coverage and polarised views – on the one hand there are calls for 48hour targets to be reinstated and on the other calls for further investment in GP practices to address capacity issues. Some consider the former target took GPs away from prioritising appointments on the basis of need. Access within 48 hours was not part of the GP core contract and the pledge “You have the right to access to a primary care professional within 24 hours or a primary care doctor within 48 hours.” is no longer part of the NHS constitution.

#### **4.7 Patient responsibility**

The NHS constitution sets out responsibilities, rights and pledges for patients, public and staff and there is an expectation that patients use health services responsibly and appropriately. Certainly patients can contribute towards improving access, through engaging with practices and providers to raise concerns and barriers, and through their own use of health services, by using the right service at the right time. However this alone will not address wider pressures that are impeding access, but it will contribute at a local level as we await the new national commissioning framework and PMS contract review.



Example of multi-lingual touch screen for patients to sign in at reception for their appointment

## 5. Findings

### 5.1 Roles and responsibilities

#### NHSE SY&B

The Area Team has responsibility for commissioning the core general practice contracts in Rotherham and subsequent contract management. They tend to deal with exceptions as contracts are not always very precise.

A memorandum of understanding has been agreed between RCCG and NHSE SY&B and from NHSE's Phase 1 report following its "Call for action" and evidence presented to this review, more partnership working and joint commissioning in the future between the two seems likely.

#### Rotherham CCG

RCCG has a responsibility to support NHSE SY&B in promoting improvements in quality of primary care medical services. The CCG has agreed a rolling programme of peer review visits with all GP practices in Rotherham, allowing each practice to benchmark itself against other practices, focusing on good practice and service quality.

The CCG commissions additional community based services from GPs that fall outside the scope of the GP contract. It also commissions GP Out of Hours services (OOH) and GP activity at the Walk in Centre (WIC) which are provided by Care UK. The WIC will be co-located with A&E at Rotherham Hospital in 2015, renamed the Emergency Care Centre.

#### Care Quality Commission (CQC)

A programme of visits by CQC assesses compliance of GP practices against the declarations submitted as part of their registration in April 2013. CQC notify the Area Team before they visit a practice and NHSE SY&B has agreed to share any concerns they have with CQC prior to a visit. The focus is on safety and quality of care but access issues are likely to be picked up in conversation with patients. CQC will visit every practice, which the Area Team lack capacity to do, and if there are issues the practice is given a performance notice and has to turn it round.

## GP practices

Individual practices are responsible for staffing and managing appointments and they determine the staff needed to deliver their contract. They have to demonstrate risk analysis and review capacity to ensure sufficiency to meet fluctuations in demand. Measures tend to focus on the number of full time GPs but head count and capacity of GPs and other healthcare professionals is important, so a more accurate measure might be total number of appointments offered.

## 5.2 How NHS England oversees and monitors access to GPs

NHSE SY&B uses the results of the GP patient survey to inform decisions when practices request a change to their contract which might impact on access, such as a change to opening hours or to close a branch. Other nationally collated performance data on a range of indicators is assisting them to develop a picture of local performance of GP practices.

Patient comments are taken very seriously and if there are a number from a specific practice NHSE SY&B will look at the patient survey results first then have the conversation with the practice to ascertain why, for example problems with locums, staff sickness, holidays or maternity leave. If the issue impacts on delivery of services they will talk it through and try and resolve matters but there will not necessarily be extra money.

CQC has greater powers than those of NHSE SY&B in the contracts but the new system does provide more leverage than in the past. Three sources of information helps triangulation – performance indicators, CQC inspection findings and GP patient survey responses, which is positive and avoids over-reliance on one data set.

Members noted that following the changes to commissioning in April 2013 a different relationship exists between NHSE SY&B and GPs compared to the previous one between the Primary Care Trust and GPs. It is now very much one of commissioner and contractors and there is a feeling that NHS SY&B is more remote than the PCT used to be and understaffed.



Members of the review group with health colleagues from the Gate Surgery

### **5.3 National pressures and how NHSE SY&B will respond to national changes**

Current and future pressures have been summarised in section 4.1. The challenge for NHS England is to develop a strategic commissioning framework and new ways of working that will deliver sustainable high quality primary care for all patients and be sensitive and responsive to local pressures and local need. Supply side factors of funding and investment; workforce planning, recruitment and retention; and quality facilities will all need to be addressed to meet growing demand.

Locally the Area Team will be working more closely with the CCG as outlined above and will be responsible for implementing the changes once the new framework is in place. They will also undertake the next phase of the PMS contract review once the mechanism is agreed, which will be a very challenging task and one that is critical to get right.

Workforce planning will be a key focus within the NHSE SY&B five year plan and the Area Team are working with the five CCGs to see how all primary care will be delivered, including services transferring from secondary to primary care.

### **5.4 Local pressures and issues**

The overall health profile, prevalence of long term conditions, deprivation levels and demographics of people in Rotherham, which all impact on need and demand for present and future services, are mentioned above. Further pressures and key local issues are set out below.

#### **Population growth**

Future projections suggest the population of Rotherham will increase by 4% to 269,000 by 2021. Growth in the number of people aged 85+ is expected to increase by 27% in this period and nearly a quarter of our current population is 60+.

The actual number of patients registered with Rotherham GPs in October 2013 was 257,400, with a weighted population of 272,637, which already outstrips the projected figure for 2021. GMS practices are paid on a weighted list and PMS practices receive a locally determined baseline allocation. NHSE is reviewing the Carr-Hill formula to consider whether the existing deprivation factors could be updated in 2014 and to increase the deprivation weighting in 2015.

#### **List size**

Overall growth for the period October 2010 - October 2013 was 0.773% on the raw list (0.727% weighted list) but this fails to reflect variations across practices. Some have had an increase in list size and others a decrease, for reasons such as transient populations, different services offered, redistribution of lists following a practice closure, or patients choosing to register elsewhere. Others may have a more static list size but a high annual patient turnover (over 50% noted in two practices) increasing the practice workload, for example with patient records.

#### **GP workforce**

Rotherham has 46 full-time equivalent GPs per 100,000 population, compared with an average of 47 across the SY&B area and 43 nationally, although the national figure is skewed by one area in London. However this does not provide a true picture of capacity as GPs may provide different numbers of sessions. Practices also often have a wider range of staff in their teams, including salaried GPs, nurse practitioners, nurse prescribers and health care assistants. Practices with PMS contracts secured growth funding to appoint salaried GPs and nurse practitioners who were deemed equivalent to 0.75 WTE GP (whole time equivalent) in terms of contribution to the clinical workload of a practice.



In addition to the ageing patient population in Rotherham there is also an ageing GP population with a large number of GPs and nurses nearing retirement. The situation is exacerbated by recruitment difficulties at a national level meaning an under supply of GPs and practice nurses. Changes to training mean there will be one year with no new registrars coming into the system.

Overall the GP workforce has not kept pace with the population growth and neither has GP funding. The share of the total NHS budget for general practice in England has declined from 10.55% in 2005-6 to 8.39% currently. Income from all block contracts is reducing and costs are increasing, with high technology costs and some local practices have had to make reductions in back office staff.

Despite increasing demand for GP services and the transfer of services from secondary care into the community, workforce growth has been in hospital consultants. Projections for future workforce growth still show consultants in hospitals far exceeding those for GPs (see below). Research by the Centre for Workforce Intelligence supports the view that the GP workforce is not growing as quickly as other areas of the health service. They state that a boost in GP training numbers of 3,250 by 2015 is required to meet expected future patient demand by 2030. Health Education England is mandated to make significant progress towards 50% of postgraduate doctor training being in general practice and it has recently announced a plan to increase the number of GPs being trained each year by 2.7%. However GP training applications have dropped by 15% this year which will further increase recruitment problems.

