ISLINGTON

GP APPOINTMENTS SYSTEMS

REPORT OF THE HEALTH AND CARE SCRUTINY COMMITTEE

London Borough of Islington
October 2014

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Chair's Foreword

Councillor Martin Klute – Chair, Health and Care Scrutiny Committee

Executive Summary

GP Appointments Systems Scrutiny Review

Aim

The review was started with the aim of assessing the performance of GP appointment systems and the service provided to residents.

Objectives of the Review

1. To assess how effective urgent and non-urgent appointment systems are and how these vary across the borough.

2. To examine GP appointments against current targets and identify any under-performing areas.

3. To collect evidence of patient experiences and assess any unmet needs.

Evidence

The review ran from November 2012 until September 2014 and evidence was received from a variety of sources including Islington Clinical Commissioning Group, Islington Health Watch, North Central London NHS Trust, GPs, Patients and the Primary Care Foundation.

Following agreement of the Scrutiny Initiative Document (set out in APPENDIX A); officers designed a work programme for the Committee meetings, visits and documentary evidence.

The submissions are detailed in the minutes of the meetings of the Health Scrutiny Committee on the Council Democracy website (http://democracy.islington.gov.uk/) or from Democratic Services at the Town Hall (Tel: 020 7527 3308).

Key recommendations:

1. Core and extended hours: That NHS England (London) works with ICCG and local GPs to develop GP surgery opening hours that offer core and extended opening hours (evenings and 7 days per week) that are adequate and appropriate to meet the population's needs across the borough, including access for key population groups, e.g. working age adults. The extended hours offer should ideally be shared and co-ordinated across the Borough with cover being rotated between practices.

2. Performance benchmarking: That NHSE works with the CCG, LMC and GP practices to agree and establish voluntary performance bench marks across the Borough for provision of appointments. Benchmarking should be based on the research findings of the Primary Care Foundation's (PCF) report 'Access and urgent care in general practice - Islington CCG' (see appendix 1), and should include ongoing monitoring (at intervals) of length of appointments, average number of appointments per patient per annum, % of patients seen by GP compared to other health professionals, length of phone calls taken by receptionists, availability of reception staff at key times, and balance of same day and book-ahead appointments. The PCF's recommendations on the appropriate levels for these benchmarks should be taken as a starting point, with GP practices allowed to deviate from these benchmarks on the basis of justifying any deviation. Benchmarking is proposed in order to reduce variability of accessibility and patient experience in obtaining appointments, which is a quality issue for the service.

3. Book-ahead appointments: The window for book-ahead appointments should be extended to six weeks as standard, following the recommendations of the PCF.

4. Means of making an appointment: All GP practices should offer a choice of access options for making appointments, including telephone, internet, and face-to-face, in order to achieve equality of access for all patient groups.

5. Long term conditions: That patient management plans and allocation of a named GP be established for patients with long-term conditions. Where patients require regular or repeat appointments, the appointment should be made by the doctor to avoid the patient having to repeatedly re-book under the daily appointment system.

6. Social support functions: That GP practices, LBI and the CCG work jointly to establish an alternative approach to providing social support services currently provided by GPs, such as school sick notes and letters in support of housing applications, to enable GPs to concentrate on core medical responsibilities. An example of an alterative approach would be, in the case of school sick notes, school nurses could be trained to assess children's fitness for school, in order to avoid taking up GP appointment slots.

7. Telephone access: That NHSE and ICCG work with all GP practices across the borough to ensure training of reception staff, including the use of a script as a basis for taking calls, to ensure staffing levels are appropriate to match demand at peak times, and that GP practices support their reception staff on an ongoing basis. Where telephone triage is used, this should be carried out in accordance with agreed protocols on best practice, to maximise the possibility that all patients have a positive experience, and to ensure that vulnerable patients are not challenged or distressed by their initial contact with the service.

Additional recommendations:

1. Procurement of additional GP services and premises: That a mechanism be established jointly between NHSE, ICCG and LBI Planning department to assess demand for GP services across

the borough, identify existing and predicted shortages – especially in areas where population is increasing due to new developments, procure new premises – where necessary by the mechanism of planning gain in new developments – and to procure GP services to fulfil existing and predicted need where identified. (The mechanism of the Bunhill Short Life Group established by NHSE in early 2014 could be used as a model for this approach – see report at appendix 2).

2. Practice nurses: That NHSE and ICCG work with GP practices to improve job security and opportunities for Practice Nurses. Measures could include rotating nurses between practices and the Out of Hours service in order to improve training opportunities, work experience, and variety and interest in the post. This on the basis of evidence heard by the committee of a shortage of practice nurses, resulting in GPs having to carry duties of the practice nurse, taking time away from their core work as GPs.

3. Funding allocation: That LBI and ICCG work together to lobby the Government to review the funding allocation formula for general practice to ensure funding adequately reflects the increased and complex needs of patients living in deprived areas, as well as the particular challenges facing general practice in London.

4. Practice information: That GP practices be required to fully publicise information regarding the availability and means of obtaining GP appointments at their practice. This information should be clear, available through all currently recognised channels of communication, and explain when and how appointments can be made, give clear information about Out of Hours Options, and the range of medical services on offer from individual surgeries in addition to basic appointments. The committee also strongly recommends the use by all practices of SMS text reminders for appointments.

5. Patient feedback: That NHSE and the CCG should work with local GP practices to establish a basket of patient feedback strategies, including patient user groups and post-appointment surveys to supplement the NHS Choices internet feedback option. Surgeries should assess feedback from all these sources to ensure they capture a balanced view of patient experience. Patient feedback should be monitored regularly.

6. Public awareness: That a public awareness campaign be developed to promote treatment options on the basis of ‘The right care, in the right place, at the right time’, and also to increase awareness of alternative treatment options, such as the minor ailments scheme in pharmacies.

