Welcome and Introduction
Welcome and introduction

Liz Wise, Programme Director, Transforming Primary Care, Healthy London Partnership

Dr David Finch- North West London Area Medical Director, NHS England, (London Region)
The Transforming Primary Care programme

- The Healthy London Partnerships is a joint venture between NHS England and the London CCGs
- The Strategic Commissioning Framework was published in March 2015
- Following consultation with over 1,500 patients, clinicians, commissioners and others, this sets out a new vision for Primary Care in London
- This has been supported by all CCGs across London, and the focus is now on how it is delivered…
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:30</td>
<td>WELCOME AND INTRODUCTIONS</td>
<td>Liz Wise</td>
</tr>
<tr>
<td></td>
<td>ACCESS AND THE WIDER CONTEXT</td>
<td>Dr David Finch</td>
</tr>
<tr>
<td>12.40</td>
<td>WHAT IS GOOD ACCESS?</td>
<td>David Groom</td>
</tr>
<tr>
<td></td>
<td>A PATIENT VIEW REGARDING ONLINE ACCESS</td>
<td>Trevor Fossey</td>
</tr>
<tr>
<td>13:10</td>
<td>HOW TO MAKE THE VISION A REALITY? (PART 1)</td>
<td>Table breakout</td>
</tr>
<tr>
<td>13:40</td>
<td>BREAK</td>
<td></td>
</tr>
<tr>
<td>13.50</td>
<td>PRIMARY CARE - THE CHALLENGES AND THE OPPORTUNITIES</td>
<td>Virginia Patania</td>
</tr>
<tr>
<td>14:20</td>
<td>DELIVERING ACCESS – PRIME MINISTER’S CHALLENGE FUND</td>
<td>Ed Diggines, Hayley Sloan, Dr Louisa Dove</td>
</tr>
<tr>
<td>15:10</td>
<td>HOW TO MAKE THE VISION A REALITY? (PART 2)</td>
<td>Table breakout</td>
</tr>
<tr>
<td>15:50</td>
<td>BREAK OUT PRESENTATIONS:</td>
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<tr>
<td></td>
<td>• askmyGP</td>
<td></td>
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<tr>
<td></td>
<td>• Delivering Access: WebGP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Delivering Access : Patient Online (record access)</td>
<td></td>
</tr>
<tr>
<td>16:50</td>
<td>CLOSING SUMMARY</td>
<td>Liz Wise</td>
</tr>
<tr>
<td>17:00</td>
<td>CLOSE</td>
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</tbody>
</table>

Champions breakout (15mins)
Access and the wider context

Dr David Finch - North West London Area Medical Director, NHS England, (London Region)
02

WHAT IS THE VISION FOR ACCESS?

Transforming London’s health and care together
What does good access look like?

David Groom, Programme Manager, Transforming Primary Care, Healthy London Partnership

Trevor Fossey, Patient Working Together Group Member, Patient Online Programme, NHS England
“The fact that different dimensions of access are valued differently by different people (and by the same people at different times and in different circumstances) presents a real challenge to the formulation of concrete measures of good-quality access.

More importantly, for general practice, it presents a challenge in how to design and deliver a truly personalised service that best responds to individuals’ attitudes and concerns about access.”
Access is a priority for patients

GP Patient Survey 2015 - London’s Boroughs

y = 0.682x + 0.3347

R² = 0.7243
What does it consist of: Rapid Access

Important particularly to patients who feel anxious enough or who are suffering sufficiently that they want to be seen or speak to someone as soon as possible.

Example patient groups:

• Mothers with infants/babies
• People with new conditions
• People whose condition has deteriorated rapidly
**Current service**

Highly variable – patient satisfaction is lower than the English average.

patients often need to call first thing in the morning and feel they ‘battle through’ on the phones to get an appointment and are told to call back the next day if they have run out (often referred to as the “8 o’clock lottery”).
Impact

Patients may become anxious or potentially go to A&E – often with conditions which general practice could have dealt with.

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Health and Social Information Centre – Relationship between A&E Attendances and results from 2011-12 GP Survey
What does the specification say?

• That all patients should be able to speak to a GP or senior nurse the same day (this may mean a phone conversation with a GP – usually within an hour but with a guarantee of same day) (A5)

• That patients will only make one call, click or contact in order to make an appointment (not be asked to call later to see if any appointments are available then) (A2)

• That in emergency situations patients will be identified and clinically assessed rapidly and responded to appropriately (A6)
Continuity

Important to patients we would benefit from an ongoing relationship with a clinician who they know and who knows them.

Important to people who have ongoing health needs which need to be understood by everyone they see.

**Examples include:**

- People with long term conditions
- People with ongoing health or social issues
- People from vulnerable groups
Variable – on average patient satisfaction with the frequency of seeing a preferred GP is significantly lower in London than the rest of England.
Patients find consultations more helpful in managing long term conditions if they see the same GP frequently.
What does the specification say?

- All patients will be registered with a named GP who will take overall responsibility for their care (A7)
- Patients will be able to book at least four weeks ahead (A1)
- Practices will provide flexible appointment lengths as appropriate (A7)
Convenience of appointment – by borough

Convenience of the appointment given

GP Patient Survey 2015
GP Patient Survey 2015
Convenient access

Important to all patients who struggle to access general practice in its current form.

Example patient groups

• Those who work a “normal” working week
• Those who want to access primary care through multiple channels

Current Service

• Many patients can not access general practice without taking time off work
• Based around 10 minute face to face GP consultations – many would appreciate phone, email, text or online approaches
• Booking is often by person or by phone rather than email
Impact

- Patients have to take **time off work to access a GP** – especially inconvenient for those who have to return to their practice for series of reviews or as part of ongoing care.

- Patients **may not bother going to or registering** with a GP at all.