	No. of GPs (WTEs)	No. of hospital consultants
2002	27,200	24,800
2012	31,700	38,200
2022 projections	37,000	59,000

*Source: Royal College of GPs*

Rotherham is recognised as a challenging community to work with because of the health issues of the local population, which may impact on GP recruitment locally. As there is no medical school here our profile is not as high amongst graduates and there is competition due to a number of options nearby. GPs who are partners are financially attached to a practice whereas for salaried GPs it is easier to move. Future service development needs GP partners but the review of PMS contracts is also deterring practices from taking on the commitment of another GP partner.

In the past there has been pump priming and Members recommend that NHS SY&B considers incentives to attract GPs to start their career in Rotherham following training in the area, such as “golden hellos”.

### **PMS contract review**

NHS England has instigated a national review of PMS contracts with the stated aims being to establish how best to apply the principles of equitable funding to PMS practices and to identify how to get best value from investment in quality improvement and innovation. Area Teams were asked to provide information about existing PMS contracts sub-divided by component parts – payment for core primary services; for innovation and improvement; and for enhanced services. This is in order to determine the outcomes that the “PMS premium” provides over and above equivalent services provided by GPs on GMS contracts, adjusted by population weighting, as there is a view in some quarters that GMS practices have “caught up”.

NHSE calculated that it pays on average a premium of £13.52 for patients registered with a PMS practice. The PMS premium is not distributed equally across all PMS practices and does not correlate with the Index of Multiple Deprivation scores. Future investment of the “premium” element of PMS funding will need to comply with a set of criteria developed by NHSE and be clearly linked to enhanced quality or services, or the specific needs of a particular population.

This is a challenging and complex issue beyond the scope of this review to cover other than in the broadest of detail above. However in the context of local pressures this review has immense significance for Rotherham given the prevalence of PMS contracts here. The Local Medical Committee has lobbied the British Medical Association and the Royal College of GPs, as local GPs view the review as a real threat fearing it will result in the removal of resources from primary care in Rotherham.

In the 1990s Rotherham was under-resourced for doctors leading to growth money for extra staff, and to provide more services, which 60% of practices applied for and received. Primary Care Trusts added key performance indicators annually to continue to get growth money, which were then rolled up in the overall contract. Locally there is no conflict between our practices on GMS or PMS contracts and the PMS contracts include all the GMS contract content.

Under this PMS review all the growth money is going and funding per patient could be equalized across all practices, irrespective of practice demographics, levels of disease and ill-health and socio-economic factors. As yet the extent and the review mechanism are unknown as no guidance has been issued at the time of writing, but there will be a knock on effect on access as practices will be in difficulties, some perhaps becoming non-viable, and with reductions in staffing. Area Teams will have two years from April 2014 to review all the present PMS contracts and then two years to implement changes.

This proposed blanket approach takes no account of the individual workloads and practice populations of different PMS practices nationally. As stated earlier GMS contracts are based on the Carr-Hill formula with weighting for socio-economic and demographic factors, but this does not apply to the PMS contracts. If there was one overall funding pot, divided by population and then adjusted for local socio-economic factors etc. this was deemed more likely to be acceptable to all GPs.

Members wish to express their serious concern about the impact this PMS contract review will have on Rotherham, both for individual practices and for patients. They recommend that the Health and Wellbeing Board take a proactive approach to mitigate risk with regard to future capacity to deliver primary care.

### **Accident & Emergency Department (A&E)**

National statistics would suggest that between 15-30% of attendances at A&E could and should be dealt with through primary care via the GP surgery, but it is difficult to assess with factual accuracy. In Rotherham the overall attendance rate at A&E has not significantly increased over the last two years, although the acuity and the number of frail elderly patients attending have risen. Patients are attending A&E who should be going to their GP, but it is difficult to quantify the extent to which this is due to poor access to GP appointments. The A&E department does not collect this specific data.

The hospital and RCGP have previously surveyed patients to ask them why they use A&E in this way and anecdotally patients will say it is because they cannot access their GP. However, this is difficult to validate and often it is because they cannot get a convenient appointment (rather than a timely appointment) and because they perceive their need is urgent when it is not. The A&E department at Rotherham has GPs working in the department seeing these patients, which includes re-educating them about where they should have been seen. One practice is aware of some frequent attenders at A&E and is trying to educate them to attend the practice.

Cultural norms also influence patient behaviour with regard to accessing health services, with some communities tending to go straight to A&E as they are used to going to a hospital if they are unwell rather than a small GP practice – again this is a question of patient education.

### **Protected learning time (PLT)**

PLT is a planned programme of training and education for practice teams, taking place bi-monthly on Thursday afternoons. It is well attended and includes issues such as safeguarding, safety, latest guidance and working with key groups of patients, which are all important for improving services. The meetings focus on clinical areas, often spanning primary and secondary care and aim to ensure that the services are well understood by those who make referrals to them or deliver them. This would also therefore provide an opportunity to share good practice on ensuring access to services.

Practices close for the afternoon and RCCG pays for out of hours cover, which is provided by Care UK (details below under Walk in Centre). This means all practices in Rotherham (including the smaller ones and the six single handed practices who generally struggle to release staff for training) are able to attend. However it can create pressures, as Members noted that PLT events had on a small number of occasions led to the WIC becoming clogged, which is supported by the information provided by Care UK. RCCG should use the monitoring data to ensure adequate cover in the future.

### **Walk In Centre (WIC)**

When patients present at the WIC they complete a registration form that includes the reason for attendance i.e. the presenting condition, which allows the WIC to identify any immediate patients. Patients often do say they are there because they cannot access their own GP, or that they are seeking a second opinion, or that they cannot wait to see their own GP, even if their appointment is the next day. Patients also advise that sometimes they have been referred by their practice if no appointments are available and on occasion Care UK (the service provider) do check with the practices concerned, especially if they are seeing high presentations on one day for a particular practice. Care UK do not read code such information as part of the patient's record so it is not reportable, but they do report on the activity coming from GP practices within the area and this provides some trends. There was no opportunity to explore this further in the review.

The OOH service currently provide call handling, GP triage and treatment where appropriate, with either the patient attending the WIC for a booked appointment (where transport can be provided if required) or the doctor visiting the patient at home. The service provides this same cover for PLT sessions, usually from 12noon until 8am the following morning. The "see and treat" element of the OOH is co-located within the WIC, so on a PLT afternoon the WIC will have two patient streams presenting, those with pre-booked appointments via OOH and those just walking in. PLT events do impact on the WIC as patients whose GP practice is closed but covered by the OOH still choose to walk in rather than ring OOH first. An advantage of having both services co-located is that they can move clinical resource across both service streams to meet demand. Care UK is given the PLT schedule in advance for the year so this should help to anticipate demand and plan resources. RCCG will be taking the impact of PLT into account at the new Emergency Care Centre.

As expected for the relevant dates in November to February for PLT there was a significant increase in numbers for the OOH service, with approximately 50-60 more patients on the Thursday than on the Wednesday or Friday either side. Numbers attending the WIC on those days however were not noticeably higher than the norm, perhaps suggesting people might have had to wait longer if there were more patients who had pre-booked appointments via OOH.

### **Moving services from secondary care**

There are a range of options for some services; ones that may be delivered at the hospital and/or by GPs, and other specialisms that could be delivered by secondary care professionals in a GP setting. The CCG have transferred some follow up services from secondary to primary care, such as the wound management LES. More are likely to follow in a planned funded

transfer, but this will need to be well managed to avoid compounding existing access and capacity issues, linking to workforce planning and premises.