Membership of the Health and Care Scrutiny Committee – 2014/15

Councillors:
Councillor Martin Klute (Chair)
Councillor Raphael Andrews
Councillor Jilani Chowdhury
Councillor Osh Gantly
Councillor Mouna Hamitouche MBE
Councillor Gary Heather
Councillor Jean Roger Kaseki (Vice-Chair)
Councillor Kaya Makarau-Schwartz

Substitutes:
Councillor Alice Donovan
Councillor Nurullah Turan
Councillor Tim Nicholls

Co-opted Member:
Bob Dowd, Islington Healthwatch

Substitutes:
Olav Ernstzen, Islington Healthwatch
Phillip Watson, Islington Healthwatch

Acknowledgements: The Committee would like to thank all the witnesses who gave evidence to the review.

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Lead officer – Alison Blair, Islington CCG

Scrutiny Initiation Document and Framing of the Review

The Scrutiny Initiation Document (SID) for the review was first considered by the meeting of the Health Scrutiny Committee on 16 October 2012.

At that meeting the Committee resolved that the Chair and LINk member meet with the CCG to discuss how the scrutiny could effectively explore this area and requested any data available on GP performance by practice.

At their meeting on 6 November 2012 the Committee considered an initial presentation from Alison Blair, the Chief Operating Officer of the Clinical Commissioning Group (CCG) and Tony Hoolaghan, associate director of Primary Care at North Central London (NCL).

The Committee noted that the GP contract did not include a limit on list numbers and that the data on GP appointments for June showed significant variation from practice to practice and this should be reduced to ensure a positive experience for all patients. GPs could not turn away patients and data could be gathered from formal complaints and PALS on performance.

Members reported that phone consultations with GPs were helpful but services again varied from practice to practice. There were various myths about what GPs were required to do and how they were funded. It would be helpful if a factsheet was available detailing what recourse there was from GPs to commissioners and what happened if they were failing.

A number of initial points of interest were raised at this stage as follows -

- The myhealthlondon website was very helpful and included data about practice performance. It was seen as a useful resource and was likely to be rolled out nationally.
- Members requested a breakdown of GP practices detailing which were group practices and which were single handed and what services were provided from each site.
- The introduction of the 111 service would mean a more locally delivered service. There would be national publicity and Islington would start operating their service from April.
- There was an ongoing issue with GP time being taken up with patients needing referral letters for housing and benefits service. This was likely to increase with the new benefit changes.

Evidence from Islington LINk

In December 2012 the Committee called the Islington LINk to give evidence to the Committee. They were represented at that meeting by Gerry McMullen who outlined the work of the LINk with patients and the conclusions drawn from that research.

The LINk had conducted their research into this area in 2010 but there were still relevant themes that could be drawn out.

The report on the exercise presented a summary of key findings -

The LINk team interviewed 119 patients in the six practices visited in August 2010. Although there was a target to obtain twenty interviews at each practice and despite making more than one visit, it was not possible to reach this target at the smaller practices. The data obtained present a snapshot

view of service users and their opinions. However, some common themes emerged from the interviews:

- *Making appointments by telephone or in person at the practice were identified as the two most common ways by which patients make an appointment.*
- *Only two of the practices visited had an online facility for patients to make an appointment and, even where that facility was available, it was only rarely used by those the LINk interviewed. Further information suggested that there may be low awareness of the online facility and/or accessing it to make an appointment may be complicated.*
- *The responses suggest that appointment systems need to offer flexibility, both in the method by which appointments are booked (phone, in person, online) and in the time of the appointments.*

One practice, Practice A, which offered all available methods of booking, monitored the appointments close enough to alter the pre-booked and walk-in appointments. This close monitoring and flexibility contributed to meeting the patients' needs.

The interviews, especially at one smaller practice, identified that the availability of appointments on a same day/walk-in basis is highly regarded by the patients at that practice.

From those the LINk interviewed at all the practices, most described the appointment systems in place as 'very easy' or 'easy' and rated them as 'good' or 'very good'. Only small numbers of those interviewed thought the appointment systems were 'difficult' and rated then as 'poor'. Negative responses were not recorded for all the practices visited but were more common in the interviews that we conducted at the medium-sized practices.

To reduce the rate of 'no shows' at booked appointments, one of the larger practices sent reminders as SMS text messages and this was welcomed by patients.

Some responses showed that some patients did not understand how the appointments system worked, for example that they could phone the practice later in the day to see if appointments had opened up. Or that, sometimes reception staff need to triage patients and so have to ask questions about their condition.

The Link had prepared key recommendations in the response to their research -

1. *Appointment systems should be flexible and closely monitored. Seasonal adjustments as well as daily adjustments (reflecting weather conditions or World Cup matches, for example) should be adapted to meet demand.*

2. *Extended hours should be offered when possible as these were valued by patients where finances permit.*

3. *Practices should produce clear, Plain English leaflets on how appointments can be made and the considerations of urgency. These should be available in a range of formats.*

4. *Patients should be made aware that if they request a specific GP an appointment on that day may not be available and should consider seeing another GP or waiting a bit longer for an advance booking.*

5. *Patients should be made aware that if they have more than one issue to discuss with a GP or need an interpreter, then they should try to book a double appointment.*

6. *Online appointment booking and online prescription ordering should be made easily accessible on websites, and its availability promoted to patients[1].*

The Committee noted that IPSOS MORI conducted research into this area and the new data would be available shortly. The new IPSOS Mori poll had changed its methodology from the previous poll so they could not be compared like for like. The poll data could be looked at and analysed to see if any relevant trends could be identified.

Access to GPs was regularly raised as an issue by patients and all GP practices should produce a practice leaflet detailing services but some practices' leaflets were not clear or were out of date. The variation in quality of GPs websites with some allowing online booking and some not was highlighted. All practices were upgrading to the EMIS system which should allow for improvements and practice managers were key to the services offered. All GPs should also have patient reference groups to gather views.

