EMBARGOED UNTIL DATE OF MEETING.

NHS Greater Glasgow

Greater Glasgow NHS Board

Board Meeting

17 September 2002 **Board Paper No. 02/61**

CHIEF EXECUTIVE, PRIMARY CARE TRUST

ACCESS TO PRIMARY CARE

Recommendation:

Members are asked to:

* Note the current situation in regard access to Primary Care Services in Greater Glasgow

* To endorse the strategy for achieving improved access and in particular achieving the 48hr access target for Primary Care Services

* To endorse the action plan for achieving and monitoring the 48hr access target for Primary Care Services

1 Introduction

1.1 Background

As part of the programme outlined in *Our National Health,* public access to an appropriate member of the primary health care team within 48hrs has been identified as a national target. The target reflects the importance of timely access to in order to achieve high quality health care as well as the value the public places on this service dimension when assessing the effectiveness of the NHS. It is worth noting that a key universal principle underpinning primary care is rapid accessibility by the public to deal with common health problems. A commitment to appropriate access is therefore a welcome reaffirmation of the importance of primary care in the health and social care system.

It is accepted that this goal will take a number of years to achieve and will involve significant service redesign, changes to the way services are used by the public and signals the need for the NHS to devote the necessary time and resources. NHS Boards are required to submit a strategy and target date for achieving 48hr access by 20 September 2002. Performance against the 48hr guarantee will be continuously monitored through the new Performance Assessment Framework for NHS Glasgow. This means it will be a focus for attention at both local and national level.

Strategies to achieve more timely access will be multi-faceted and although there will be local initiatives there are a number of issues that can be more effectively addressed throughout Scotland. The recent report of the Primary Care Modernisation Group, *Making the Connections*, has already begun to detail a workplan for national collaboration on specific initiatives aimed at improving access.

At a local level Greater Glasgow's Primary Care Strategy provides a long term direction and investment plan for improving capacity and access to services. Within this context, a strategy has been devised to gather information, test new approaches and focus short-term actions to achieve the 48hr access target.

Pending the outcome of this preliminary work, it is difficult to accurately predict the service, and cost implications of achieving this target. However, a target date of April 2004 has been set and will be reviewed as the strategy is fully developed and costed.

This paper defines access, describes the current situation in Greater Glasgow and highlights long, medium and short term strategies in the following areas;

- Increasing Capacity
- Managing Demand and Service Redesign
- Assessment, Triage and Practice Redesign

2. Definitions of Access to Primary Care Services

2.1 Defining Access

The definition of access has been identified by SEHD as:

access to an appropriate member of the primary care team by direct contact (telephone or face-to-face) between the patient and the professional in line with the practice's consultation arrangements where:

- professional, clinical advice is sound and given within 2 working days in accordance with the clinical needs of the patient: and
- a professional, clinical opinion and/or diagnosis is required in order to determine a further course of action e.g. to treat, to refer or to provide professional advice

2.2 Defining Professional and the Primary Care Team

- professional means a doctor, nurse or health visitor in the practice with which the patient is registered, who is competent to deal with the patient's clinical needs

Significantly, the description of the primary care team (as distinct from a GP consultation) is deliberately aimed at ensuring that the full capacity of the growing and integrated primary care team is brought to bear on the need to provide timely access for people. Similarly, appropriate access to service is not defined solely through a face-to-face contact and must necessarily involve the use of other forms of communication, particularly telephone assessment and advice.

3. Capacity within Primary Care

3.1 Current Situation within Greater Glasgow

Primary Care is achieving an appropriate level of access for those in most urgent need through the provision of emergency and same day appointments. This level of access is often achieved at the expense of less urgent or routine care.

Where a person is requesting to see a specific practitioner then this delay can be significant although this is at the choice of the individual and will not be assessed as part of the ‘48hr’ commitment.

In June of this year, the Trust undertook a baseline audit of the current access to a GP appointment.