### **Premises**

Many factors impact on a practice maintaining good access to services, including premises. It is not only a question of physical access to and within a building for patients with mobility impairments and parents with pushchairs, but may also be a shortage of treatment or consulting rooms. Many older buildings were not designed to accommodate the range of services now commonplace in primary care and new buildings or extensions (where space allows) provide an opportunity for redesigning the way a practice delivers services to meet demand. Premises are an issue for GPs who will face a large increase in list size or an increase in patients with specific care needs, for example as a result of new housing developments or new private sector residential care facilities locating in their area. Practices are not always involved in consultation or discussion about new developments at an early stage.

Improvements to premises or new buildings are funded through Private Sector Capital Grants. GP practices are asked to submit a project initiation document (PID) to the Area Team and if the Area Team supports this in principle it is then considered at regional level. If region also support the PID the Area Team then look at potential means of funding. An audit of estate is planned by NHSE SY&B, including potential spare space in other public sector buildings.



Treeton Medical Centre - one of the five practices that participated in the review

### **5.5 How GP practices manage appointments and promote access**

Nowadays people are encouraged to be more proactive about their own health and to seek advice earlier with concerns or health problems. However some witnesses felt that people tend to see their GP more readily these days for minor things; going to their GP for general advice or advice that they could obtain from pharmacies, nurses or NHS 111. It might be difficult to address this without more use of triage or increasing the number of doctors. Many patients do have a positive long standing relationship with their GP, but more general awareness raising is



needed to recognise the support and services available from other services and health professionals (as in the Choose Well campaign). Balancing the different priorities and expectations of patient groups is a key question, summed up in this extract from Monitor's report:

"... different patient groups want different things from general practice. In particular, for many older patients, those with long-term conditions, disabilities or communication and language barriers, continuity of care is an important requirement. These patients prefer to develop an ongoing relationship with an individual GP who can help them to manage their treatment and co-ordinate their care. Many time-constrained or less frequent users of general practice place a greater emphasis on swift and easy access than on continuity of care."

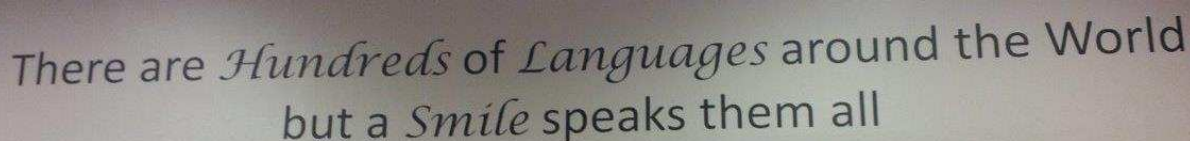
### **Opening hours**

Each practice is required to offer sufficient access to services during the core hours of 08:00 to 18:30 Monday - Friday to meet the reasonable needs of its patients. Standard booked appointments are for ten minutes although some practices offer the facility for patients to book double appointments if necessary.

An Extended Hours DES was introduced in 2008-9 and has been rolled over each year. In 2014-15 it allows greater flexibility for practices to work together in order to provide the most appropriate service for patients. 29 out of 36 practices in Rotherham provide additional appointments outside core hours: in total 92 hours and 551 additional appointments (as at December 2013) with a mixture of early morning and/or evening appointments. (See Appendix B for the practices in this review.)

Early morning appointments are intended to help working people who may find it difficult to take time off work to attend their GP practice. However anecdotal evidence from practices suggests these are not always taken up by working people but by retired people who get up early. It is a question of balance as GPs do not want to waste appointments. Finding it difficult to take time off work may be one reason why people working in or near Rotherham town centre might elect to use the WIC, including for non-urgent appointments. From the GP patient survey (GPPS) question which asks if working people can take time off work to see a GP 34% of respondents in Rotherham in the first data set, increasing to 36% in the second said no, compared with England overall with 32% in both. (See Glossary for details of survey dates.)

Based on GPPS results 81% were very or fairly satisfied with the opening hours at their practice. 79% agreed that their surgery was open at convenient times for them with 15% saying no and 6% who did not know. For the 15% who said no, Saturdays and after 6:30p.m. would be additional opening times that would make it easier for them to see or speak to someone - 73% for both slots. Seven day working across the health and social care sector, linked to hospital discharges, is a focus of discussion nationally but it is difficult to see where the additional resources would come from to sustain services for seven day working, given current recruitment issues and the ageing GP workforce.



*There are Hundreds of Languages around the World  
but a Smile speaks them all*

One of several positive messages at the Gate surgery

### **Appointment systems**

Practices offer a range of appointment systems, combining some or all of the following methods: – open access surgery (sit and wait); booked appointments (on day and in advance);

emergency appointments; home visits; appointment letters for specialist nurses/clinics; telephone triage; and on-call doctor as well as booked appointments. Many send text reminders about appointments the day before.

All the practices involved in the review have appointment booking in person, by telephone or on-line. Currently the take up of on-line bookings is low and any that are not booked by a certain cut off point are freed up for other patients. One practice said they did not anticipate a large demand for on-line services as most of their patient population were not on-line at home.

Rotherham is beginning to introduce more triage, particularly later in the day, but this is not always well received by patients. Practices themselves report varying experiences of using triage with one practice having stopped as they were overwhelmed by the volume of calls and found it difficult to identify immediate clinical need. In contrast another practice (not visited in the review) is introducing a new triage system. Practices mentioned patient behaviours and expectations:

“They might say they need an emergency appointment and then mention four or five different things, so the practice would deal with the urgent one first and reschedule an appointment to deal with the rest”.

“We still have a high number of patients who insist on seeing a GP when a nurse would be more relevant and able to deal with their problem.”

“Has been known for people to ring on the day for an appointment, get one booked and then DNA.”

No “one size fits all” given the differences between practices and it is positive that more practices have signed up for the extended hours DES. Members recommend that all practices consider part of each day for sit and wait appointments. This would be popular with patients and avoids early morning phone pressures as patients report frustration at being asked to ring at 8a.m., take numerous attempts to get through and when they do no appointments are left. Statistics on waiting times to obtain a GP appointment are not routinely collected. One advantage of having a telephone queuing system is that it advises people how long they are likely to wait before their call is answered, which is better than constant engaged tones.

Practices emphasised how helpful it is if patients are willing to provide more detailed information when contacting them for an appointment. This assists them in assessing the situation and identifying the most appropriate person in the practice team to provide the service needed, which often does not have to be the GP. Members recognised the barriers to this approach, such as a possible lack of privacy in some reception areas to talk about personal issues or unwillingness by patients to divulge what they feel is personal information to non-medical staff. Potentially this is another area where the Patient Participation Groups (PPGs) could assist.

This also links to reception staff training as there are complaints about receptionists being grumpy and unhelpful. Public perception is often that they are a barrier, although the GP satisfaction survey results are good with 88% saying receptionists were very/fairly helpful. Ideally the focus should be to “work with patients” to find a system that works for both practices and patients.

“Great service, have always been able to get same day appointment or following day.”

“Getting an appointment hard. 8a.m. there is a queue. Have to wait over 3 weeks”

“ ... Practice Manager always calls back within 24 hours. Reception’s extremely helpful.”

“They always ask what is wrong even when it is personal.”

*Source: Healthwatch*

## Missed appointments - DNAs

It is important to raise understanding with patients that if they no longer need a booked appointment, or are unable to attend, they should inform the practice. Non-attendance means lost clinical time and reduced numbers of appointments available for others to book, which also leads to poor patient survey results.

Statistics on non-attendance, known as DNAs (Did Not Attend), are not routinely collected but NHSE SY&B provided statistics for two practices and the indication is that DNAs are significant for many practices. Booking appointments well in advance seems to increase DNAs. NHSE SY&B intend to survey all practices to identify the rate of DNAs. What is not known is the specific reason why a patient did not attend or cancel.