Timings for walk in appointments could also be misleading, for example at Bart's their clinic hours were stated as 8am-2pm but the last patient to be accepted would be at 12:45pm. For patients to make an informed choice they needed to have all the information about what services were available to them and the inconsistency of information was a major issue highlighted in the survey. It would be helpful to have a list of parameters for the services GPs were required to provide. Information should be sought on what was in the GP contracts and what financial incentives they would gain to provide additional services.

Evidence from NHS North Central London

At their meeting on 25 March 2013, the Chair welcomed Dr Henrietta Hughes, Acting Medical Director, NHS North Central London to the meeting to present her evidence. Dr Hughes explained her position in the new structures as Medical Director designate for the North East area of London where she would have responsibility for commissioning GPs after 1 April 2013.

Dr Hughes outlined the process of annual contract review. Each GP practice would complete a detailed document for submission to the contracts team, part of which would specify the clinic times offered to patients. The BMA recommended 4.6 appointments per patient per annum as a guide. Where it appeared that a practice had fallen below this guideline figure it would be asked to draw up an action plan which might propose an increase in the number of appointments per GP, the appointment of more GPs, or additional nursing time, or a combination of all of these inputs to ensure that more appointments were offered to patients.

Other options open to GP practices included the booking and cancellation of appointments on-line and text reminders to patients,

In the current system each PCT cluster had a complaints department. Under the new NHS structures complaints would be part of the responsibility of primary care development at Clinical Commissioning Group level.

In London patients could also use the My Health London website[2] to give feedback to their GPs.

[1] Extract taken from Islington LINk Enter and View Report: GP Services: Patient Experiences of Appointment Systems at Medical Centres in Islington

[2] www.myhealth.london.nhs.uk/

It appeared that there was evidence to suggest a large degree of inconsistency between GP practices. Also, it may be that some patients present at A&E instead of making an appointment with their GP. In the next stage of the review it would be useful to the Committee to have access to statistics from the acute hospitals showing which patients, and how many, presented at A&E and from which surgeries whether across the borough or from outside its boundaries.

The following points were made by Dr Hughes in response to questions from members of the Committee:

- There are a number of different approaches amongst GP practices, dictated in part by the size of the practice, the patient population, the range of options available for booking appointments e.g. online booking, book ahead, book on the day or the day before. The Committee might wish to look at demand trends and the flexible approaches to access the service.

- GP practices have different ways of handling appointments and dealing with emergencies. Some for example employed a telephone triage system; others might still rely on a telephone queuing system at the start of the working day. There were intelligent ways of planning demand: for example a practice could ask patient groups and vary the mix. This sort of approach would often be well received. The choice lay between book ahead and managing demand on the day.

- Telephone triage was a good way of managing demand on the day. To work effectively GPs needed to be at the front end of a telephone triage system. This could be very effective but depended on good telephone consultation skills and good safety netting. The criteria for a good triage system were good listening skills, and the ability to ask the right questions. Medicine was an art: it would always involve a judgement as it was partly about knowing when something was not right.

- A telephone triage system for managing ‘on the day’ appointments seemed to have much to commend it and the Committee would give further thought to including it as one of its recommendations.

- All patients should be able to register with their GP practice and all should have a standard experience. Patients’ lists were reviewed at regular (2/3 yearly) intervals. This was important as funding was geared to patient numbers and inactive ’ghost’ patients can misrepresent the size of the workload.

- Instant messaging was being trialled and there were experiments also involving tele-medicine, telecare and skype.

Evidence from GPs and GP representatives

At their meeting on 23 April 2014 the Committee heard evidence from Dr Robbie Bunt, Islington GP, Chair Islington LMC, Dr Katie Coleman, Islington GP, Joint Clinical Vice-Chair, Islington CCG, Dr Jo Sauvage, Islington GP, Joint Clinical Vice-Chair, Islington CCG, Dr Julie Sharman, LMC Secretary, Londonwide LMCs together with Alison Blair, Chief Officer, Islington CCG and Avni Shah, Head of Commissioning, Islington CCG.

In his introduction, Dr Robbie Bunt referred to the role of local medical committees as the statutory professional organisation elected by GPs to represent all NHS GPs and practice teams. In Islington there were 37 practices, some of which were small single-handed practices whilst others had multiple partners, nurses and care assistants, and very large patient lists. GP practices were independent businesses.

London and Islington faced very real challenges: for many practices lists turned over by 30% a year and taking on new patients created a huge additional workload. There was also huge diversity in the local population: 42% of local people were born outside the UK; 20% did not speak English as a first language; and the borough had amongst the highest child poverty rates in the country. Islington was the 5th most deprived London borough and the 14th most deprived borough in England. This was surprising, given the high house prices in parts of the borough but many patients suffered from severe mental health problems, psychosis, and drug and alcohol-related conditions.

Dr Katie Coleman was a GP at the City Road Medical Centre which 14 years ago had taken over a depleted list comprising 2,800 patients, many of them elderly, which had since increased year on year to around 7,000. A 30% churn was typical and might involve registering 50 new patients in a week which understandably had a disruptive effect on the practice. Bunhill and Clerkenwell were amongst the most densely populated wards in the borough and a large number of patients had severe mental health issues and extreme levels of depression and anxiety. These issues could not easily be dealt with in 10 minute consultations.

The practice was juggling priorities. It was doing its best to manage demand, provide high quality services, and help patients to see their GP on demand. As an alternative approach it was piloting a new service called 'Dr First', the aim of which was to significantly improve patient access to GPs, and at the same time, reduce the demand on GPs, A&E and Walk-in clinics. Under 'Dr First', phone lines would be opened at 8.45am on weekdays, and patients would be called back by a senior doctor and a decision taken in each case either to invite the patient to come in to the surgery for a consultation, to book an appointment in advance, or to be dealt with there and then on the telephone. Out of 74 calls, ten patients needed to be seen by a doctor on the day, eight chose to make an advance booking and the rest were dealt with on the phone.

The pilot would run for a year and then be evaluated but the early signs were that this system was helping the practice to manage demand more effectively.