- **Patients may go to A&E** if they can’t access general practice outside of normal working hours.
What does the specification say

• Routine appointments bookable on Saturday morning for all patients at the practice where they are registered (A3)

• Practices open 8 am to 6.30pm 5 days a week for pre-bookable appointments (A3)

• Urgent and pre-bookable appointments available 8am to 8pm 7 days a week in the local area (A4)

• Online services to be promoted to book appointments, order prescriptions, view medical records and email (A2)
Patients using online services – by borough

Patients using online services

GP Patient Survey 2015
Online Services

• **99%** of London GPs have enabled their system for online appointment booking

• Only **9%** of GP appointment slots are available to book online

• Only **14%** of Londoners have an online account that enables them to book appointments, repeat prescriptions and access the medical record.
What does good access look like?

Trevor Fossey, Patient Working Together Group Member, Patient Online Programme, NHS England
A patient’s perspective of Patient Online – Trevor Fossey

Brief background to access of records at:
Regis Medical Centre, West Midlands

2012

Online
Prescriptions
Online
Booking

2013

Power of
Information
• On PPG agenda & engaged
• Easy read document

2014

Online access to
GP record
• Jan 2014
• E-prescriptions

2015

Promote to
patients
• PPG to support
• Explain benefits

2016

Embed
• PPG to support
• Engage patients
• Maximise Benefits

Your Health Partnership

The Power of Information

Online Prescriptions

Online Booking

Power of Information

Online access to GP record

Promote to patients

Embed
Online access: Transactional Services

NHS England Patient Online

- GP Appointments Online
- Repeat Prescriptions Online
- View Your GP Records Online

Home

- Book Appointment
- My Future Appointments
- My Past Appointments
- Current Prescriptions
- Change Pharmacy
- Change Password
- Change Contact Details
- Grant Additional Access
- My Summary Patient Record
- My Detailed Patient Record
- Childhood Vaccinations
- Questionnaires
- View Test Results
- Help
- Logout
Personal access: GP records screen

**NHS England Patient Online**

- GP Appointments Online
- Repeat Prescriptions Online
- View Your GP Records Online

**Home**

- Book Appointment
- My Future Appointments
- My Past Appointments
- Current Prescriptions
- Change Pharmacy
- Change Password
- Change Contact Details
- Grant Additional Access
- My Summary Patient Record
- My Detailed Patient Record
- Childhood Vaccinations
- Questionnaires
- View Test Results
- Help
- Logout
Ahead to notes and test results

Check accuracy of record
Review & contemplate GP notes
Time to understand test results

### Albumin

#### Related tests:
- Proalbumin
- Microalbumin
- Liver function tests

#### The Test

**http://www.labtestsonline.org.uk/**

**How is it used?**
When is it requested?
What does the test result mean?
Is there anything else I should know?

**How is it used?**

Since the concentration of albumin in the blood can be low in many different diseases and disorders, albumin testing is used in a variety of conditions to help diagnose disease, to monitor changes in health status with treatment or with disease progression, and as a screen that may serve as an indicator for other kinds of testing.

**When is it requested?**

A doctor requests a blood albumin test (usually along with several other tests) if a person seems to have symptoms of liver or kidney disease.

Doctors may also request a blood albumin test when someone has an infection or inflammation as its concentration may provide a marker of the severity of the condition.

**What does the test result mean?**

Low albumin concentrations in the blood can suggest liver disease. Liver enzyme tests are requested to help determine which type of liver disease.

Low albumin concentrations in the blood can reflect diseases in which the kidneys cannot prevent albumin from leaking from the blood into the urine and being lost. In this case, the amount of albumin (or protein) in the urine also may be measured.
Benefit of access to notes

Online access to my own records has

• helped change my own ‘culture’ towards my own health care
• benefitted my wellbeing, particularly mental health
• resolved the dichotomy of messages from GP:
  o “we encourage you to self-manage your own health”
  o “we don’t trust you with online access to your own records”

Overview/summary of experience

• Greater involvement in own wellbeing
• Feel more in control & engaged with my own health
• Less risk if I have future issues → peace of mind and ‘at ease’
• More inclined to visit doctor if required
• Now feel that Physical Health is on a more equal footing with Financial Health
• Good foundation for the future & easy to access
• My mental health has benefitted
HOW TO MAKE THE VISION A REALITY? (PART 1)
1. What are some of the challenges in delivering good access in your area?

2. Which elements of the good access which has been described do you think will be the most difficult to deliver and why?
03

HOW ARE OTHERS DELIVERING ACCESS?
Primary Care Challenges & Opportunities

Dr Virginia Patania, Managing Partner, Jubilee Street Practice

Don’t forget to tweet us at @HealthyLDN #HealthyLDN
Executive Summary

• Primary care is having to meet rising demands within existing or even diminished resources, particularly those practices in deprived areas

• JSP are tackling this by:
  • Implementing a same day appointment telephone triage system
  • Shifting work between skill mixes to optimise efficiency, increase patient access to care
  • Our staff came up with 42 interventions that could impact JSP's ability to deliver care effectively which we have been implementing

• Now we are taking our message and key learnings to the national stage and informing related agendas (e.g. co-commissioning)
It is not news that the primary care environment is becoming more demanding and this situation is particularly acute for practices in deprived areas.

1. Changes to GP contracts
2. Increased demands on core contracts
3. Shift of care from secondary to primary care
4. Increased workload from integrated care
5. Primary care core funding formula that does not reflect the increased workload associated with deprivation
As we wanted to do everything we could to meet the challenge head on, we needed data and to develop a plan from two angles.

“Looking outwards” to a contracting level:
- Quantify the impact of the contract changes on all practices.
- Establish the impact of the changes on our specific area to determine the resource pool available for the management of demand.