	April – June 2013		July - Sept 2013		April – Sept 2013			
	Appts offered	DNAs	Appts offered	DNAs	Total No. appts offered	Total No. DNAs	Total DNA as % of appts offered	Clinical time (on an average 10 minute appt)
<b>Practice Y</b>	7,099	879	7,340	939	14,439	1,818	12.6%	Approx. 300 hours
<b>Practice Z</b>	unknown	415	unknown	408	unknown	823	unknown	Approx. 137 hours

DNAs are important given the preponderance of practices that only have booked appointments, which can lead to people going elsewhere, such as the WIC or A&E. As well as encouraging patients to cancel unneeded appointments the issue is also how to free up appointments for others. One advantage of open surgeries with “sit and wait” appointments is no DNAs and no wasted clinical time, although there could still be DNAs for any clinics running simultaneously.

The QOF discouraged the “sit and wait” system as the performance indicator required a fixed number of appointments and at that point practices moved away from open systems. As the QOF indicators have gone this could be an opportunity to encourage more sit and wait appointments, although GPs are concerned about potential large queues of patients waiting for the surgery to open and waiting room size can be an issue in smaller practices.

Some practices will implement sanctions if patients are constantly not turning up, but these are limited and quite rare – usually a letter to say the patient is no longer registered with the practice or directing people to open surgery in the future if the practice has that in place. One practice explained that with DNAs they check why the person was coming and if it is important that they are seen they will follow up with them and rebook.

In order to reduce DNAs some practices send reminder texts as a matter of course to their patients who have a mobile phone. This has helped but means keeping records up to date with contact numbers. Reminders on practice websites and in PPG newsletters (as in the example below) also emphasise the importance of cancelling appointments if unneeded or if the patient is unable to attend. Practice leaflets should include information to help raise awareness.

“We send an automated text message to remind you of any appointments you may have as a courtesy. It is still **YOUR** responsibility to remember your appointments and contact the surgery if you cannot attend as this appointment can be used for another patient waiting to be seen.”

As well as working closely with the PPG and the CCG patient network to raise awareness of this issue, and to educate patients about the importance using the appropriate service, partners could consider revisiting the local Choose Well campaign to include DNAs. The campaign is conducted through a variety of media and was sustained over the winter period to address winter pressures focused on ensuring that patients access the right service at the right time.

## Out of Hours Service

This service provides cover when GP practices are closed, including for the PLT sessions as above. Although the GPPS showed 43% of respondents do not know how to access the OOH service, if patients ring their practice when it is closed they are automatically connected to the OOH service. Websites and practice leaflets have the relevant information.

The OOH service uses some locums and some local GPs, not free lancers but salaried regular staff. Most of the service consists of telephone advice or patients going to the WIC rather than home visits (see Appendix D for an overview). Home visits are mainly lone, elderly people without transport and where needed end of life care plans are shared with OOH providers; another example of good practice. As expected highest demand is during weekends and bank holidays, with an increase also on PLT dates.

Care UK report to RCCG, who together with the other four CCGs in the area, meet with NHSE SY&B regarding quality, outcomes and delivery. Ideally in the longer term there would be a common electronic patient records system shared between practices, A&E and the OOH. The OOH service meets the needs of GPs, standards have increased and the service received an improved satisfaction rating for overall experience in the patient survey of 71.5% (Appendix C).



## Welcome display in reception

## Patient participation

Most practices have participated in the Patient Participation Directed Enhanced Service which has run for the last three years, is extended for a further year from April 2014 and is likely to continue in future years to encourage patient input on health and service design. It incentivises practices to establish (if not already in place) a patient participation group (PPG), jointly determine priorities to improve services, elicit patient feedback via a questionnaire and then agree with the PPG what actions the practice can take to make improvements. This presents



an ideal opportunity for patients to raise access and appointment systems if they feel they are not working well. One practice Members visited had prioritised the appointment system with its PPG for the patient survey and as a result increased staff to answer the phone at peak times.

Area Teams validate the practices against the national specification and monitor the action plans encouraging “quick wins” first so that patients see their involvement is contributing to positive change. From December 2014 participation in the Friends & Family Test will replace the requirement for local surveys.

The PPGs are viewed as worthwhile, although ensuring representativeness of the local community is important. Some practices have both a group that meets regularly and also a virtual group with communication by email/text/phone, which enables more patients to be involved who may face constraints in attending meetings. The CCG engages with the PPGs and values the input from the groups, working with them to develop a CCG patient network. They also actively encourage GP practices to share good practice about successful groups. Several practices already had patient groups prior to the DES so hopefully the DES will have facilitated new groups that will be sustained in the future.

The PPGs will be a key group to help drive improvements to access in their practices and they could also help with the awareness raising that is needed about using the right services and cancelling unneeded appointments.

### **GP practices in the review**

Members of the review group visited four very different practices in the borough and received a completed template from the fifth. Practices received a copy of the questions used as the basis for discussion in advance (see Appendix A). The willingness of the practices to participate in the review was appreciated by Members who valued the opportunity to talk directly with GPs and their staff about their experiences of improving access and managing appointments. Appendix B provides an overview of the five practices involved, showing how they vary significantly in terms of size, patient demographics and appointment systems. Below are some of the key points noted:

- flexibility in their approach to appointments – changing systems if they were seen not to be effective
- keenness to involve patients, either through their PPGs or “question of the month”, and a member from one PPG took part in the discussion with Members
- mix of male and female GPs in all practices
- practices said they see all unwell children and would not send anyone away who needed to be seen

### **Good practice - communication and improving access**

Excellent examples of good practice to ensure access to GP services through effective communication and taking account of patients’ needs were noted during the review. A particular highlight was the UCount2 young people’s clinic at Kiveton Park (see below).

Members are keen to ensure a regular opportunity to share good practice between GP practices on improving access for patients and examples of effective communication is developed and maintained, possibly through the Practice Manager Forum or a PLT event.

## UCount2

Youth clinic aimed at young people 12 – 25 years, held twice a week on Tuesdays and Thursdays from 3.30–5.00pm in school term time. Advice and help is provided on all matters of health and living including stress, growing, bullying, relationships, contraception, sexuality, drugs and alcohol. It is open to any young people in the area. No appointment is necessary and confidentiality is strictly maintained.

Young people had input on what they wanted at the clinic and on the décor of the dedicated space. They are given a small card with the details on and when the youth clinic is closed they can go to reception with their card and will be interviewed by a nurse in a small interview room. All young people are sent a birthday card when they are 13 with details of UCount2.

### **Black and Minority Ethnic communities**

The Black and Minority Ethnic (BME) population in Rotherham is 8.1% (2011 census) which is lower than the national average. However several practices have a much higher percentage BME population, ranging from 10.3% to over 50%, and are also located in areas with higher than average deprivation. These practices also have a higher than average patient turnover. A growing number of languages are spoken in the Borough and although not as high as in Sheffield (over 90), in schools in Broom and Canklow for example there are approximately 25.

The Gate surgery is a small specialist practice established specifically to meet the needs of some of the most vulnerable and marginalised groups. As such it does not have a set geographical boundary and also serves a very transient patient population. The practice has a multi-lingual welcome display in reception and signage/log-in screens in several languages. Staff engage with patients, including through the provision of health clinics at a local third sector organisation. Initial assessments for new patients are very in depth, including social issues. The surgery encourages patient involvement through ad hoc mini surveys and a “question of the month” on the notice board in reception.