Dr Jo Sauvage confirmed this view and stressed that, as some patients were concerned about being dealt with over the phone, triage was always dealt with by a senior clinician who was able to apply clinical criteria and make a judgement in each case either to see the patient or deal with him or her over the phone. Invariably, lower thresholds would be applied for children, for the elderly and for those who did not speak English as a first language.

In response to the evidence the Committee raised various points:

Capacity was a concern. The perception locally was that patients were generally dissatisfied with the arrangements for accessing their GP. The impression was that the service was not as accessible as it should be and that people in work in particular found it difficult to make an appointment. It was this that had prompted the Committee to carry out a review with clear but tightly focused objectives. The intention was to make some best practice recommendations which added value and which made sense in practice. This was partly why the Committee had asked Dr Henrietta Hughes, as the Medical Director with responsibility for commissioning GPs in this part of

London, to comment on the draft recommendations in due course. Against that background the Chair asked the following questions:

a) *To what extent was capacity an issue particularly in the south of the Borough?*

b) *Where does responsibility lie within the new NHS structures for strategic decisions such as when and where to provide a new health centre or practice as part of a new housing scheme?*

c) *Some practices operate 'walk-in', same day appointments but does this deter some patients who are not prepared to wait for an unscheduled appointment?*

d) *Who should make decisions on triaging patients, in the 'Dr First' pilot it's a senior doctor but for some out-of-hours consultations this would be done by an administrator?*

In response to the Chair's questions it was stated that senior clinicians should triage calls under 'Dr First' and it was very important that the same doctor saw those patients who came in for a face-to-face consultation as a result. As far as possible, the process from the call onwards must be managed from end-to-end by a senior clinician.

NHS England was the contractor for new GP services although Clinical Commissioning Groups also had responsibility for improving the quality of primary care and access.

Core hours in the GPs contract were from 8.30am to 6.30pm subject to variation by local agreement. In Islington 27 out of the 37 GP practices operated an enhanced service i.e. provided a service outside of the core contracted hours. As an example the City Road Medical Centre provided an extended hours service from 6.30pm to 8pm on two evenings each week. Although this was intended to help people in work, access at these times was not in any way restricted.

GP practices operated as individual businesses and developed services in line with patients' needs. There was no 'one size fits all' solution and the 'Dr First' pilot was one of a number of different approaches. Capacity was a major issue. Many patients had long-term conditions such as respiratory problems, heart disease and diabetes, all of which used to be dealt with in hospital. If they were to respond effectively and manage the increased demand, both volume and complexity of cases, GPs practices needed long-term continuity and certainty of funding for their business plans.

It was essential that patients understood that they had a responsibility to look after themselves. GP practices were struggling to manage demand, due partly to the size of the lists and partly to the complex nature of the conditions of some patients particularly those with significant mental health problems.

This situation was not helped by the numbers of patients presenting with minor ailments which might just as easily be dealt with by a visit to the local pharmacy, and by patients who made appointments simply to ask their doctor for a letter to assist them with a housing application, or those sent by a local school to get a doctor's sick note for their child when the proper course might have been for the parent to look after the child at home. The BMA had issued guidelines for the number of appointments per patient per annum which meant practices were under pressure to meet these targets.

The increasing complexity of patients' needs had created opportunities for cross-working. Every practice had a link person. There were links with councillors as well.

'Dr First 'was work in progress. It was being piloted alongside other different approaches which would be evaluated in 12 month's time including the impact on other surgeries in the vicinity. The practices involved were working closely with the Clinical Commissioning Group. Patients' surveys would also be carried out. All GPs practices should have patient participation groups and wider groups to collect patient feedback.

The witnesses referenced the Islington LINk's research project in October 2010 'Patient Experiences of Appointment Systems at Medical Centres in Islington' which amongst other things had recommended that appointment systems should be flexible and also that practices should produce clear leaflets explaining how appointments could be made and what to do in cases of urgency. This was a contractual commitment.

In light of the evidence received the Committee resolved that they should review the final recommendations of the report with LMC, CSU and CCG prior to publication of the report.

Evidence from Patients

At their meeting on 23 May 2013 the Chair welcomed three patients to the meeting, Kay Dixon, Michael Rowlands and Rose McDonald, each of whom in turn gave their views in response to the following questions put by the Chair:

The appointments process

1. *How do you usually make an appointment with your GP e.g. by telephone, in person, on-line? Is it same day booking, advance booking, walk-in clinic etc.?*

2. *How is the booking of emergency appointments handled?*

3. *How satisfied are you with getting an appointment, the opening hours of your practice, and getting through on the telephone?*

4. *Are the arrangements clearly stated and clearly understood? (The practice must publish how patients can access a GP.)*

5. *Do you have to take time off work to attend a GP appointment? Does your GP practice offer extended hours e.g. before 8am, after 6.30pm, weekend opening*

Seeing the GP you want to see

6. *How satisfied are you that you can see your preferred doctor most or all of the time?*

Areas for improvement

7. *How could the appointments system be made easier for you/what improvements would you like to see?*

Responses from Patient 1 –

1. *By telephone for same day and advanced bookings. Ring on the day at 8am. It was also possible to book afternoon appoints by telephone during the lunchtime period before 1.30pm.*

2. *She was fortunate in that she had always been able to get a same day appointment.*

3. *The arrangements were clearly stated on the practice's website. Opening hours may differ from day to day.*

4. *This patient had retired. Extended hours were offered with two early morning consultations starting at 8.00am and two in the evenings at 6.30pm/7.00pm.*

5. *The patient was able to see her preferred doctor most of the time. (The practice normally had six GPs).*

6. *In her experience the appointments system worked fairly well. Appointments could be made via the website for the longer term but not for same day appointments. Some patients would prefer to make appointments on line.*

The following points were made in response to questions from other members of the Committee:

- The best advice was always to phone early before 8.am for a same day appointment.
- The patient would always prefer an appointment with her own GP: for reasons of continuity of care and also to build up a relationship between patient and doctor.
- Advance bookings were usually offered two weeks ahead.
- The practice tended to offer an appointment on the next available timeslot rather than offering a choice of time.