“Reflecting inwards” on a practice level:
- Understand how we could optimise operations in the practice to do more with existing or reduced resources.
As a practice we addressed how we could “stretch” our existing resources

We developed a programme of practice level changes to meet the following objectives:

1. **Improve** patient access of care by better utilising existing supply to more efficiently meet demand

2. **Review** practice skill mix to ensure all staff are working to the top of their licence, improving cost efficiency and patient access

3. **Streamline** patient handling to improve patient experience and limit unnecessary contact with staff

4. **Cascade** best practices to reduce mistakes otherwise affecting quality of care or patient experience, e.g. missing prescriptions
In 2013, we started this journey by implementing Doctor Direct in order to **create more available “patient contacts”**.

This increase in patient contacts has been delivered on equal or reduced GP resource.

**Average GP/patient contacts per 1000 patients per week**

- **2013**: 66.2
- **2014**: 115.6
- **2015**: 117.9

**GP/patient contacts offered per 1000 patients per week at JSP**

- **Total**
  - **2013**: 66.2
  - **2014**: 115.6
  - **2015**: 117.9
- **Telephone**
- **Face to face**

SOURCE: Analysis of JSP practice summary statistics
However, we have seen an **overall increase** in the number of calls coming through the Doctor Direct system, creating more pressure on the practice as a whole.

**Total calls received by JSP per average month**

- **Jan-Aug 14**: 4932 calls
- **Sep-Dec 14**: 5069 calls
- **Feb-Apr 15**: 6890 calls

**SOURCE**: Audit of patient calls to JSP January – December 2014
Therefore this year we embarked on a comprehensive programme (42 interventions) to **improve operations in our practice using existing resources**.

<table>
<thead>
<tr>
<th>Example problems facing JSP</th>
<th>Data collated to understand scale of problem</th>
<th>Type of intervention needed</th>
<th>Example programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to meet demand generated by Doctor Direct system</td>
<td>▪ Variation of number of calls by clinician and comparison with target call number</td>
<td>▪ Reduce variation between clinicians</td>
<td>▪ Staff training session on resolving issues on telephone</td>
</tr>
</tbody>
</table>
| Pressures increasing on GP time, unable to find resources to hire more GPs | ▪ Cost benefit analysis of shift  
▪ Analysis of conditions/appts that could be shifted to other staff | ▪ Skill mix optimisation | ▪ Nurse hiring scheme  
▪ Condition presentation protocol |
| Patients struggling to get through to the practice, negatively impacting experience | ▪ Analysis of call volume by time: establish “peak times”  
▪ Analysis of tasks admin staff should handle | ▪ Improve technical access | ▪ Admin hiring scheme  
▪ Creation of “duty admin” role |
| Unclear and complex processes means that staff are wasting time | ▪ Staff interviews  
▪ Prescribing process mapping  
▪ Room stocking process mapping | ▪ Optimise use of staff time | ▪ Prescribing process codification  
▪ Room stocking codification |
There is significant variation between the number of calls each clinician is dealing with per session.

* Session defined as half a full working day; 9:00AM to 12:30 PM, OR 1:30 PM to 6:00 PM

SOURCE: Average calls per session by doctor Oct ’13-14
Moving all doctors to target number of calls supplies **84 more appointments per week** to patients

Comparison current doctor capacity and assumed capacity if all doctors match target number of calls

<table>
<thead>
<tr>
<th>Day</th>
<th>Current appointment capacity</th>
<th>Capacity with minimum targets</th>
<th>Difference in # appointments offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon</td>
<td>250</td>
<td>338</td>
<td>+88</td>
</tr>
<tr>
<td>Tue</td>
<td>200</td>
<td>210</td>
<td>+10</td>
</tr>
<tr>
<td>Wed</td>
<td>165</td>
<td>180</td>
<td>+15</td>
</tr>
<tr>
<td>Thu</td>
<td>156</td>
<td>167</td>
<td>+11</td>
</tr>
<tr>
<td>Fri</td>
<td>128</td>
<td>130</td>
<td>+2</td>
</tr>
</tbody>
</table>

**SOURCE:** Analysis of average calls per session by doctor Oct ’13-’14
We conducted a practice wide audit into how many **patient** contacts were seen by appropriate members of staff.

### PROFILE OF DEMAND FORM

**Unique #:** 23  
**Date of observation:** Monday, 02/02/2015

This sheet is designed for primary care staff during their working day. It will help us understand what type of work we are doing.

**Instructions:**

- Place ticks in the appropriate columns for each patient contact, both face to face and telephone. Please remember to include the EMIS number.
- Record the type of problem, whether a new or follow up appointment, who could have dealt with it and whether a telephone appointment would have been appropriate.

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>New or f/up</th>
<th>Could have been dealt with by</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMIS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chronic Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Episode</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Follow Up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Associate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Pharmacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Pharmacist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-manage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Face to Face</td>
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</tbody>
</table>
We estimated that **45% of patients seen by GPs today in JSP could be seen by an alternative staff member** or the patient could self-manage.

GP assessment of who was best placed to resolve patients request or problem who were currently seeing/speaking to a GP:

- **GP**: 54.90%
- **Practice nurse**: 5.8%
- **Prescribing nurse**: 15.8%
- **Physician associate**: 2.5%
- **Local pharmacist**: 0.8%
- **Admin**: 5.8%
- **Practice pharmacist**: 4.3%
- **Self-manage**: 10.1%

SOURCE: Work shift between skill mixes, NATCANSAT analysis of JSP staff appropriate skill mix audit 2015
At JSP, we wanted to first shift suitable work to nurses which would only make a small saving but more importantly would **free up GP time** to focus on other patient issues.