A total of 179 (83%) practices were surveyed and the results showed that 74% of practices were able to meet the target. The remaining 26% were unable to offer a routine appointment within 48hrs and patients had to wait as follows:

10% by third day
7% by fourth day
4% by fifth day
3% by sixth day
1% by seventh day
1% by eighth day

See Attachment 1 for a summary of results by LHCC

Between LHCCs the number achieving the target ranged from 50% to 100%. This variability arises from a complex range of supply and demand factors associated with accessibility. There are significant differences in General Practice (related to independent contractor status) which lead to differences in organisation and capacity, for example length of appointment times. The size, type of practice populations and seasonal factors will also have an impact upon waiting times.

Although not synonymous with the 48hr access definition the availability of GP appointments will be the focus for the public’s judgement and experience of access. Equally significant is the availability of telephone advice and triage systems as a means of meeting the access target. Currently a number of practices operate triage systems for home visits, emergency appointment and minor illness advice. However, these are not consistently available and therefore do not provide an assurance that access is available in those practices that are not providing appointments within the 48hr period.

There is specific reference in the Greater Glasgow Primary Care Strategy to increasing the capacity of primary care to meet current demands. This will assist towards achieving the 48hr target for waiting times indirectly through the provision of additional resources to meet the needs of specific patient groups, particularly in areas of high deprivation. Although an important framework for development, it does not provide the short-term strategies required under the Scottish Executive direction.

4 Strategy and Action Plan

4.1 The Greater Glasgow Primary Care Strategy provides the overall context for improving access and quality of primary care services. The strategy outlined below and the attached Action Plan (Attachment 2) identifies a range of initiatives that compliments the overall approach while ensuring the national target is met. The actions are linked to long, medium and short-term timescales. The long and medium term initiatives concentrate on the development of increased capacity and redesign while the short-term initiatives focus on the ability of patients to access services within 48hours.

4.2 Long Term Initiatives towards "Increasing Capacity"

These initiatives will require significant redesign of service delivery that will need to be supported by increased capacity and additional financial resources. In addition, long-term initiatives will require the engagement of secondary care. Some of the long-term aims are dependent upon the implementation of national plans.

Significant examples include:

- Chronic Disease Management Programme which, through a four year programme will provide resources to deliver best practice care in Diabetes, Ischemic Heart Disease, Chronic Obstructive Pulmonary Disease, Stroke, Rheumatoid Arthritis, Epilepsy and Multiple Sclerosis. This will facilitate a standardised level of care to be delivered to patients in the seven disease groups and will meet the access requirements for these patients.

- A primary care mental health initiative is currently rolling out across Greater Glasgow. This initiative is aimed at patients suffering acute episodes of mild-moderate mental health problems.

- The establishment of joint elderly service teams will provide a responsive, intensive and comprehensive assessment. This development will provide easier access to a wide range of health and social services.

- The development of joint Community Addiction Teams arises from policy and strategic initiatives at both national and local levels in relation to integrated service delivery.

- Personal Medical Services (PMS) developments for homeless people and those living in nursing homes have been approved and will significantly alter the demands upon primary care improving access to relevant services.

- The distribution of resources throughout the city is being progressively altered to reflect the unique circumstances in areas of high deprivation. Future investment will be more clearly linked to workload and demand. A research project is being conducted in Possilpark with the University of Glasgow to assess the type and level of services needed in communities with compounding multiple health and social problems.

- The way in which outpatient appointments and information exchange with the secondary sector is processed is being redesigned using information technology and will provide the opportunity to reduce the amount of time currently spent by GP practices.

- Major initiatives to address the relationship between primary and secondary care are being sponsored by NHS Glasgow. A Patient Access Team is currently being proposed to facilitate collaborative redesign. The introduction of Ambulatory Care Centres offers the opportunity to redesign access to investigations and same day interventions. Primary care participation and influence on this process will enable a focus on the issues that have an impact on practice effectiveness and efficiency.

4.3 Medium Term Initiatives towards "Managing Demand & Service Redesign"

These initiatives will require redesign of referral pathways and professional roles and involve practitioners related to General Practice such as pharmacists, allied health professionals and other community service providers.