Responses from Patient 2 –

1. *By telephone or sometimes she would attend in person and queue for a same day appointment because it was so difficult to make an appointment otherwise. In her experience she was more likely to get an appointment by queuing. There was no walk-in clinic. She did sometimes make advance bookings: these were often 4/5 weeks in advance. Her GP was only in half a day a week and she needed to see this particular doctor as part of her post-surgery care.*

   An example was given of an instance where she had phoned at 1.40pm for an afternoon appointment and by the time her call was answered all of the appointments had gone and so she had attended in person at 1.15pm on the next day and queued for an appointment.

2. *Not satisfied. She would let the telephone ring for 5 minutes but often in her experience all of the appointments have gone – and so she prefers to queue in person. The surgery opened at 8am and closed at 7pm. Emergency appointments were available on Fridays for patients who chose to walk in and wait. The practice was not open at weekends.*

3. *She had found out about the arrangements by default, nothing was displayed on the notice board. The surgery was working with Harmoni. The patient outlined the circumstances which had led to her making a complaint against the practice.*

4. *As a carer, she preferred appointments during the daytime although occasional evening appointments would also help. She would prefer appointments at weekends or later in the evening. (7.30pm/8pm)*

5. *See 1. above.*

6. *The system would be easier if patients phoning early in the morning were offered afternoon appointments once all of the morning appointments had gone. She gave an example of an instance when the walk-in centre had not been prepared to see her because it was 10am. She felt that she was knocked back on a regular basis at a very busy surgery.*

The following points were made in response to questions from other members of the Committee:

- Patients were only allowed to present with one issue per appointment but what happens if they have related symptoms? There isn't enough time and while double appointments may be available in her experience there were never two vacant slots together.
- The practice had about five GPs, one or two of whom were new doctors.

Responses from Patient 3 –

1. *By telephone or advance booking. If a same day appointment were required he would have to phone and book an appointment with a GP who would call him back. The return call was made by a doctor mostly although on one occasion a receptionist had made the call.*
   This system was called 'Dr First'. He was extremely perturbed about how the system works. On one occasion, when suffering from a heart condition, he had walked in and ended up being taken to the Whittington by ambulance. Last year he had been told he couldn't be seen by walking in but if he had had a mobile phone he could have stepped outside and called for an appointment. Advanced appointments were usually made three weeks ahead if the patient wanted to see a specific GP and two weeks for any GP in the practice.

He believed that patients had a basic right to see a GP if they were not feeling well. He should not be put in a position of having to explain himself – of having to give a clinical justification to a doctor (or receptionist).

Under 'Dr First', a GP would call back within an hour and usually give him an appointment at a specified time. The elderly, infirm or confused, or those with language problems, might be put off. The system tended to favour those who were middle class, educated, self-confident and articulate, and relied on patients being able to give a clinical justification.

The practice had six GPs.

2. *Getting through on the phone was not difficult in his experience.*

3. *He had no idea what the opening hours were and did not recall seeing them on display at the surgery.*

4. *The patient was retired. He didn't know whether extended opening hours were available.*

5. *He didn't have a preferred GP - ten years ago he did, but not any longer.*

6. *He questioned the value of the triage system (Dr First). In his opinion this system doesn't work for the reasons given in answer to Question 1. above. It may be good for doctors and for reducing queues but now the practice was empty. He believed that patients who felt unwell should be allowed to go into their surgery and sit and wait to be seen by a doctor. This was an important part of their social wellbeing.*

The following points were made in response to questions from other members of the Committee:

- Six weeks ago the patient had gone direct to A&E after waiting for a letter from his GP and UCL had encouraged him to contact them directly and make appointments with them rather than through his GP.
- It may not be widely known that patients with long-term conditions may be able to make double appointments.
- The appointment system no longer works on the basis of a personalised doctor/patient relationship. The patient must take what is offered and can by-pass his GP if he has a serious condition. 'Dr First' had de-personalised the doctor/patient relationship.

The Chair thanked the patients for volunteering to answer questions from members of the Committee and for giving their own personal experience and stressed that the anecdotal evidence which the Committee had heard during the meeting had been very helpful in raising some issues that might usefully be followed up in the scrutiny review.

Evidence from Acute Hospital Trust

At the meeting of the Committee on 3 September 2013 evidence was heard from representatives of Whittington Health. By way of introduction the Chair explained that the Committee was trying to understand why A&E services were so overloaded at the present time and whether attendances at A&E varied from one GP practice to another. It was also trying to understand the underlying trends e.g. the numbers of patients who attend A&E from particular GP practices – whether there were there certain types of patient that present more frequently than others i.e. with particular types of complaints, and whether there were there any discernible trends related to particular practices.

Carol Gillen, Director of Operations, Integrated Care and Acute Medicine, Whittington Health and Humayun Mian, ED Operations Manager attended the meeting.

To give an impression of the size and scale of the Emergency Department's work:

- 90,000 patients per annum
- Mean daily arrivals 260 – (has been as high as 335 in recent weeks)
- 22% Paediatrics

- 2% Trauma & Resuscitation
- 46% Minor injuries / Primary Care
- 30% medical / surgical

An overview was given of the pathways for patients arriving by ambulance as well as for those who walk-in. A key feature was the urgent care centre, an integrated part of the Emergency Department which opened in April 2010. Open daily from 08:00am – 22:00pm, 7 days per week, 365 days per year, it was staffed with Emergency Nurse Practitioners & General Practitioners working as part of local GP Consortium, 'WISH.'

A breakdown was given of patients discharged from the urgent care centre and this showed that in July 2013 the vast majority of patients (numbering more than 2,000) were seen by a nurse practitioner or a GP at the centre. Most of the other patients were seen by doctors on a training programme.

An overview of departures (from the urgent care centre) showed that the vast majority (around 1,600) were discharged to their GP to follow up and over 900 'well' patients were discharged with no follow up required.