### Comparison of cost to deliver work* shifted from GPs to nurses

<table>
<thead>
<tr>
<th>Delivered by</th>
<th>Cost of delivering work</th>
<th>Saving per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>£74</td>
<td>£210</td>
</tr>
<tr>
<td>Nurse (mix)</td>
<td>£707</td>
<td>£56</td>
</tr>
<tr>
<td>Physician Associate</td>
<td>£979</td>
<td>£339</td>
</tr>
<tr>
<td>GP</td>
<td>£1,318</td>
<td>£1,318</td>
</tr>
<tr>
<td>Admin</td>
<td>£1,320</td>
<td>£1,320</td>
</tr>
</tbody>
</table>

* "Work" refers to the percentage of Doctors' work that can be shifted to different skill mixes per week, i.e. 15.9%
In order to implement these skill mix changes we developed a protocol using a **staff audit for which conditions should be dealt with by each type of professional**

26/05/2015

**Jubilee Street Practice**

**Who to see - patient conditions**

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Doctor</th>
<th>Nurse</th>
<th>HCA</th>
<th>Physician Associate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatry (Chiroprody) requests</td>
<td></td>
<td></td>
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<tr>
<td>Private medical</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Pregnancy - First Booking</td>
<td></td>
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<tr>
<td>Pregnancy Follow up appt</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Rashes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral done/sent?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ribs - painful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shingles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sick line (Ongoing)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Side effects of medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinusitis</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Skin Infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking cessation 1 to 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking cessation Group (MClub)</td>
<td></td>
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</tr>
</tbody>
</table>
The audit showed where there was consensus between staff types around who should resolve each type of condition.

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Doctor</th>
<th>Nurse</th>
<th>HCA</th>
<th>Physician Associate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abscess</td>
<td>12.1%</td>
<td>72.6%</td>
<td>0.0%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Abdominal pain (&amp; problems)</td>
<td>81.0%</td>
<td>0.3%</td>
<td>0.0%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Abrasions</td>
<td>0.3%</td>
<td>84.2%</td>
<td>11.8%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>35.3%</td>
<td>3.3%</td>
<td>0.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Asthma (Acute)</td>
<td>21.3%</td>
<td>60.3%</td>
<td>0.0%</td>
<td>18.4%</td>
</tr>
<tr>
<td>Asthma (Review)</td>
<td>0.0%</td>
<td>97.1%</td>
<td>0.0%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Back pain</td>
<td>32.4%</td>
<td>2.9%</td>
<td>0.3%</td>
<td>64.4%</td>
</tr>
<tr>
<td>Bleeding between periods</td>
<td>24.1%</td>
<td>23.0%</td>
<td>2.3%</td>
<td>44.0%</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>3.3%</td>
<td>43.0%</td>
<td>53.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Boils/ Abscess</td>
<td>3.7%</td>
<td>78.2%</td>
<td>0.0%</td>
<td>18.1%</td>
</tr>
<tr>
<td>BP medication</td>
<td>19.1%</td>
<td>72.2%</td>
<td>0.3%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Breast Lump</td>
<td>57.9%</td>
<td>6.5%</td>
<td>0.0%</td>
<td>35.6%</td>
</tr>
<tr>
<td>Breast pain</td>
<td>45.2%</td>
<td>0.7%</td>
<td>0.0%</td>
<td>54.1%</td>
</tr>
<tr>
<td>Burns</td>
<td>6.2%</td>
<td>93.5%</td>
<td>0.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>21.6%</td>
<td>51.2%</td>
<td>0.0%</td>
<td>27.1%</td>
</tr>
<tr>
<td>Chest Infection</td>
<td>18.1%</td>
<td>16.0%</td>
<td>0.0%</td>
<td>65.9%</td>
</tr>
<tr>
<td>Chest pain</td>
<td>94.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Chickenpox</td>
<td>13.5%</td>
<td>52.8%</td>
<td>5.7%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Cold sore</td>
<td>0.0%</td>
<td>72.8%</td>
<td>14.3%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Colds</td>
<td>0.3%</td>
<td>49.0%</td>
<td>5.7%</td>
<td>44.9%</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>0.3%</td>
<td>87.1%</td>
<td>5.7%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Constipation (Under 5)</td>
<td>66.3%</td>
<td>0.7%</td>
<td>2.9%</td>
<td>30.1%</td>
</tr>
<tr>
<td>Constipation (Over 5)</td>
<td>18.4%</td>
<td>7.5%</td>
<td>0.0%</td>
<td>74.0%</td>
</tr>
<tr>
<td>Contraception - review</td>
<td>6.7%</td>
<td>87.6%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Contraception - new</td>
<td>6.7%</td>
<td>90.1%</td>
<td>0.0%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Cough</td>
<td>0.3%</td>
<td>31.8%</td>
<td>0.3%</td>
<td>67.5%</td>
</tr>
<tr>
<td>Cuts</td>
<td>2.9%</td>
<td>84.3%</td>
<td>8.3%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Cystitis (Adult – Women)</td>
<td>9.0%</td>
<td>87.6%</td>
<td>0.0%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Diarrhoea and vomiting (Children)</td>
<td>24.5%</td>
<td>8.9%</td>
<td>0.0%</td>
<td>66.6%</td>
</tr>
<tr>
<td>Diarrhoea and vomiting (Adults)</td>
<td>7.3%</td>
<td>25.5%</td>
<td>0.0%</td>
<td>67.2%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>69.0%</td>
<td>11.0%</td>
<td>0.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>DN/HV/Midwife</td>
<td>62.5%</td>
<td>27.6%</td>
<td>6.8%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Doppler exam</td>
<td>12.6%</td>
<td>78.2%</td>
<td>6.0%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

SOURCE: “Who to see” patient analysis 2015, NATCANSAT analysis
To improve patient access, we identified a need to better align admin capacity with patient demand

- **Problem with patient access**
  - Patients unable to reach the practice during peak hours (analysed through analysis of missed calls)
  - Front desk don’t feel well resources leading to strain on staff