### **Good practice: Languages**

- Language cards on reception to pinpoint the language
- Use of Google translate and other more technical medical on-line translation software
- Multi-language cards on reception with common problems to help identify initial needs
- Face to face and telephone interpreters (recognising the appropriate method depending on the circumstances)
- Booking interpreters in advance for full sessions as some are more difficult to book, which is also more cost effective
- Asking the patient to say back to them what has been said/agreed so they know the patient has a clear understanding

Practices have access to interpreting services commissioned South Yorkshire wide, but these are discretionary rather than mandatory services. Members noted the good practice in communicating with patients, but did have concerns about the use of family members, especially children, as interpreters. Care also has to be taken with free on-line translation services as they can produce some inaccurate results. All GPs and their staff need to feel confident in using telephone interpreters, with training provided to instil that confidence. Members recommend that NHSE SY&B continues to fund and commission interpretation services as they are very necessary for safe and effective consultations with patients. They recommend that NHSE SY&B should also review current provision to see if economies could be achieved through signing up to Rotherham MBC’s framework agreement.

## Learning Disability, Autism and Sensory impairments

Practices were confident they knew their patients well and could take account of their individual needs. All used markers on patient records to identify support with communication. Good practice examples are included below.

### Good practice: Learning Disability and Autism

- First or last appointments in the day if that suits the patient better
- Use of alternative entrance so no need to go through reception if that would be stressful for the patient
- Designated staff with special interest in learning disability
- Easy to read information
- Ringing patients to talk to them rather than sending letters
- Patients are asked if they want to bring a family member/carer with them for support if this seems better for their care
- Ringing patients if they have missed an appointment
- Staff participating in well received training delivered by Speak Up
- Registers of patients with learning disability

### Good practice: Sensory impairments

- Pen and notepad handy on reception for deaf and hard of hearing patients
- Hearing loops and BSL interpreters
- Explaining procedures very clearly to blind patients

## Older people

From the Support for Carers scrutiny review last year Members were aware of the positive work taking place through the Integrated Case Management pilot. GPs lead a multi-disciplinary team of health and social care professionals working with a group of patients with long term conditions to signpost them to early support. 88% of practices took part and there are over 6000 plans in place. Linked to this is the Social Prescribing Service pilot which enables a link from GPs through a number of VCS Advisors into the VCS sector and the various alternative support options to help meet non-clinical needs of patients and to support carers.

This work links closely to the new one year DES introduced for 2014-15 - *Avoiding unplanned admissions and proactive case management of vulnerable people* which aims to improve services for patients with complex health and care needs who may be at higher risk of unplanned admission to hospital. One element of this is to improve access to telephone appointments, or where required, consultations, for patients identified in this service.

It is not envisaged that the new requirement to have a named GP for over 75s will have a knock on effect on access for other patients as all patients are registered with a GP now. The named GP will have overall responsibility for the individual patient i.e. in a care coordination role (as in the pilot above), but other GPs may still be involved in the care of that patient. Concerns raised by GPs were if it leads patients to believe they can only see their named GP when they make an appointment, or if they expect to see that GP every time, which might not be possible.

### Good practice: Older people

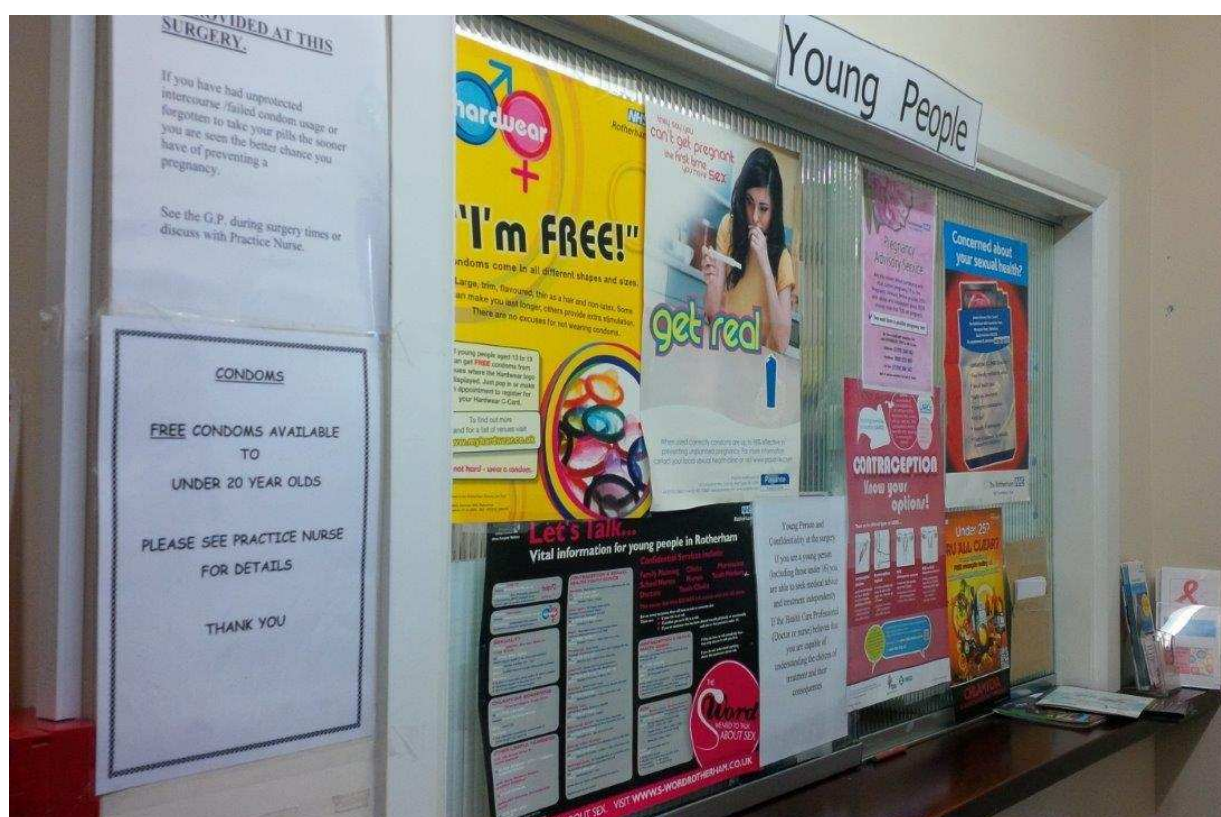
- Folder for patients with all necessary information in case of emergency or need to use OOH, as no standard IT system for sharing patient electronic records between all health providers
- Social prescribing to voluntary and community sector support

## Young people

Members noted the positive work to ensure their practices were friendly and welcoming for young people, although a couple of practices thought they could develop more. Engendering health awareness at a young age is central to the prevention and early intervention agenda and will hopefully encourage more young people to make positive choices about their own health and wellbeing, sustained throughout their lives, resulting in a reduced demand for healthcare.

### Good practice: Young people

- Young people-friendly display in reception – health, sexual health and contraception, with confidential access
- U16s can see a nurse on their own
- Links with local schools – young people attending the practice as a group from school or practice staff attending school assembly
- Treating young people with respect and being sensitive and discreet in reception
- Involved in PPG



Display targeted at young people in Greenside Surgery - one of the five practices that participated in the review

## Modern Technology

Moving any services to more on-line access raises concerns about people who do not have smartphones or computers, or ready access to the internet, particularly older people or people from less affluent communities. Conversely computers and mobile phones can be invaluable for people who find it difficult to leave their home or who have computer software to facilitate communication. In other parts of the country practices report success with online consultations and there are increasing IT skills across all age groups.

It is a question of balance and ensuring good access for all patients through a range of means. Encouraging the use of new on-line systems and new technology could start with new patients when they first register and with younger patients who are often more accustomed to using the internet and new technology.



NHSE SY&B should consider developing an App with practice information that people with smartphones and tablets can download to assist them with knowing about opening times, OOH and so on, on the lines of the Nottinghamshire model.