There were a number of reasons why some patients appeared to prefer the urgent care centre to their own GP, most of them related to access:

- Access: Lack of GP appointments on an evening – both actual and perceived
- Access: there seems to be a lack of available services at GP practices e.g. clinic for dressings
- Access: Unable to contact GP surgeries (or cannot book an appointment)
- Patient Choice: Convenience (attendance times were limited whereas the Emergency Department was open 24 hours a day.)
- Patient Choice: Perception of the Emergency Department being the safest place to be treated especially in the case of parents.
- A GP was based in the Emergency Department.

Recent trends showed:

- Higher number of attendances on an evening.
- Increased attendances on a weekend
- Introduction of 111 service i.e. this was a factor during the original roll out but no longer.
- High number of attendances upon initial launch (Majors and Urgent Care Centre).
- Referrals & Activity.

The statistics showed an increase of referrals during the months of April –July 2013 from both the 111 Service and Out-of Hours. A key factor however was that the Emergency Department had experienced a disproportionate increase in the numbers of patients presenting with minor complaints. One of the more significant factors that may account for this was the capacity of GP surgeries to cope with demand.

Variance by GP practice was usually dependent upon:

- Proximity to Emergency Department – if it was very local, patients may be making a choice

- Availability of appointments (emergency or at short notice)
- Accessibly of appointments (systems make a difference)
- Appointment booking facility – Some practices use automated service
- Services available at GP practice
- Demographic details of patient group

A number of points were raised in the discussion that followed. It appeared that 46% of attendances at the Emergency Department related to minor injuries although it was stressed that any cases where patients needed an X-Ray of any other form of diagnostic could only be dealt with in a hospital setting. Nevertheless, this posed a huge pressure on the Emergency Department.

In reply to questions from the Chair and other Members of the Committee, Mr Mian confirmed that information was collected on the reasons why patients presented at the Emergency Department and this could be made available on request. It could also be analysed by post code and presented by area or by GP practice. Repeat users of the service were also tracked. Records were kept of any patients who re-attended within seven days and 14 days.

Carol Gillen explained that the Whittington was already feeding back to GP practices where the evidence appeared to support local clinics being held to help patients manage particular conditions. In that sense the hospital's information was shared with other clinicians in the community. The hospital met primary care service providers, adult services and other partners on a regular basis to identify patients who may be presenting regularly at the Emergency Department in order to help them manage their condition. A lot of work was being done to help patients with long-term conditions. Many of these had alcohol-related problems and where appropriate patients would be referred to the drug and alcohol liaison team or other community-based services. She added that district nurses and social workers were also doing a lot of good work in the community.

Progress of the Review

At the same meeting Alison Blair, Chief Officer of Islington Clinical Commissioning Group was invited to respond to the presentation from the Whittington, and explained that Islington and Camden CCGs had commissioned a one day audit/data collection exercise on Monday 9 September 2013 focusing on urgent care services at the Whittington, the Royal Free and UCLH together with walk-in centres and out of hours services. The aim was to identify the reasons why patients were presenting at A&E and how many of them had phoned in to their doctor's surgery on the day and were attending at A&E because they couldn't get an appointment. Any data that clarified this point would make an important contribution to the Committee's review. It was confirmed that the data analysis would be shared with the Committee.

Nationally, it was thought that around 20% of the patients who attended A&E should have gone to see their GP instead. Feedback from the one day audit would add to the body of knowledge locally. There was then a question of how this message should be communicated to the public and what more could be done to achieve a better outcome.

The Committee discussed the draft report with Alison Blair. She stressed that each GP practice worked differently, many of them had different appointments systems and some of these worked better than others. Different approaches offered patients choice and should be encouraged. It was suggested that the Committee could consider a recommendation which encouraged GP practices to offer to meet different demands from patients in different ways rather than offering one standard

approach. Perhaps practices should employ a hybridised approach to appointments. It was questioned whether patients knew what was available even though each practice was required to produce a leaflet and publicise their surgery arrangements on their websites.

Draft recommendations were discussed. Many of them related to procedural matters even though Islington faced considerable demographic challenges. The Chair emphasized that the Committee had agreed at the outset to a tight focus on appointments systems but the report could still identify further areas for investigation. One of the key areas was the challenge to primary care services posed by demographic change. Another was demand and capacity and the implications for primary care in the borough: this included aspects of demand which were development-related (particularly in the south of the borough) and also to the treatment of patients with long-term conditions. NHS England had strategic responsibility for providing additional GP practices to meet new and changing needs and for bringing interested parties together when necessary to discuss problems and devise solutions. With that in mind the Chair proposed that a meeting should be convened with a representative of NHS England together with Alison Blair and Julie Billett, Joint Director of Public Health to discuss issues arising from changing demand in the south of the borough.

Consideration of Draft Recommendations

At their meeting on 18 November 2013 the Committee considered an interim report from the Chair and draft recommendations:

Chair's Interim Report

This scrutiny was initiated as a result of anecdotal evidence put to members that there was considerable difficulty in obtaining appointments at some GP practices across the Borough. This scrutiny also takes place against the background of unparalleled and increasing pressure on hospital A&E departments, and with a secondary element of anecdotal evidence suggesting that some patients simply by-pass their local GP and instead, present at A&E as an alternative initial point of contact with the Health Service.

The scrutiny was agreed and initiated in January 2013, and it had been intended to issue a final report and recommendations towards the end of this year. However, in April 2013 the newly formed Islington Clinical Commissioning Group (ICCG) launched a funded initiative called 'Improved Access to GPs', which is investigating various improvements which could well interact with the objectives of this scrutiny. It therefore seemed best, in order not to lose the momentum gained from the scrutiny to date, to issue an interim set of recommendations from the committee to reflect our findings to date, covered by a brief commentary (this note) on progress. And for the committee to revisit its recommendations and link them wherever possible with the ICCG outcomes once the 'Improved Access' initiative is completed. It should also be noted that these recommendations have been shared with and commented on by ICCG, NHS England (London) and the LMC, with the intention being that if we can achieve broad agreement with stakeholders on the recommendations, or at least agreement to differ, the recommendations will be pertinent and relevant, and have a higher likelihood of implementation.