- **Leavers to address issue**
  - Increasing admin/ reception capacity through additional hours
  - Dissemination of best practices, targeting higher rate of work
  - Redistribution of existing resources to better match demand and supply
In order to establish resource gap, we needed to **measure baseline capacity** and putting in place **access targets**

**Establish Baseline Capacity**
- Measured average length of time per call per half hour interval in order to assess patient contact time per time/day
- Calculated reception resources based on rota, contracted hours and annual/sick leave (to determine actual, not theoretical resource)
- Analysed call traffic by volume of calls per half hour interval

**Estimate additional resource requirement**
- Set targets based on several different strategies for matching access
  1. Minimum staff manning reception of 4 per half hour
  2. Call target per half hour per staff member (e.g. 9 calls per staff per half hour)
  3. Resources required to meet average patient contact time per half hour, including “trickle admin” time
What we found was that **activity per staff by time was highly varied**, and that additional staff had a significant impact.

![Average number of calls handled per admin/reception staff by time](image)

**Calls received**

**Revised call traffic following addition of admin staff**

**Highlighted areas show greatest variation between supply and demand based on addition of resources**

**SOURCE:** Jubilee Street Practice % total calls received by time Jan – Dec 2014
We conducted a resource gap analysis on the basis of **three** different staffing options

1. **Target minimum staffing levels of 4 people manning reception/admin at all times**
   - WTE gap calculated as XXX
   - [Consider other data]

2. **Target more appropriately matching demand and supply based on average calls per [time]**
   - WTE gap calculated as
   - [Consider other data]

3. **Target matching staff based on average contact time and generated admin tasks**
   - WTE gap calculated as
   - [Consider other data]

As a practice, need to decide what is the most appropriate methodology for you to action on

SOURCE: Source
To address patient and staff concerns about the inefficiencies in our prescribing process, we created a comprehensive map of the process, suggested changes and a protocol to make the changes stick.
To address **staff concerns about wasted clinical time due to equipment in clinical rooms**, we have introduced a new protocol for room restocking.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
</table>
| - Room stocking is a **non-standardised** process leading to  
  - **Confusion of responsibility**  
  - Poor understanding of appropriate stock levels  
  - Reorder point is unknown  
- Clinical rooms are not routinely checked leading to **expired and lost equipment**  
- Doctors **wasting clinical time** gathering equipment  
- Rooms poorly/inconsistently stocked  
- Unclear how regularly items are used | - **Standardised** room stocking  
  - Regular timing for restocking  
  - Regular quantity of items restocked based on clinician review of necessary items  
- Responsibility for restocking removed from doctors, **freeing up clinical time**, and increasing appointment supply  
- System in place for exceptional stock requests  
- All rooms have **minimum levels of appropriate stock** for any patient appointment  
- **Use of items captured** to allow appropriate reordering/restocking points to be revised and updated |

---

**INVENTORY ALERT**

<table>
<thead>
<tr>
<th>Item</th>
<th>Room</th>
<th>Quantity</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue pot</td>
<td>Dr. Salma Ahmed</td>
<td>2</td>
<td>RETURN CARD ONCE PROCESSED</td>
</tr>
</tbody>
</table>

**Clinical Equipment**

<table>
<thead>
<tr>
<th>Clinical Equipment</th>
<th>Expectation of what each room should have</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alco sterets</td>
<td>2</td>
</tr>
<tr>
<td>Alco wipes</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol hand gel</td>
<td>1</td>
</tr>
<tr>
<td>Aprons (blue)</td>
<td>1</td>
</tr>
<tr>
<td>BD microbalance needles</td>
<td>*</td>
</tr>
<tr>
<td>Blue pots</td>
<td>2</td>
</tr>
<tr>
<td>Cervix brush</td>
<td>2</td>
</tr>
<tr>
<td>Cervical smear solution</td>
<td>2</td>
</tr>
<tr>
<td>Charcoal swab</td>
<td>4</td>
</tr>
<tr>
<td>Chlamydia swabs (M+F)</td>
<td>3</td>
</tr>
<tr>
<td>Cleaning solutions</td>
<td>*</td>
</tr>
<tr>
<td>Condom packs</td>
<td>2</td>
</tr>
<tr>
<td>Cotton wool</td>
<td>1</td>
</tr>
<tr>
<td>Dipstix</td>
<td>1</td>
</tr>
<tr>
<td>Disposable thermometer</td>
<td>*</td>
</tr>
<tr>
<td>Dressing towels</td>
<td>1</td>
</tr>
<tr>
<td>Examination gloves/latex</td>
<td>1</td>
</tr>
</tbody>
</table>

**PRACTICE OPTIMISATION**
Success of interventions will be **measured against defined clinical and project specific objectives**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Definition of success</th>
<th>Review/ measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse hiring scheme</td>
<td>▪ Reduced strain on doctors, greater supply of appointments to patients</td>
<td>▪ # patient appts in clinical time&lt;br▪ Rerun work shift data collection&lt;br▪ Review incidences of patient handover&lt;br▪ Check staff understanding of task functions and responsibilities</td>
</tr>
<tr>
<td>Condition presentation protocol</td>
<td>▪ Patients are directed to the appropriate skill mix to deal with their condition as the first point of contact</td>
<td>▪ Review % of calls abandoned</td>
</tr>
<tr>
<td>Admin hiring scheme</td>
<td>▪ Admin are able to handle a greater number of patient contacts</td>
<td>▪ Record time required to respond to admin tasks&lt;br▪ Review change in capacity to deal with patients</td>
</tr>
<tr>
<td>Creation of “duty staff” role</td>
<td>▪ Admin specific requests dealt with more quickly&lt;br▪ Duty staff able to respond to ad hoc requests without clinical time disruption</td>
<td>▪ Review # issues with prescriptions&lt;br▪ Review process for redundancies</td>
</tr>
<tr>
<td>Prescribing process</td>
<td>▪ Streamlined protocol for patient journeys with staff function well understood</td>
<td>▪ Frequency of clinicians stocking own rooms&lt;br▪ Regularity of ordering&lt;br▪ Use of KanBan cards</td>
</tr>
<tr>
<td>Room stocking codification</td>
<td>▪ Doctors’ needs for clinical items are met, and all rooms have basic inventory above minimum levels</td>
<td>▪ Review staff function, assess staff understanding and pair GPs via a buddy system for peer learning</td>
</tr>
<tr>
<td>Staff training</td>
<td>▪ Reduce errors and variation between staff</td>
<td>▪ Frequency of clinicians stocking own rooms&lt;br▪ Regularity of ordering&lt;br▪ Use of KanBan cards</td>
</tr>
</tbody>
</table>
Every intervention is measured not only on patient outcome success but also on **financial impact for the practice**