Services can be reconfigured to have an effect upon the management of demand and subsequently waiting times. It will involve ensuring the appropriate professional is available at the right time in the course of treatment as well as efficiently matching resources to needs. For example, GP consultations are inappropriately used as a gatekeeper to some services and direct access will lead to more prompt attention and reduce demand on GP time.

Examples include:

- The introduction of self-referral systems to physiotherapy and podiatry services within eighteen months. This will eliminate unnecessary GP consultation and speed up access to these services. Additionally it will also enable patients to improve their knowledge and capacity to self-care.

- The introduction of primary care support workers in practices and treatment rooms. Through the development of this new role, other members of the primary health care team will gain additional capacity to deliver best practices models for chronic disease management.

- Trials of over the counter (OTC) medication will be rolled out nationally and transfer the burden of minor ailments from the GP practice to the community pharmacy setting. Pharmacies are increasingly now equipped to allow more personal consultations to be conducted discreetly. This will also eliminate the need for patients to access GPs and therefore increase their access to treatment and advice.

- Redesigning the referral route between Optometrist and Ophthalmology will eliminate unnecessary referral via the GP and increase access times to this service. An evaluation of the process and the effects for patients and members of the Primary Health Care Team will determine the best model to adopt across Greater Glasgow NHS.

- It has been recognised that the GP consultation is being used as a gatekeeper to some non-medical services inappropriately and therefore adding unnecessary demand. At a Scottish wide level, a number of areas are being addressed where the GP is being used to provide access to welfare provision as opposed to providing health care.

4.4. Short Term Initiatives towards "Assessment, Triage and Practice Redesign"

The immediate actions required focus upon practice redesign, initial assessment data collection/monitoring.

- A methodology for practice level redesign called the ***Primary Care Collaborative*** has been successfully introduced in England. Its purpose is to manage demand through the design of assessment and appointment systems and to facilitate the introduction of chronic disease management programmes (CDM) at practice level. The introduction of this approach in Glasgow would be timely given current local CDM developments. Some of

the innovations arising from this approach have already been adopted in some practices and although not a panacea it will offer expertise for practices to undertake the analysis and changes required. This programme will be introduced in to Glasgow based upon the outcome of the data collection process that identifies specific practices that require support. It is anticipated that twenty-five practices will participate in the first six months.

- Initial assessment and triage is central to achieving the 48hr target. Firstly, it standardises the way in which priority is assessed for each individual and therefore those that require early intervention receive timely care. Secondly, it enables people to make contact with a health professional in the primary care team within the 48hr period and ensures that they have access to the right service. To determine the level of existing triage services an initial survey will be undertaken. This will provide information as to the various models in existence and the affect on accessing a member of the primary health care team. Current anecdotal evidence suggests that various levels of current assessment take place by telephone from receptionist screening to medical telephone consultation.

- Trials of nurse assessment and triage services at practice, health centre and LHCC level will be introduced this year. These will provide further evidence on which to base future strategies. One trial will operate a default system for patients of participating practices that cannot receive an appointment within 48hours, prioritise based on agreed protocols and offer potential alternative routes for service. This approach will have to be carefully integrated with the introduction of NHS 24 and the operation of after hour's emergency services. Areas that have already been identified to support these trials are Eastwood LHCC and Eastern Glasgow LHCC. Other LHCC's have intimated through early discussions an interest in demonstrating the effectiveness of various forms of triage.

- The initial data collection on the availability of GP appointments will be refined and improved to measure access to the entire primary care team. It is proposed to be conducted on a quarterly basis and will enable comparison to be undertaken against previous results and monitor progress on implementation of the strategy. Evaluation and monitoring will enable access to be continuously monitored through the Performance Assessment Framework for NHS Glasgow. Those areas that consistently experience difficulty in achieving the 48hr target will be provided with support to assess demand and redesign service arrangements.

5. Cost Implications

There are significant cost implications to improving access over the long term. The Local Health Plan and Primary Care Strategy financial frameworks are the primary and appropriate vehicle for directing this investment. It will be essential to maintain current commitments to service developments that address the capacity of Primary Care. In particular, the expected redistribution of GMS funding based on the Arbuthnott formula is required to complete the full roll out of the Chronic Disease Management Programme.