## 5.6 GP Patient Survey

This is a national survey conducted annually and the patients invited to participate are a percentage of those seen in the last six months by their GP practice. The surveys are useful for comparative purposes with results available nationally, by clinical commissioning group and by GP practice. However it must be noted that sample sizes are small (approximately 4400 respondents for Rotherham in total) and for smaller practices and those with a high patient turnover there may be few respondents (under 30 for several). Nonetheless the information provides some indication of satisfaction levels with each practice, its services and their availability to patients.

Table 2 in Appendix C shows a downward trend for the overall satisfaction measures. However Rotherham is performing better compared to other areas in SY&B and England as a whole, except for overall convenience of making an appointment. For the questions most relevant to this review Rotherham generally mirrors the national pattern at CCG level, with 1 or 2 % variations (positive or negative) from the national average, but with some significant variations between the 36 individual practices in Rotherham.

Some of the key results are given below and others are referred to directly in the text. The survey shows the range of patient experience and also the differences in patient behaviour regarding how far in advance they contact the practice to make an appointment, although overall in Rotherham 40% wanted one the same day. The main reason for not being able to get an appointment/convenient appointment was that there were none on the day the respondent wanted (51%), but even then 42% did go the appointment offered.

GP Patient Survey	Data collected July 2012 – March 2013			Data collected Jan 2013 - Sept 2013		
Question	National	Rotherham overall	Rotherham range for practices	National	Rotherham overall	Rotherham range for practices
Ease of getting through to surgery by 'phone – very or fairly easy	75%	75%	50-98%	74%	73%	49-99%
When did you want to see/speak to them i.e. GP or nurse:						
Same day	41%	40%	23-62%	42%	40%	18-63%
Next working day	12%	13%	3-27%	12%	14%	4-26%
Few days later	24%	23%	9-39%	24%	24%	8-42%
Week or more later	6%	6%	0-23%	6%	5%	0-17%
Able to get an appt						
Yes	74%	73%	57-96%	73%	73%	53-92%
Yes but had to call back closer to or on I wanted	13%	12%	0-27%	13%	11%	0-24%
No	10%	10%	0-18%	10%	13%	1-24%
How long until you saw or spoke to GP/nurse:						
Same day	36%	34%	10-65%	37%	34%	11-62%
Next working day	13%	13%	4-42%	13%	14%	3-44%
Few days later	33%	35%	15-57%	32%	34%	15-58%
Week or more later	15%	16%	3-42%	15%	16%	1-49%
Convenience of appt						
Very	47%	48%	29-83%	46%	48%	24-78%
Fairly	46%	44%	17-61%	46%	44%	22-62%
Not very /not at all	8%	8%	0-16%	8%	8%	0-19%

The main indicator that does stand out is the number of respondents saying they went to either A&E or the WIC if they were unable to get an appointment/convenient appointment with their GP. Nationally the response was 9% whereas in Rotherham it was 15%, rising to 18% in the second data set. In contrast fewer respondents in Rotherham decided to contact their surgery another time than across the country – 8% in Rotherham compared with 13% nationally. This demonstrates there are patients who experience difficulties and it comes back to striking a balance between clinical need, patient expectations and convenient access.

## **6. Conclusions**

As the NHS undergoes considerable change this is presenting difficulties and challenges for practices and patients. As so much is determined at national level scope for change at local level through effective commissioning of services matched to local need and sharing innovative practice is paramount.

There are no simple solutions to improving access to GPs when resources are increasingly under pressure. On the supply side there is reducing funding, shortages of GPs and nurses, and premises that are not always suitable for the increasing range of services now delivered at GP practices, especially with the transfer of services from secondary care. Patient demographics with a growing and ageing population, coupled with the prevalence of ill health and long term conditions, and local deprivation in some areas, means increasing demand. This needs adequate resourcing to ensure good access to services for all patients.

Patients' experiences of accessing GPs do vary from practice to practice; their expectations and preferences are changing, and it comes back to striking the balance between clinical need, patient expectations and convenient access.

GPs offer a range of appointment booking systems and one size doesn't fit all given the variations in practice size and practice populations. Members noted some very good practice and willingness to trial new systems but would like to ensure all practices adopt hybrid and flexible systems, including considering opening up some time each day for sit and wait appointments.

Patient voice is important and NHS England needs to ensure that patients' views on access are heard. There is scope to build on the improvements already seen through the involvement of the patient participation groups.

GP practices should regularly share best practice on providing good access to patients, as the review highlighted innovative practices around flexibility, communication, meeting the needs of different groups, and youth clinics for example. Access to professional interpretation services is important to ensure effective and safe communication with patients and should be maintained.

Patients need to be encouraged to be more proactive and to assume greater responsibility for their own health, described by one local GP as "empowered patient self-management. Patient education to support this is important. There is a need for generic information about which is the right service and the right health care professional and specific information about how their own surgery works, as it varies from practice to practice. Patients failing to cancel unneeded appointments, known as DNAs, seem to be an increasing problem and public awareness needs to be raised about the negative impact this has.

Gaps in management information exist that would help to build a fuller picture of patient access to different health services and reasons for their choices. Statistics on waiting times for GP appointments; DNAs and the reasons why; and statistics on why patients chose to go to A&E or the Walk in Centre when they should have been treated at their GP practice, are not routinely

collected. However usefulness would need to be balanced against the time and costs of data recording and analysis, potentially resulting in less time with patients.

The PMS contract review is a major concern as Rotherham is in danger of losing significant resources as the majority of our practices have this type of contract.

In light of the future challenges for Rotherham outlined in this report, the review recommends that a proactive approach is taken by the Health and Wellbeing Board to mitigate risk in relation to the capacity to deliver sustainable and accessible primary care for all our community.

## **7. Recommendations**

### **Improving access**

1. Patients' experiences of accessing GPs vary from practice to practice; therefore NHS England needs to ensure that patients' views on access are reflected in the forthcoming Personal Medical Services contract re-negotiations and five year commissioning plan.
2. The continuation of the Patient Participation Directed Enhanced Service in 2014-15 should be used to ensure patients are well informed and empowered through the Patient Participation Groups to challenge poor access and suggest improvements. All practices should be encouraged either to participate in the PPDES or to establish other effective mechanisms for ensuring patient engagement.
3. Although recognising the importance of clinical need, the expectations and preferences of patients are changing, and practices should explore more hybrid and flexible approaches to appointments. All GP practices should be encouraged to have a part of each day for sit and wait slots.
4. NHS England should maintain access to interpretation services for GPs, with an emphasis on professional services, supported by training for GPs and practice staff to increase confidence in using telephone services where appropriate.
5. NHS England should review their current interpretation provision to see if economies could be achieved through signing up to Rotherham MBC's framework agreement, which is open to partner agencies.

### **Sharing existing good practice**

6. GP practices should regularly showcase best practice and share successes on providing good access to patients through existing means such as the practice manager forum and Protected Learning Time events. (Please see pages 19-22 for good practice examples.)

### **Improving information for patients**

7. Patient information and education is important, both generic information about local services and specific information about how their surgery works.
  - a. GP practices should ensure their practice leaflets and websites are kept up to date about opening times, closure dates for training and how the out of hours service works.
  - b. NHS England should explore developing an App with practice information that people with smartphones and tablets can download.
  - c. Health and Wellbeing Board should consider developing a borough wide publicity campaign to raise awareness about the impact of not cancelling unneeded appointments.

- d. GP practices should work with their reception staff, patients and Patient Participation Groups to encourage patients to provide more information to staff when contacting the practice, enabling them to see the right person in the practice team.
- e. Health and Wellbeing Board should consider revisiting the “Choose Well” campaign to raise awareness of how to access local services and which is the most appropriate service in a range of situations.

