

Greater Glasgow NHS Board

Board Meeting

Tuesday, 15 April 2003

Board Paper No. 03/26

**CHIEF EXECUTIVE
GREATER GLASGOW PRIMARY CARE NHS TRUST**

PRIMARY CARE ACCESS STRATEGY UPDATE

RECOMMENDATION

The NHS Greater Glasgow Board is asked to:-

- (a) note the progress being made on access initiatives within the Trust and to endorse continuation of the approach adopted;
- (b) to note that practice redesign and triage training costs are not directly funded by the Scottish Executive and there financing will need to be considered in finalising the priorities for the Local Health Plan.

A. BACKGROUND

In October 2002 the Primary Care NHS Trust submitted to Greater Glasgow NHS Board its initial proposal to improve *Access to Primary Care*. The aims of the strategy are to improve access to services across a range of measures and at the same time support the short-term goal of ensuring access to an appropriate member of the primary health care team within 48 hours by April 2004.

The strategy was divided into three sections:

- Long Term initiatives towards "Increasing Capacity"
- Medium Term initiatives towards "Managing Demand & Service Redesign"
- Short Term initiatives towards "Assessment, Triage and Waiting Times"

Following endorsement of this strategy by the NHS Board and SEHD the Trust was asked to submit an update in April 2003. Although this update is focused upon the short term initiatives designed to meet the '48 hour' commitment there have been considerable achievements in respect of the overall strategy that have been documented in the Primary Care Strategy Phase 2. There is a temptation to think that the access strategy is concerned only with patients being to access an appointment with a GP within 48hours. Although this is one strand of the strategy, and perhaps the most visible one, it is not the only one.

In the longer term the access strategy is concerned with a fundamental rethink and redesign of services within primary care towards streamlining ways that patients may access these services. The long and medium term initiatives in the Access Strategy are an integral part and discussed in more detail in the Primary Care Strategy, Phase 2.

In the meantime the Primary Care Modernisation Group is operating at a national level to refine the definitions and measures of achieving the '48 hour' commitment, sharing good practice and addressing key areas that are appropriately dealt with on a national basis. These directions will be incorporated as appropriate in the Greater Glasgow strategies.

B. FOCUSING ON SHORT TERM INITIATIVES

The Current Situation

There are currently two measures of performance against the 48 hours target; returns from the General Practice stocktake of available appointments and number of practices that operate telephone triage by health professionals.

The initial GP appointment stocktake was undertaken in June 2002 and showed that of the 83% of practices that responded, 74% were able to provide a routine appointment within the 48 hour period. There was some scepticism about these results as they were inconsistent with anecdotal experience and only measured access at a single point in time.

A subsequent stocktake in December 2002 changed to a methodology more widely adopted in the UK that involved measuring the third available appointment over five consecutive days. An almost identical result was achieved in that 75% of the practices that responded met the 48 hour commitment. However there was a response rate of only 50% of practices. (Attachment 1)

The lack of compliance with the stocktake process is indicative of the ambivalence shown towards the target by General Practice and some suspicion about how this information would be used by the PCT.

Efforts continue through a working group involving LMC representatives to identify a satisfactory process of measuring performance against the target. It is anticipated that response rate will alter once the actions designed to support practices to achieve the target become more visible. It should also be noted that the proposed new GMS contract provides an incentive for achieving access targets that will consequently improve the data collection process.

Should voluntary participation in the supply of data continue to be problematic then it will be necessary to introduce alternative methods of data collection to assess performance against the target.

Practice Redesign

In June 2000 a programme supported by the Primary Care Collaborative in England commenced and now covers 18.2 million of the population. The purpose of this programme was to improve access and reduce the level of mortality of patients with coronary heart disease. It has been shown that through this approach there has been a significant improvement in each of the above areas.

The Scottish Primary Care Collaborative has in conjunction with the National Primary Care Development Team co-ordinated the setting up and operation of the first wave of this programme in Scotland. The Health Minister launched this on the 25th March 2003. This program should not be seen as a panacea for addressing all the issues for improving access in primary care. As practices go through the Collaborative programme, issues may be discovered that cause the Primary Care Access Strategy to be refocused or changed. At that time the direction of the strategy would be reconsidered and further submissions for resources would be made if necessary.