The current primary care strategy is appropriately focused on achieving the longer and medium term actions to improve access. However, the review of the strategy in September – December 2002 will provide the opportunity to assess the implications

of the 48hrs access target and bring forward priorities that will have a more immediate impact.

In the meantime, a number of short-term actions are designed to improve our knowledge of the current situation and test new approaches. In particular, practice redesign and establishment of triage models will need to be funded. The following items were submitted for funding through the Waiting Time Initiatives;

		£'s (K)
*	audit and data collection	9,000
*	information technology	22,000
*	pilot triage nurses and training	43,000
*	practice redesign	140,000
		£214,000

This bid was unsuccessful and alternative sources of funding are now being explored.

6. Conclusion

The target date of April 2004 to achieve 48hrs access is ambitious. Although Greater Glasgow is well placed through the current commitment to primary care development there is a need to develop new and short-term strategies.

Based on the results of the first phase of practice redesign, pilot triage and data collection a fully developed and costed strategy will be prepared and submitted to the NHS Board in March 2003.

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Attachment 1

RESULTS SUMMARY OF STOCKTAKE ON THE AVAILABILITY OF A ROUTINE GP APPOINTMENT

The following points summarise results from the analysis of the stocktake returns from LHCCs.

1. All 16 LHCCs undertook the stocktake. (Refer Appendix A, page 1.)

2. A total of 179 returns were received. This equated to an 83% level of practice participation. (Refer Appendix A, page 1.)

3. Percentage returns in individual LHCCs ranged from 50% to 100%. (Refer Appendix A, page 1.)

4. Analysis of the 179 returns showed. (Refer Appendix A, page 2.)

   - 74.3% with an appointment available on or before the second day (this is an indication of the availability of 48 hour access to practices). Availability by subsequent days is:
   - 84.4% by third day
   - 91.7% by fourth day
   - 94.5% by fifth day
   - 97.3% by sixth day
   - 98.4% by seventh day
   - 98.9% by eighth day
   - 100% by ninth day

5. Appointment availability in individual LHCCs ranges from: (Refer Appendix B.)

   - 16.7% to 95.5% by second day
   - 50.0% to 100% by third day
   - 75.0% to 100% by fourth day
   - 75.0% to 100% by fifth day
   - 75.0% to 100% by sixth day
   - 87.5% to 100% by seventh day
   - 92.8% to 100% by eighth day
   - 100% by ninth day

6. Graphs showing appointment availability in each LHCC against sector and Greater Glasgow wide availability are attached.

STOCKTAKE ON THE AVAILABILITY OF A ROUTINE GP APPOINTMENT (AT 11:30AM ON TUESDAY 25 JUNE 2002)

RETURNS FROM 16 LHCCs SHOWING APPOINTMENT AVAILABILITY OF PRACTICES (IE THE NUMBER OF PRACTICES WITH AN APPOINTMENT AVAILABLE ON THE SAME DAY, NEXT DAY, ETC)

Appointment Availability	LOCAL HEALTH CARE COOPERATIVES (LHCCs)																	
	W1	W2	W3	W4	W5	NE1	NE2	NE3	NE4	NE5	NE6	S1	S2	S3	S4	S5	TOTAL	No. of practices as % OF TOTAL
	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	No. of Practices	(179) RETURNS
Same Day	2		5	3	1	5	1	3	1			1	2	2	4	8	38	21.2
Next Day	2		2	2	7	2	5	3	3	1	4	6	4	5	4	8	58	32.4
Second Day	1	1	1	3	1	3	4		3			4	6	2	3	5	37	20.7
Sub Total (note 1)	5	1	8	8	9	10	10	6	7	1	4	11	12	9	11	21	133	74.3
Third Day	1	1	2			1	1	1	3	2	1	3			1	1	18	10.1
Fourth Day		1	1	1				1	2	2	1	1		3			13	7.3
Fifth Day								1	2		1	1					5	2.8
Sixth Day					1		2	1		1							5	2.8
Seventh Day	1											1					2	1.1
Eight Day	1																1	0.5
Ninth Day							1		1								2	1.1
Total No. of Practice returns (note 2)	8	3	11	9	10	11	14	10	15 (note 4)	6	7	17	12	12	12	22	179	100
No. of Practices in LHCC Area (note 3)	8	5+1	10	12	16+1	11	14	13	24	12	7	19+1	13	12	14+1	22	216	
Percentage (%) Returns	100	50	100	75	59	100	100	77	63	50	100	85	92	100	80	100	83	