- JSP records key metrics concerning cost; total net income, expenditure and profits
- “Success” of interventions will also be viewed in terms of financial impact
  - Impact on finances will be reviewed monthly in order to determine effectiveness of projects to ensure they are still viable

<table>
<thead>
<tr>
<th>Income &amp; Expenditure Report</th>
<th>Accumulative Total 14/15</th>
<th>Monthly Average</th>
<th>Forecast 14/15</th>
<th>Targets</th>
<th>Remaining Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial year 2014-15</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Month 1</td>
<td>Month 2</td>
<td>Month 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Practice income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Income</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>GMS Statement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achievement/scored</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reimbursements 12/13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below is PCT income paid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to JSP for reimbursement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>against expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registrars Reimbursement</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(on GMS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Dom Rates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ActualRent- paid in advance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>by PCT, needs to be paid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to landlord every quarter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total net income</strong></td>
<td><strong>£0.00</strong></td>
<td><strong>£0.00</strong></td>
<td><strong>£0.00</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Payroll Staff Admin        |         |         |        |        |        |        |        |        |        |        |
| (Gross costs)              |         |         |        |        |        |        |        |        |        |        |
| Payroll Nurse costs        |         |         |        |        |        |        |        |        |        |        |
| Temporary / Agency staff   |         |         |        |        |        |        |        |        |        |        |
| Network salaries           |         |         |        |        |        |        |        |        |        |        |
| reimbursed (enter on as     |         |         |        |        |        |        |        |        |        |        |
| minus figure)              |         |         |        |        |        |        |        |        |        |        |
| **Total**                  | **£0.00** | **£0.00** | **£0.00** |        |        |        |        |        |        |        |
| Salaried GP’s & oncosts    |         |         |        |        |        |        |        |        |        |        |
| Locums                     |         |         |        |        |        |        |        |        |        |        |

**SOURCE:** JSP record of accounts
Lessons we learnt along the way

- Practices have a lot of data and opportunities to collect invaluable insights. Use it!
- Equipping yourself with data is the only way primary care can have credible conversations with decision makers
- Being transparent with your data gets your point across
- Implement practice interventions based on data, track their impact and their return on investment

- Long lasting change can only happen in practices when all the staff are involved in identifying, prioritising and implementing interventions
- Clear leads/ role models needed from each practice staff group
- Impact should be assessed and successes celebrated together
- Bring all your stakeholders with you, it will increase your strength

- Find any relevant platform or bandwagon to make your argument
- People will listen if you clearly articulate your argument again, and again!

- Open the door and let others contribute their data, arguments etc.
- Be prepared to redefine what you believe about general practice
We are now taking our data, interventions and lessons to a wider audience in an attempt to help **shape local and national thinking**.

**Related strategies:**

- Co-commissioning / future of primary care
- PM Challenge Fund
- Urgent Care
- Integrated care
- Practice/ network optimisation plans
- Primary care funding formula negotiations
Prime Minister’s Challenge Fund

Dr Edward Diggins, GP Partner at the Rydal Practice in Woodford Green, Redbridge

Hayley Sloan, Head of Transformation for Primary Care, Southwark Clinical Commissioning Group

Dr Louisa Dove, Associate Director in Quay Health Solutions

Don’t forget to tweet us at @HealthyLDN #HealthyLDN
Dr Edward Diggins, GP Partner at the Rydal Practice in Woodford Green, Redbridge
Journeys into Demand Led Care

BARKING AND DAGENHAM, HAVERING AND REDBRIDGE
“It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something.”

Franklin D. Roosevelt
"Can I have an appointment?"  
"Call back tomorrow at 8am or routine appointment two weeks – could try walk in centre"

"Can I see someone?"  
"Two hours later  
"The nurse has seen you but this needs a doctor review"

"I was seen in WIC and they say I need to see a doctor"  
"No problem, a doctor will call you back"

I've seen the WIC and they say I need to see a doctor"  
"Actually this is a long term issue, see your GP in the morning"

"I can't see anyone else, can you please see me?"  
"No this is a GP issue, I'll book you into the UCC"

"I was sent here by A+E, can you help?"  
"Yes, here's your prescription but please go to see your GP to check resolved"
Core GP hours
Supply led service

Out of Hours
Demand led service

- Telephone call
- Resolved
- UCC
- Visit
Unknown unmet demand, going into A&E, OOH
Telephone