Each of the four waves over the next two years will comprise of 5 practices from 20 LHCCs throughout Scotland. In agreement with the Scottish Primary Care Collaborative the bid from Glasgow will not necessarily comprise of 5 practices per LHCC but could be an amalgamation of several LHCCs.. This is due to the fact that 63 practices have expressed an interest in participating in this program but not necessarily 5 per LHCC. This agreement was reached so that those LHCCs with less than 5 interested practices were not excluded from the process. This also helped to support one of the key elements of the collaborative approach to establish a body of knowledge to actively disseminate to other sites the achievements through participation in the programme. The bids for Wave One from Glasgow will cover 30 practices and it is assumed that this number will be successful in each of the subsequent 3 waves. It is anticipated that over a two year program using the Collaborative "buddy" system that 90% of general practices in Glasgow will have an opportunity for involvement in the Collaborative aims and methodology.

A bid will be submitted to the Scottish Primary Care Collaborative by the end of April outlining the following:

- project managers to support each group of practices
- clinical and managerial leadership
- descriptors of LHCC and participating practices
- demographics and socio-economic
- innovation and commitment to continuous improvement
- patient and care involvement
- spread of continuous improvements
- funding available
- funding commitment from Trust/LHCC

The current specific measurable aims for the practices will be that 90% of patients can access a routine appointment within 48 hours. This target therefore supports those aims identified in *Partnership for Care, Primary Care Access Strategy* and proposals in the new GMS contract. An additional specific measurable aims for practices will be to

generate early, demonstrable improvements in the management and care of patients with Diabetes. The final measures will be decided by an expert reference panel but it is likely that this will support the current development of the existing Chronic Disease Management Programme in Glasgow.

A job description for the Collaborative project managers has been completed and in anticipation of the bidding process has been advertised as fixed term/secondment opportunities. This is to ensure that the project managers will have been appointed to support the successful practices at the beginning of the program.

The Scottish Executive has provided funds to cover salary and practice participation costs but the local NHS system is expected to cover additional operating costs. Each participating practice will receive £5,000 to support its costs associated with participation in Year One of the programme.

The costs associated with local delivery of this program have been estimated on the assumption that 30 practices will be successful in each of the four waves of the bidding process. It should be noted that this figure will vary dependant upon the final success of the bids. Each subsequent wave will require the same level of funding to support their involvement in the program but it is not yet clear what funding will be able from the Scottish Executive to support this. It has been assumed that the level of funding will not be significantly different and therefore the submission for additional resources has been made on this premise.

In summary to support all 4 waves of 30 practices each over the next 2-3 years will require local funding of £131,250 in year 1 and £162,630 in year 2.

Assessment and Triage

Evidence from practices undertaking the Primary Care Collaborative approach have demonstrated that by introducing a triage service it improves the level of access for patients. Significantly, the operation of a professional triage system meets the commitment to access to the Primary Health Care Team within 48 hours.

To establish the current level of triage in Glasgow a survey was undertaken in September 2002. This showed that 28 practices were actively operating some form of professional triage although the method varied considerably and little formal training had been undertaken.

To determine the value of triage and test models it was decided that two pilots would be undertaken and these commenced in October 2002. The practices undertook a period of data collection, protocol development and role review prior to introducing a triage service in December 2002.

Two approaches have been tested:

- Triage was undertaken by the Practice Nurse between the hours of 8.30-10.30. This would involve telephone and face to face contact for patients requesting home visits, emergency appointments or generally dissatisfied with their appointment time.
- Triage was undertaken by either the Practice Nurse or GP at designated times of the day. This would involve telephone and face to face contact for patients requesting home visits, emergency appointments, walk ins, generally dissatisfied with their appointment time.

Both practices were also supported through an IT system to deliver triage and collect data:

- appointment availability against 48 hours using 3rd routine available appointment
- types of clinical activity
- outcomes of triage activity
- patient satisfaction
- staff satisfaction.