### **Capacity to deliver primary care**

- 8. In light of the future challenges for Rotherham outlined in the report the review recommends that a proactive approach is taken by the Health and Wellbeing Board to mitigate risk to the delivery of primary care.
- 9. NHS England should consider incentives to attract GPs to start their career in Rotherham following training in the area, to help address the demographic issues of our current GPs.
- 10. Rotherham CCG should collect and analyse monitoring information to ensure services are resourced to meet peaks in demand during protected learning time at the new Emergency Care Centre from 2015.
- 11. NHS England needs to be more proactive in managing increases in GP demand due to new housing developments, rather than waiting for existing services to reach capacity.
- 12. Rotherham MBC, when considering its response to the scrutiny review of supporting the local economy, should ensure health partners are invited by the Planning Department to be part of the multi-disciplinary approach to proposed new developments.

## **8. Thanks**

Our thanks go to the following for their contributions to our review:

### **Partners**

Dawn Anderson - Rotherham Clinical Commissioning Group  
Louise Barnett - Rotherham Foundation Trust  
Nathan Batchelor - Rotherham HealthWatch  
Garry Charlesworth - NHS England  
Thomas Cook - Care UK  
Karen Curran - NHS England  
Chris Edwards - Rotherham Clinical Commissioning Group  
Eleri de Gilbert - NHS England  
Victoria Linden - NHS England  
Dr Chris Myers - Local Medical Committee  
Dr Neil Thorman - Local Medical Committee  
Edith Whitehead - NHS England

### **GP practices in Rotherham**

Greenside Surgery  
Kiveton Park Medical Practice (including a member of their Patient Participation Group)  
The Gate Surgery  
Treeton Medical Centre  
Woodstock Bower Surgery

## **9. Background papers**

Written information from NHS England Area Team September 2013  
Report to Health Select Commission 12 September 2013  
Notes of briefing meeting with NHS England Area Team 25 November 2013  
Notes of evidence sessions on 18 December 2013 and 24 March 2014  
Notes of visits to GP practices January – March 2014  
Written information from Care UK, HealthWatch, RCCG and TRFT March 2014  
National Patient Survey Data – June 2013 and December 2013

Rotherham Health Profile 2013 – Public Health England  
Improving General Practice – A Call to Action - NHS England 2013  
Improving General Practice – A Call to Action, Phase 1 Report - NHS England March 2014  
Right care, first time Report on outcome of public consultation - Rotherham CCG 2013  
Commissioning Plan 2014 - 2019 Rotherham CCG  
Discussion document following Monitor's call for evidence on GP services -  
Monitor February 2014  
Primary Care Today and Tomorrow, Deloitte 2012  
Review of PMS Contracts NHS England February 2014 Gateway Reference 01091

Access to GP Services Specialist Scrutiny Panel report – Ealing June 2010  
Access to GPs Report from Sheffield LINK January 2011  
Access to GPs in Bexley Briefing for Health OSC September 2012

## Access to GPs scrutiny review

Date	How does the practice organise its appointment system? (e.g. sit and wait, slots kept for emergencies, all pre-booked).  How can patients make an appointment? (e.g. on line, phone, in person)
Name of GP practice	How willing are patients to see another member of the team, other than a GP, who can provide the health care or service they require?
Review group members present	Are there a significant number of people who make appointments and do not attend, without letting you know?
Representative from Speak Up	Demographic profile - anything significant for your practice such as higher or lower numbers of a particular group than the Rotherham average e.g. by age, ethnicity?
Officer support	Rotherham has an ageing population and high incidence of limiting long term illness. Will GPs in Rotherham be able to cope with the anticipated rise in demand?  Especially with a named GP for over 75s?
Staff involved from GP practice (name and role)	How do you ensure effective communication with: - people from Black and Minority Ethnic communities; - people with learning disability; - people with visual or hearing impairments?
Contract type  PMS/GMS/APMS	How are you planning to move to more on-line services? How will that impact on your practice and patients?
Single site or multiple	How do you ensure your practice is “young people friendly”?
Single GP or partnership (no. FTEs)	Is there much demand for the out of hours service?
Total staff and their job roles/hours.  Gender mix of staff/GPs.	Do you have any innovative approaches to patient access that you would like to highlight? Or ideas for improvements?
List size and any significant recent changes. GP:patient ratio	How could NHS SY&B help GPs to increase patient access?
Annual patient turnover	How does the practice cover protected learning time?
Do you have a triage system? How well does it function?	How useful is the annual patient survey and how do you respond to the results?
Does your practice operate an enhanced service with extended hours beyond the 8am to 6.30pm core hours? (details to explore)	Do you have a patient participation or reference group? Explore details.
How long is your average appointment?	Any other issues or concerns you would like to raise – national or local?

## Appendix B Overview of participating GP practices

	Practice A	Practice B	Practice C	Practice D	Practice E
<b>Staff</b>	2 Partner GPs 1 Salaried GP (7 sessions) 2 Practice Nurses 1 Health Care Assistant 1 Practice Manager Plus admin & reception staff Wider team – midwife, district nurse, community matron, mental health, dieticians, health visitors.	3 Salaried GPs (1WTE plus 1 session) 3 Specialist Nurses 2 Health Care Practitioners 1 Phlebotomist CX and management team Plus admin & reception staff. Wider team – midwife, shared care coordinators, health trainer, health visitor.	5 Partner GPs (4 WTE) 2 Salaried GPs (1.5 WTE) 2 Advanced Nurse Practitioner (WTE 1.8) 5 Practice Nurses 2 Health Care Assistants (WTE 1.5) 2 Practice Managers Plus telephonists, admin and reception staff	2 Partner GPs (15 sessions) 2 Salaried GP (13 sessions) 2 Practice Nurses 1 Practice Manager Plus admin & reception staff Wider team – no information  Training practice – 1.5	6 Partner GPs 2 Salaried GP 6 Nurses 4 Nursing Assistants 1 Practice Manager Plus admin & reception staff Wider team – no information  Training practice – 2
<b>GPs</b>	2 Male and 1 Female	2 Female and 1 Male	4 Male and 3 Female GPs	3 Male and 1 Female GPs	5 Male and 3 Female GPs
<b>List</b>	Slight increase recently, large increase anticipated. Steady turnover.	Very transient population so high patient turnover, always had 1500+, 1950 current.	Fairly static list size with reasonable turnover.	Larger than average and increasing each year.	Large and increasing
<b>Ext hour</b>	Wed 6:30 - 8:00pm	Friday 7-8am	Mon-Thu 7-8am Mon & Tues 18.30–20.00pm	Mon 18:30-21:00	Mon-Fri 18:30-19:00 Tues 7-8am
<b>Appt</b>	10 minutes	10 mins, can book a double	10 minutes	Open access varies	Ave 12 mins (used to be 5)
<b>Appointments</b>	50% pre-bookable up to 2 weeks in advance and 50% on day in morning for a.m. surgery and afternoon for p.m. surgery. No sit and wait. Once all on the day appts booked triage by doctors with emergency slots booked if all appts gone. Minor illness triage driven by nurses.	Pre-booked appts. Additional clinics a.m. and p.m. for 10 people per day for urgent appts. Walk-ins for emergencies, sit and wait. Looking to have a nurse practitioner. Website mentions ringing for phone advice or for nurse appt.	Some triage – same day and on call GP all day for urgent appts. Routine appointments 8:30 – 11a.m. and a variation of routine appts in afternoon. If patients walk in - offered the next free relevant appt with triage nurse, on call GP or SDS GP. If ring offered an appropriate time that day.	Mixed system – some booked a.m. and p.m. and some sit and wait. 1 doctor every a.m. with open access surgery, 2 on Mondays when busier. Emergency appts in afternoons. Nurse triage in afternoons – speak with patients or leave message for doctor to ring back.	No longer any triage and not sit and wait as such. Advance bookings up to 5 weeks. Morning surgery as well as on call doctors a.m. and p.m. (2 on Mon) who also do emergencies/home visits.
<b>DNAs</b>	Reduced for GPs due to sending letters, significant numbers for PN and HCA. Increase if appts bookable over 2 weeks ahead.	Quite a problem, text reminders have helped to reduce.	Big problem	No major problem – try and educate any regulars and have in past signposted to open access surgery	Increased but not that many as tend not to book too far ahead, pre-bookings tend to lead to DNAs.
<b>Demographics</b>	No significant demographic factors.  New housing developments will increase list.	Large BME population from different communities. Very high number of transient patients. Young average age, over 50% under 30. Other socially excluded groups.	Large BME population from different communities. Had high number of transient patients. Lower average age. Very deprived area with high levels chronic disease	Traditional practice but above average number with long term conditions.	New housing developments nearby add to pressure.