The scope of the scrutiny is actually quite narrow – The effectiveness of GP appointment systems. However, it has the potential to open up all sorts of supplementary lines of enquiry about staffing, NHS structures, and many other issues. We have resisted this temptation and stuck to the narrow focus of the terms of the scrutiny, in order to try and reach some meaningful conclusions.

Our early hope was that we could source some statistical evidence that would help demonstrate which practices were more effective at dealing with appointments, and where patients were preferring A&E attendance. However, we found that the available statistics were too generalised to offer any dependable conclusions. This is not a fault of the data collection, but a measure of the complexity of the issue of when, where and how patients present themselves. What we have found is that subjective and anecdotal evidence of patients, doctors, practice managers, ICCG, and A&E staff offers far more revealing insight into the functioning of the system as a whole. In particular, we heard that different practices operate very different types of appointment systems, but equally successfully and effectively, that different cohorts of patients prefer different approaches to appointments, and that different patients of the same practice sometimes have very different experiences of the effectiveness or otherwise of the appointment system. It is therefore more or less impossible to recommend that one approach to appointments is more effective than another.

To my mind, the most fascinating evidence came from staff at Whittington A&E, who were briefed to present to the committee their (where necessary) subjective views on whether they see more patients from one practice or another, whether certain profiles of patients are more likely to present than others, and any other impressions they might have of where their patients are coming from and why. It was clear from this presentation that a significant number of patients that present at A&E are best seen by the Urgent Care Centre, and that at least 20% of these could have seen their GP instead. We heard that GPs with an online or 24hr phone appointments system generally seem to deliver fewer patients to A&E.

We heard that some parents take their children straight to A&E because they believe that hospital is the 'safest place'.

We heard that the implementation of the 111 service had not significantly increased attendances at A&E, once it had settled down. And most interestingly, we heard that the typical wait to see a doctor at the Urgent Care Centre (with no appointment) is 1.5 to 2 hours. This makes a striking contrast with GP surgeries, where a same-day appointment can mean waiting for up to 4 hours, sometimes at the surgery, to see a doctor, and where, if an appointment is not available on the day, the wait can often be 2 weeks for a 'bookable' appointment. This contrast in experiences can't help but suggest that there could, or even should, be a challenge to GPs to find ways of managing their appointment systems, to the point where patients no longer consider Urgent Care Centres as an easier alternative to an appointment with their GP.

Overall, whilst we have learned that it is very difficult to compare the appointment systems of different GP practices because they operate so differently, there remains anecdotal evidence that some GP practices continue to be more successful in operating their appointment systems than others. The challenge therefore, is to establish some kind of benchmarking system, that can achieve a consistent measure across practices of their effectiveness in delivering appointments to patients. It would be fair to say that the committee does not at the moment have a clear idea how this can be achieved, but we hope to achieve a consensus that this would be relevant and useful, and to secure agreement with GP practices across the Borough that they ought to be able to achieve broadly similar levels of performance in relation to appointments, whilst maintaining their individual approaches, and to find a consensual way of measuring this.

The one area where the Committee has allowed itself beyond the strict remit of the Scrutiny is the question of overall provision of GP surgeries. Again, anecdotal evidence suggests that GP surgeries in certain areas of the borough are currently over-stretched, and it is a matter of fact that in areas

such as Bunhill and Clerkenwell, a number of high-volume residential developments have been or are currently being completed, with a corresponding increase in population, yet no increase in GP provision has been initiated in response to these increases. What the committee has found, is that since the NHS reforms were introduced in April 2013, there is no established process or structure to both assess the need for additional GP provision, or to procure that provision. The Committee is very keen to help broker the establishment of such a process, and supplementary recommendation 1 attempts to capture this.

I am of the view that further constructive discussion is needed on both establishing workable benchmarking for the delivery of appointments, and also the establishment of a process to procure new GP provision. I am hopeful that the 'Improved Access' initiative will inform the former, and that ongoing discussions and meetings will help establish the latter. In the mean time, the draft recommendations are a summary of the committee's findings to date.

Cllr Martin Klute – Chair

Draft recommendations –

1. *Core and extended hours: That Islington CCG, working with NHS England, ensure that the availability of core and extended hours in Islington general practice is adequate and appropriate to meet patient's needs.*

2. *Performance benchmarking: That performance bench marks for GP appointments be established across the borough, in order that voluntary performance targets can be agreed with all Practices. (This recommendation seeks to drive up performance standards, where necessary, by the mechanism of peer pressure rather than a contractual approach, and to achieve a greater consistency of performance without challenging differing management approaches to appointments between individual practices.) The Committee note that NHS England are at present developing methods of benchmarking, and that following publication of proposals the Committee will review this again.*

3. *Patient feedback: That the committee, working with the CCG, review current approaches to patient feedback, in order to establish consensus on best (and most effective) practice, and drawing on the lead from acute hospitals in securing feedback on an individual appointments basis. The feedback to be used to inform under recommendations 1 and 2.*

4. *Long term conditions: That alternative appointment systems be established for patients with long term conditions that require regular appointments, in order to avoid the requirement to repeatedly re-book under the daily appointment system.*

5. *Social support functions: That GP practices, the Council and the CCG work jointly to establish an alternative approach to providing social support services currently provided by GPs, such as school sick notes and letters in support of housing applications, to enable GPs to concentrate on core medical responsibilities.*

6. *Practice information: That GP practices be required to fully publicise information regarding the availability and means of obtaining GP appointments at their practice. This information should be clear, available through all currently recognised channels of communication, and explain when and how appointments can be made, give clear information about Out of Hours Options, and the range of medical services on offer from the surgery in addition to basic appointments.*

The committee also strongly recommends the use by all practices of SMS text reminders for appointments to reduce

DNAs.