50% Resolved

50% Came in
Reception takes call

GP phones patient

Problem solved

Come and see another clinician

Come and see GP

Admin completed
GP bookings made by time of day - last 4 weeks

F86012 Rydal
24/04/2013
Demand for GPs per hour, by hour & working day

F86012 Rydal

at 12 calls/hour
<table>
<thead>
<tr>
<th>Long Term Conditions</th>
<th></th>
<th>Acute Illness</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Phone</td>
<td>Face</td>
<td>Conv</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>M/S</td>
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<tr>
<td>Mental Health</td>
<td>10</td>
<td>5</td>
<td>0.50</td>
</tr>
<tr>
<td>Derm</td>
<td>14</td>
<td>5</td>
<td>0.36</td>
</tr>
<tr>
<td>Endo</td>
<td>2</td>
<td>0.00</td>
<td>8</td>
</tr>
<tr>
<td>Resp</td>
<td>4</td>
<td>4</td>
<td>1.00</td>
</tr>
<tr>
<td>Gynae</td>
<td>2</td>
<td>0.00</td>
<td>8</td>
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<td>Colorectal</td>
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<td>0.20</td>
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<td>ENT</td>
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<td>General Surg</td>
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<td>0.90</td>
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<tr>
<td>Other</td>
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<td>Referrals</td>
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<tr>
<td>Results</td>
<td>76</td>
<td>2</td>
<td>0.03</td>
</tr>
<tr>
<td>Total</td>
<td>203</td>
<td>34</td>
<td>0.07</td>
</tr>
</tbody>
</table>
It’s popular, demand shifting from phone to online over 45% in 4 months. Note weekends.
Patients are submitting in working hours, well spread compared with telephone rush
83% of submissions are in hours. 17% OOH includes weekends and holidays.
All ages are accessing online, 0 to 102 years old. 60/40 female/male split is usual for GP demand.
Most users are patients, but parents and carers are important too.
74% of users want help from anyone, 26% ask for a named GP, 10% most popular.
Over time, an increasing number of patients providing feedback say the new system is better.
Last 4 weeks, overall 60% say new system is better, inc 63% of seniors 60+, 64% of all who have used the system more than once.
Top 10 Conditions

- Cough
- Back pain
- Skin condition
- Chest/throat infection
- Digestion
- Headache
- Abdominal pain
- Urine infection
- Ear/nose/throat
- Fever
Rydal Group Practice

375 High Road, Woodford Green, Essex, IG8 9QJ
Opening hours: Monday to Friday 8am to 6.30pm
Tel: 020 8504 0532

My Rydal
The quick and easy way to make an appointment or order a prescription.

Offered Health Services
See all the health services that the Rydal Group Practice offers.

Practice Information
General contact and staff information.
My Rydal

The quick and easy way to make an appointment or order a prescription.

Request an Appointment  ||  Contact the Surgery  ||  Order a Prescription

Quick Access

Visit our new askmyGP service to request a consultation or ask a question at any time and receive a prompt call back within surgery opening hours.

Click Here
How can we help?

Get help from your practice

Self care - find advice now on NHS Choices

Using the askmyGP service, provided by your GP, you can request help at any time. You will be called back promptly within your chosen time frame.
Do you want to ask about
Who would you like help from?

<< Back

Privacy Policy
Had we solved the whole problem at a practice level?

- No financial incentive for success so massive distortions in service across the region
- Our staffing is so low we still can’t provide 100% access and needed overflow capacity (£125 v. £168)
- We were still failing in the proactive care element of primary care and public health
- We have no control over the rest of the pathways by other providers
- Burnout occurs when passionate, committed people become deeply disillusioned with a job or career from which they have previously derived much of their identity and meaning. It comes as the things that inspire passion and enthusiasm are stripped away, and tedious or unpleasant things crowd in – Mindtools.com
HBD Access Hubs Conversion Rate

**HUB 1**

**HUB 2**
Weekend GP trial scrapped as few patients show up

Chris Smyth Health Editor
Kat Lay Health Correspondent

Weekend GP appointments have been scrapped in one of David Cameron’s key pilot schemes after doctors said no one was turning up. Patient campaigners called the decision “ludicrous”.

Weekend GP appointments were filled in Yorkshire surgeries testing out-of-hours care and only half of Saturday slots were taken up, doctors did not want to book appointments at surgeries other than their own.

Dr Pleydell said the group’s funds were “better spent on other initiatives” such as community nursing.

Roger Goss, of Patient Concern, said the pilot should have run longer. “It is a sweeping generalisation [to say patients don’t want weekend appointments],” he said. “What about all those practices where people cannot get appointments for two or three weeks?”
The negatives

- In Hub 2, the host practice accounts for 43% of the patients seen there in a month
- 210 patients v. 2 sent by the lowest referrer in the area
- The number of patients correlates directly with two factors – geographical distance and performance in the GP satisfaction survey
- New Hub 3 is in by far the highest scoring area for access and we are struggling to get above 30% usage despite the local hospital just having recorded the poorest A+E performance in the country
- Increased the demand for floating sessional workforce
- Undermined the credibility of the federations with a perception that we have inefficiently spent money the practices could have used
The positives

- Formed three federations and gave them the experience of setting up and running a service collaboratively.
- Built a GP led overflow infrastructure including access hubs and a central call centre which had exceptional patient satisfaction.
- Helped us to work in partnership with the local trust and the OOH provider.
- Developed a genuine integrated patient record solution.
- Prepared us for the next step - VANGUARD.
Vanguard

- 111/Online Tool
- Triage

Primary Care Transformation

- Local Authority
- NELFT
- PELC
- Pharmacy Trust
- Schools
- Carers
- Care Navigation
- Secondary Care

Capitated budget, Appointment booking, Shared Record, Governance, Workforce
Key messages

- Do not write off General Practice based Primary Care as the solution – it may need to modernise and network but it’s still the cheapest, safest, highest quality location for modern primary care
- Realise that General Practice is full of dedicated, innovative teams looking for ways to improve
- Remove the perverse counter – incentives to effort
- Cultivate a “Lean” culture in the NHS predicated on continuous, incremental improvement on the shop floor – create mechanisms to identify it, facilitate it and spread it
Aggregation of Marginal Gains

- 1% Improvement
- 1% Decline

Time →
PMCF in Southwark

Hayley Sloan, Head of Transformation for Primary Care, Southwark Clinical Commissioning Group

Dr Louisa Dove, Associate Director in Quay Health Solutions

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Southwark – Extended Primary Care Access

Wave 1 Challenge Fund Site

- The 'Southwark' context
- What we did in practice
- How is it going?
- What lessons have we learnt?
- What are we going to do next?
The Southwark context (1/2)

A vibrant and diverse inner-London borough of 300,000 people

Four neighbourhood groups of practices; geographically coherent around natural communities

Two GP Federations (Improving Health and Quay Health Solutions) holding contracts for services and quality improvement schemes

Two emerging Local Care Networks supporting multi-specialty community working and population-based delivery
The EPCS helped address strategic challenges and build new relationships

How to manage access across a complex urgent care system?