## Appendix C

**Table 1 Overall experience indicators from GP patient survey**

Organisation	Proportion of Respondents with Good Overall Experience											
	Overall experience of GP surgery			Overall experience of Out of Hours GP services			Overall experience of making an appointment			Convenience of appointment		
	2011-12	2012-13	Change	2011-12	2012-13	Change	2011-12	2012-13	Change	2011-12	2012-13	Change
England	88.3	88.7	-1.5↓	70.9	70.2	-0.7↓	79.1	76.3	-2.8↓	93.3	92.5	-0.8↓
SY&B Area	88.8	87.2	-1.5↓	75.3	73.1	-2.1↓	78.4	75.2	-3.2↓	93.7	93.0	-0.8↓
Barnsley	90.6	88.4	-2.2↓	75.6	69.8	-5.9↓	81.9	76.3	-5.6↓	95.1	94.3	-0.8↓
Bassetlaw	89.8	87.9	-1.9↓	76.6	79.6	+3.0↑	81.9	81.2	-0.8↓	93.0	92.5	-0.4↓
Doncaster	89.1	87.6	-1.4↓	81.1	80.7	-0.5↓	79.9	76.5	-3.4↓	94.3	93.9	-0.4↓
Rotherham	89.1	88.5	-0.6↓	70.3	71.5	+1.1↑	78.2	76.4	-1.9↓	94.0	92.3	-1.7↓
Sheffield	87.5	85.8	-1.7↓	72.5	68.0	-4.5↓	75.4	72.2	-3.2↓	92.8	92.2	-0.6↓

Source NHS England December 2013

With the exception of Rotherham and Bassetlaw for the OOH indicator the statistics show a downward trend on all four indicators by CCG, for the Area Team as a whole and in England:

- Overall experience of the GP surgery by patients in Rotherham has reduced slightly from 2011/12 to 2012/13 (-0.6) but by less than the national reduction in satisfaction for this same indicator (England -1.5) and less than the other CCG areas in SY&B.
- Overall experience of patients in Rotherham with OOH has increased over the same period.
- Overall experience of making an appointment with a GP has reduced by -1.9 against a national reduction in satisfaction of -2.8% and a SY&B overall reduction of -3.2%.
- However satisfaction with convenience of an appointment with a GP has reduced in Rotherham over this period (-1.7%), more than the national and SY&B position, and is the lowest in the area.

**Table 2 GPs per 100,000 population**

CCG Name	GP Providers	Registered population	GPs per 100,000 population
BARNSELY	99	248,441	40
BASSETLAW	50	112,079	45
DONCASTER	155	309,619	50
ROTHERHAM	116	253,284	46
SHEFFIELD	287	570,324	50
<b>AREA TOTAL</b>	<b>707</b>	<b>1,493,747</b>	<b>47</b>
<b>REGIONAL TOTAL</b>	<b>7,258</b>	<b>15,718,338</b>	<b>46</b>
<b>NATIONAL TOTAL</b>	<b>24,083</b>	<b>55,704,177</b>	<b>43</b>

Source NHS England December 2013



## Appendix D      Overview of Out of Hours and Walk in Centre Activity

Below is an overview of activity for both services covering the period 1/3/13 to 1/3/14.

### Walk in Centre

- 53,063 total patients with a daily average of 145 patients
- 13,140 patients were aged 0-9 and 16,544 aged 10-29
- 29,359 female and 23,453 male patients
- 29,253 patients where no ethnicity recorded – blank, not stated or patient refused (119)
- 19,971 patients were British/White British/Mixed British codes with the remaining 3,839 patients from nearly 100 different ethnic group codes
- 43,372 were registered with Rotherham, 6,871 with Barnsley, Doncaster or Sheffield and 2,013 from a total of 148 other PCTs/LCBs
- 47,444 patients had Rotherham postcodes with S65 and S61 the highest, each over 9,500
- Times of visits were quite evenly spread throughout the day with 4,200-4,700 patients in each of the one hour time slots from 9am to 7pm
- Busiest times as expected were weekends and bank holidays
- Highest number of patients in one day 255 on Saturday 28 December 2013
- Lowest number of patients in one day 86 on Friday 7 June 2013
- For PLT dates in Nov-Feb no major increase in numbers but times of patients not available
- 1,230 patients walked out
- Core activity:

Advice and prescription	25,522
Advice only	13,457
Clinician advice	4,592
Prescribed medicine	3,153
	<b>46,724</b>

### Out of Hours service

- 32,466 total records with a daily average of 89 patients
- 8,492 patients were aged 0-9 and 9,225 aged 60+
- 18,451 female and 12,542 male patients
- 1,440 blank records for age and gender
- No ethnicity data provided
- 30,430 patients had Rotherham postcodes with S65 and S61 the highest, each over 5,300
- Busiest times as expected are weekends and bank holidays
- Highest number of patients in one day 283 on Good Friday 29 March 2013
- Lowest number of patients in one day 24 on Friday 30 August 2013
- As expected for PLT dates when practices are closed in the afternoon in Nov-Feb significant increase in numbers with approx. 50-60 more patients on the Thursday than on the Wednesday or Friday either side
- Case type:

Primary care centre i.e. WIC	13,612
Clinician advice	10,941
Home visit	5,334
	<b>Total 29,887</b>
- Priority on completion:

Emergency	989
Urgent	1,656
Less urgent	26,584

## Glossary

APMS	Alternative Provider Medical Services – type of GP contract
CQC	Care Quality Commission, the quality and safety regulator with responsibility for monitoring, inspecting and regulating primary care services.
Care UK	Provider of the Out of Hours service and urgent care at the Walk in Centre
DNAs	“Did Not Attend” – patients not cancelling appointments they no longer need
GMS	General Medical Services – type of GP contract
GPs	General Practitioners
GPPS	GP Patient Survey
LMC	Local Medical Committee
Monitor	The sector regulator for health services in England. Their role is to protect and promote the interests of patients by ensuring that the whole sector works for patients’ benefit.
NHS	National Health Service
NHSE	NHS England (national)
NHSE SY&B	NHS England Area Team South Yorkshire and Bassetlaw
OOH	Out of Hours GP services
PLT	Protected Learning Time
PMS	Personal Medical Services – type of GP contract
PPG	Patient Participation Group
RCCG	Rotherham Clinical Commissioning Group
SY&B	South Yorkshire and Bassetlaw
TRFT	The Rotherham Foundation Trust
WIC	Walk in Centre for urgent care
WTE	Whole time equivalent

### Carr-Hill Formula

The Carr-Hill formula is based on a series of adjustments: age and gender of patients (children, women and older people have higher weights); nursing and residential homes index; additional needs of the population relating to morbidity and mortality; patient turnover and adjustment for the unavoidable costs, including market forces factor and rurality index.

### GP Patient Survey Data

The first set of data covers the period July 2012 to March 2013. The second set was published in December 2013 and covers surveys from January- March 2013 and from July- September 2013, so overlapping in part with the first data set.