Identification of LHCCs and total number of patients registered with practices in the LHCC area:

W1	49,326	Anniesland/Bearsden & Milngavie
W2	21,566	Drumchapel
W3	49,152	Clydebank
W4	50,717	Westone
W5	60,288	Riverside
NE1	67,445	Strathkelvin
NE2	63,189	Maryhill/Woodside
NE3	52,111	North Glasgow
NE4	112,692	Eastern Glasgow
NE5	30,390	Bridgeton & Environs
NE6	34,604	Dennistoun
S1	92,198	South East Glasgow
S2	53,938	Camglen
S3	58,646	Eastwood
S4	67,201	Greater Shawlands
S5	92,338	South West Glasgow

note 1: This sub total indicates the number of practices in each LHCC with 48 hour access availability.

note 2: A returns total greater than the number of practices in the LHCC area indicates return(s) from a branch surgery.

note 3: +1 indicates a practice in the LHCC area which is not a member of the LHCC.

note 4: A further 3 completed returns were submitted to the LHCC after the results summary was compiled.

STOCKTAKE ON THE AVAILABILITY OF A ROUTINE GP APPOINTMENT (AT 11:30AM ON TUESDAY 25 JUNE 2002)

RETURNS FROM 16 LHCCs SHOWING APPOINTMENT AVAILABILITY OF PRACTICES AS A PERCENTAGE OF THE TOTAL NUMBER OF PRACTICE RETURNS TO THE LHCC

	LOCAL HEALTH CARE COOPERATIVES (LHCCs)																	Cumulative
Appointment	W1	W2	W3	W4	W5	NE1	NE2	NE3	NE4	NE5	NE6	S1	S2	S3	S4	S5	Greater Glasgow	Appointment
Availability	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage	Average (note 2)	Availability
Same Day	25.0		45.4	33.3	10.0	45.4	7.1	30.0	6.7			5.9	16.7	16.7	33.3	36.4	21.2	21.2
Next Day	25.0		18.2	22.2	70.0	18.2	35.7	30.0	20.0	16.7	57.1	35.3	33.3	41.6	33.3	36.4	32.4	53.6
Second Day	12.5	33.3	9.1	33.3	10.0	27.3	28.6		20.0			23.5	50.0	16.7	25.0	22.7	20.7	74.3
Sub Total (no	62.5	33.3	72.7	88.8	90.0	90.9	71.4	60.0	46.7	16.7	57.1	64.7	100.0	75.0	91.6	95.5	74.3	74.3
Third Day	12.5	33.3	18.2			9.1	7.1	10.0	20.0	33.3	14.3	17.6			8.3	4.5	10.1	84.4
Fourth Day		33.3	9.1	11.1				10.0	13.3	33.3	14.3	5.9		25.0			7.3	91.7
Fifth Day								10.0	13.3		14.3	5.9					2.8	94.5
Sixth Day					10.0		14.3	10.0		16.7							2.8	97.3
Seventh Day	12.5											5.9					1.1	98.4
Eighth Day	12.5																0.5	98.9
Ninth Day							7.1		6.7								1.1	100.0
Total (nomina	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Identification of LHCCs:

W1	Anniesland/Bearsden & Milngavie
W2	Drumchapel
W3	Clydebank
W4	Westone
W5	Riverside
NE1	Strathkelvin
NE2	Maryhill/Woodside
NE3	North Glasgow
NE4	Eastern Glasgow
NE5	Bridgeton & Environs
NE6	Dennistoun
S1	South East Glasgow
S2	Camglen
S3	Eastwood
S4	Greater Shawlands
S5	South West Glasgow

note 1: This sub total indicates the availability of 48 hour access to practices.
note 2: Greater Glasgow average is the total number of practice returns from 16 LHCC as a percentage of the total (179) practices.