- Coordination
- Capacity
- Consistency

How to manage and improve population outcomes?

Develop the right services: Walk-in-Centre → EPCS

Develop the right primary care partnership: GP federations

Develop the right system partnership: LCNs (MCPs)

How to manage inequality and variation across our populations?
What did we do in practice? (1/3)

The CCG and federations worked together with practices to develop and deliver

- Alongside the Prime Minister’s Challenge Fund the CCG co-invested recurrent funding (as part of a wider transformation package)

- Federations worked closely (and quickly) with member practices to co-design an operating model

- We approached the implementation as a phased roll-out across the two halves of the borough
What did we do in practice? (2/3)

All of which was done in a very short space of time

- **2014**
  - **Jan**: Challenge Fund bid submitted
  - **Feb**: Challenge Fund bid successful
  - **Mar**: Business Case developed
  - **Apr**: Provider Expressions of Interest sought
  - **May**: Business case & CCG funding approved
  - **Jun**: GP Federations confirmed as providers
  - **Jul**: South Federation formally established

- **2015**
  - **Jan**: Co-design of pathway with practices (south)
  - **Feb**: Service mobilisation (south)
  - **Mar**: Co-design of pathway with practices (north)
  - **Apr**: Service mobilisation (north)
  - **May**: North site launched
What did we do in practice? (3/3)

We developed and began to implement an integrated service model.

- Coordination
- Capacity
- Consistency

Appts: 87,000
Phone: 39,000
Contacts: 126,000
How is it going? (1/3)

Overall utilisation is lower than expected but improving over time

• Low weekend utilisation
• Practice utilisation variable
• Utilisation likely to increase as service model develops
• North site phased approach to implementation

Number of appointments offered versus those booked by month

<table>
<thead>
<tr>
<th>Month</th>
<th>Available</th>
<th>Booked</th>
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</thead>
<tbody>
<tr>
<td>Apr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
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<tr>
<td>Jun</td>
<td>North</td>
<td></td>
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<td>Jul</td>
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<td>Aug</td>
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<td>May</td>
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<td>Jun</td>
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<td>Jul</td>
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<td>Aug</td>
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</tbody>
</table>
And daily patterns suggest peak demand in the middle of the day
Patient satisfaction for those who attend the service is high

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage of patients likely or extremely likely to recommend the service*</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>93%</td>
</tr>
<tr>
<td>May</td>
<td>94%</td>
</tr>
<tr>
<td>June</td>
<td>93%</td>
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<tr>
<td>July</td>
<td>95%</td>
</tr>
<tr>
<td>August</td>
<td>94%</td>
</tr>
</tbody>
</table>

*North service
What have we done well?

- Practice engagement & co-design
- Service development and implementation group
- Project management
- Information sharing
- Patient engagement
- PMCF and locally commissioned service for 3 years
- GP Federations delivering service
- Integrated model with practices and GPOOH provider
What will we do next?

There is lots of scope to expand

- Expand scope to include routine appointments
- Developing HCA / ANP workforce opportunities
- Creative ideas for recruitment and retention of GPs
- Test bed for improving population health and other Federation-led initiatives
- Testing in-house EPCS telephone management (south pilot)
- Service improvement group to ensure responsive, high quality service
Summary of today’s discussion

- **Southwark context**: Part of an overall strategy to support primary care transformation and population-based care

- **What**: Partnership working and co-design (in short timeframe) to deliver 87,000 new appointments

- **How is it going**: Utilisation is lower than expected but improving, and patient satisfaction is high

- **What lessons**: This is difficult but achievable, particularly with the right package of development and support

- **What next**: There is lots of scope to expand although some barriers too (e.g. contract restrictions and routine appointments)
Q&A

Dr Edward Diggins, GP Partner at the Rydal Practice in Woodford Green, Redbridge

Hayley Sloan, Head of Transformation for Primary Care, Southwark Clinical Commissioning Group

Dr Louisa Dove, Associate Director in Quay Health Solutions

Liz Wise, Programme Director, Transforming Primary Care, Healthy London Partnership

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HOW TO MAKE THE VISION A REALITY? (PART 2)
1. What do you think you can do to resolve some of the challenges described in Part 1?

2. Is there one pledge from what you have heard which you can take back ‘to base’ to improve access?

3. Are there areas you would like to hear more about or are there other sessions it would be helpful for the programme to run?
You’ll have the chance to visit **2 out of the 3** of these following innovations

**Suite 3**  
**WebGP**  
*Murray Ellender*

**Debenture Lounge**  
**Patients Online**  
*Richard Ince & Trevor Fossey*

**Pakistan Suite**  
**AskmyGP**  
*Harry Longman*

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#HealthyLDN
Breakout sessions on Access

1. When the alarm rings please move to your first session. You will have **25 minutes** to hear about this area and ask questions.

2. **25 minutes later**… The alarm will ring again, and please move to your next breakout.

3. The alarm will ring a **third time**, as a signal to move back to your tables.
Summary and Close
Thank You