Although the results will not be formally available until late April 2003 it is evident that triage supports practices in achieving the access target. Additionally it shows that the service that the patients receive as a result of triage is more appropriate to their needs. The introduction of a triage service in General Practice changes the dynamics of service provision. Demand alters as well as which health professional is involved in service delivery. This in turn has the potential to create a cascading effect within the Practice that may create access issues for patients using different types of services. It should therefore be noted that triage while improving immediate access has in turn the potential to identify other access issues that will require other strategies and resources to manage.

Progressive take up of triaging models will be dependent upon the outcome of the pilot evaluation and the practice redesign initiative. However, we can estimate from current training uptake that nearly 50% of practices in Greater Glasgow will be undertaking triage within eighteen months. To support this rollout it is recognised that staff must undertake a level of training that ensures professional competence. A contract has now been let with the DTC Primary Care Training Centre in Bradford to provide two triage-training courses in 2003/2004 for up to 48 Nurses at a cost of £28,800. This six-month course is accredited through the University of Huddersfield and meets the identified requirements for implementing a triage service. Current indications are that there is a need for a further 2 courses in 2004/2005 to support the extension of triage. Funding is required for these triage training programme (see Attachment 2)

C. CONCLUSION

Our current state of knowledge about timely access to service is growing but still insufficient to adequately monitor performance against the 48 hour target. At best we can assume that 25% of practices are unable to meet the access target. The two main short term strategies of practice redesign and triage will advance significantly in the course of the next year and will, if other UK experience is consistent in Glasgow, be able to address this shortfall as well as providing more confident measures of performance.

TOTAL RESPONSE FOR SECOND GP APPT STOCKTAKE

Name of LHCC	Nos d	DID NOT RESPOND	Response	16/12/2002		17/12/2002		18/12/2002		19/12/2002		20/12/2002		average over one weeks	
				<48HRS	>48HRS										
ATTACHMENT ONE															
Clydebank	10	70%	30%	67%	33%	67%	33%	67%	33%	100%	0%	100%	0%	80.20%	
ABM	8	13%	88%	86%	14%	86%	14%	71%	57%	71%	29%	57%	43%	74.20%	
Drumchapel	5	60%	40%	50%	50%	50%	50%	50%	0%	50%	50%	50%	50%	50.00%	
North Glasgow	13	38%	62%	75%	25%	88%	13%	63%	38%	75%	25%	75%	25%	75.20%	
Strathkelvin	12	50%	50%	67%	17%	67%	17%	67%	17%	67%	0%	83%	0%	70.20%	
Maryhill-Woodside	13	54%	46%	67%	33%	50%	50%	50%	50%	67%	33%	67%	33%	60.20%	
Eastern	24	63%	37%	67%	33%	56%	44%	56%	44%	67%	33%	78%	22%	64.80%	
Westone	12	33%	67%	50%	50%	75%	25%	75%	25%	75%	25%	75%	25%	70.00%	
South West	22	41%	59%	100%	0%	92%	8%	85%	15%	100%	0%	92%	8%	93.80%	
South East	19	63%	37%	71%	29%	86%	14%	86%	14%	71%	29%	86%	14%	80.00%	
Riverside	15	47%	53%	100%	0%	88%	13%	88%	13%	88%	13%	88%	13%	90.40%	
Shawlands	14	50%	50%	100%	0%	100%	0%	100%	0%	100%	0%	86%	14%	97.20%	
Eastwood	12	67%	33%	50%	50%	50%	50%	50%	50%	50%	50%	75%	0%	55.00%	
Dennistoun	7	57%	43%	100%	0%	100%	0%	100%	0%	100%	0%	100%	0%	100.00%	
Camglen	13	38%	62%	88%	13%	88%	13%	88%	13%	88%	13%	88%	13%	88.00%	
Bridgeton	12	50%	50%	67%	33%	50%	50%	33%	67%	67%	33%	50%	50%	53.40%	
	211	50%	AVERAGE TOTALS	50%	75%	24%	75%	25%	71%	27%	77%	21%	78%	19%	75.16%