Primary Care Access – Action Plan **Attachment 2**

Long Term Initiatives towards "Increasing Capacity"

	Initiatives	Aims	Lead/Involvement	Target Date
1.	Chronic Disease Management Programme	• Resource appropriately a standardised level of care to seven disease groups • Standardise organisation and delivery of services to these patients • Meet defined access requirements for these groups	CDM Project Manager LHCC's GP Practices CDM Committee	Milestones 2001-2004
2.	Primary Care Mental Health	• Establish appropriate services in every catchment area • Provide alternative to GP consultation through provision of a wider range of services	Primary Care Mental Health Sub-Committee LHCCs, Mental Health Services, Social Work Departments	2001-2003
3.	Joint Elderly Services	• Establish joint teams throughout Greater Glasgow • Provide responsive, intensive and comprehensive assessment services for at risk individuals • Provide GP with case management/coordination support for these individuals	Elderly Services Project Manager Elderly PIG LHCC's, Social Work Departments, Acute Trusts	2001-2003
4.	Possilpark Research Project	• Quantify and evaluate service requirements (cost, interventions, staff types) for a practice population characterised by multiple deprivation	PMS Project Manager Keppoch Medical Practice University of Glasgow	2002-2004
5.	Secondary Care Interface	• Redesign and increase investment in areas where waiting times are unacceptable • Establishment of Access Teams • Participation in redesign working groups	NHS Glasgow Yorkhill, North & South Clinical Forums	2004

6.	Addiction Services	• Establish Community Addiction Teams.	Joint Implementation Committees	2002-2004
7.	PMS Homeless and Nursing Homes Practices	• Establish practices and deliver new and expanded services	PMS Development Officer Homeless and Nursing Home Committees	2002-2003

Medium Term Initiatives towards "Managing Demand & Service Redesign"

8.	Direct Access Physiotherapy and Podiatry	• Introduce self referral and triage systems to speed up access to services • Eliminating unnecessary gate keepers to these services • Improve patient knowledge and self care capacity • Reduce unnecessary GP consultation	PC Redesign Coordinator Head of Profession LHCC's	Jan 2004
9.	New Practice Staff Classifications	• Introduce a different skill mix by use of primary care support workers in clinical/treatment settings	PC Redesign Coordinator OD Manager LHCC's GP Practices Senior Clinical Professionals	April 2003
10.	Extend Pharmacist and Optometrist Role	• Identification of Pilot Sites and introduce a direct supply of over the counter medications and repeat prescriptions • Introduce direct referral from optometrists to ophthalmologist	PC Redesign Coordinator PC Development Officer Director of Pharmacy GP Practices Pharmacists Optometrists	2002-03
11.	Review of GP Gatekeeping Role	• Review of gatekeeping and assessment roles at national level in areas such as housing, sickness, benefit/leave etc	PC Modernisation Group	2003

Short Term Initiatives towards "Assessment, Triage and Waiting Times"

12.	Practice Redesign	• Introduce Practice redesign, analysis and support for individual practices (twenty five practices in year 1)	PC Redesign Coordinator Scottish Executive GP Practices	April 2003
13.	Assessment and Triage	• Establishment of NHS 24 • Link PCT information about service availability and criterion for access to NHS 24 • Undertake survey to identify existing triage services • Conduct triage trails at various levels: cross practices/health centre/LHCC	PC Redesign Coordinator NHS 24 LHCC's IT Department GP Practices	April 2003
14.	Waiting Times Monitoring	• Quarterly GP Consultation time survey • Develop ongoing data collection methodology for GP Practices re access times	PC Redesign Coordinator LHCC's GP Practices	April 2003
15.	Develop Access Strategy	• Provide second phase strategy and cost implications to achieve target of April 2004	PC General Manager	April 2003