7. *Telephone triage: That where telephone triage is used, this should be carried out in accordance with agreed protocols on best practice, to ensure that all patients have a positive experience, and that vulnerable patients are not challenged or distressed by their initial contact with the service.*

8. *Public awareness: That a public awareness campaign be developed to promote treatment options on the basis of 'The right care, in the right place, at the right time', and also to increase awareness of alternative treatment options, such as the minor ailments scheme in pharmacies.*

The Chair stated that given the trials currently being carried out supported by the Primary Care Foundation, were still ongoing that the Committee should only present interim recommendations at this stage and further recommendations and a final report should await the outcome of these trials. The Chair added that Martin Machray, the Director for Integrated Care and Governance at Islington CCG had written to him with details and he would arrange for this to be circulated to Members of the Committee.

The Chair also added that he was meeting Islington CCG and Neil Roberts of NHS England to discuss how best it could be planned to ensure that premises were procured in appropriate areas to meet the needs of the community in the borough given the changing demographic needs.

Martin Machray stated that he would try to submit the initial findings of the trials to Committee, including data sources, prior to April, so that their recommendations could inform the contract process. It was therefore resolved that the interim report and recommendations be noted and that further more detailed recommendations would be formulated once the results of the trials referred to above are known.

Healthwatch GP Mystery Shopping Exercise

Whilst waiting for the results of the trials the Committee heard evidence at their meeting on 25 February 2014 on the GP Mystery Shopping exercise Islington Healthwatch had carried out.

Bob Dowd introduced the findings of Healthwatch's mystery shopping exercise to investigate how GP practices in the borough responded to enquiries about complaints and what complaint information they displayed for patients.

The mystery shopping found that whilst a third of practices had leaflets that were easy to find, just under a third displayed no information about complaints at all. Some practices, but not all, had posters and some of these were out of date. The detailed findings are in section 3 of the report, but the main finding was that, as with GP appointment systems, there is no consistency across the borough, with surgeries apparently working in isolation and widely differing standards between them. There was no apparent explanation for this; the practices which scored well or badly did not appear to have any common characteristics. Bob Dowd noted that unlike appointments systems, there was a complaints procedure that all the surgeries should be following. Healthwatch had made a number of recommendations in the report. Alison Blair invited Bob Dowd to attend a forthcoming Practice Manager Forum to discuss these. Bob Dowd advised this survey would be followed up by a further mystery shopping exercise in a year's time.

Presentation of Draft recommendations to the Health and Wellbeing Board

The Chair attended the meeting of Islington's Health and Wellbeing Board on 12 March 2014 to present the draft recommendations of the Committee.

In discussion the following points were made:

- There should be standard expectations about access to GPs. However, there was also a need for flexibility in appointment systems to cater for the various needs of patients
- It was noted that NHSE had set up a project to look at services in the south of the Borough. It was also noted that three GP practices had been successful in bids to the Prime Minister's Challenge Fund to improve access.
- With regard to recommendation 8, relating to public awareness, the NHS had already produced public leaflets on "Choose the right treatment" to encourage people to choose the NHS service that could best treat their symptoms, rather than attending A&E
- That further multi-disciplinary work and communication be carried out on recommendation 5, relating to "Social support functions" and the inclusion of "school sick notes" provided by GPs. The Council's message to children and parents was that children must attend school. A multi-disciplinary approach would help to identify those seeking sick notes most frequently from a GP and any underlying issues.

Report from the Primary Care Foundation - "Improving Access and Urgent Care in General Practice"

At their meeting on 16 September 2014 Henry Clay, representing the Primary Care Foundation presented their report into "Improving Access and Urgent Care in General Practice" to the Committee.

Extract from "Improving Access and Urgent Care in General Practice" -

In March 2013 Islington Clinical Commissioning Group launched a Local Enhanced Service (LES) to improve access for patients to GP practices across the Borough. The initiative had two options:

Option A; the "Doctor First" approach, or

Option B; dedicated support to undertake a bespoke review of current systems and processes, through the Primary Care Foundation (PCF)

The report was designed to provide a summary of Option B, showing the differences on a practice by practice view.

2. Process

Initially 27 GP practices accepted the PCF option. The process is that GP practices capture data about their systems, processes, consultations, telephones and staffing for a sample week. This data is uploaded via a web portal to the PCF website, where it is checked, analysed and published in a practice specific report. The report includes a comparison of the practice's indicators against evidence based benchmarks, describing, amongst many other things, an optimum balance of:

- *Comparative activity of GPs and nurses, when looking at national indicators*

- *Available patient appointments for GPs, nurses and other health care professionals*
- *The split of appointment availability across the primary care team*
- *How soon patients can get an appointment and the availability of appointments they can book in advance*
- *How easy it is to get through on the phone and how often they are asked to call back*
- *What happens when patients request a home visit*
- *What patients say about access to routine and urgent appointments and their overall experience of making an appointment*
- *How consistent their reception staff are in dealing with a range of requests for urgent appointments, their level of confidence and how recently they have received training*

Within each practice report there are approximately nine pages of information that describe these findings. Included also is additional information describing the generic background, evidence and rational that underpins their report, together with suggestions about what GP practices find helpful in reviewing their systems and processes.

The PCF met with the GP practices to talk through the findings and offer any clarification or additional information necessary to help the GP practice move forward, together with any further support required to complete their changes (round 1). In addition there are a number of requirements within the LES that are not managed by the PCF.

An action plan was produced by each practice, with support from the PCF, to help them plan and implement any necessary changes.

The CCG commissioned a repeat of this process to help understand the impact of any changes made by the GP practice since round 1 (shown in round 2).

3. Status

The participating GP practices (see appendix 1) have completed their round 1 requirement, with most gathering their data during a period from March - May 2013. All GP practices received their reports and follow up visits during the summer of 2013. In addition to the original 27 practices, 1 further practice joined (for round 1 and 2) and a further practice more recently (for round 2 only). All 29 GP practices completed their round 2 work, received their reports and have been offered further support and a follow up meeting.

Finally, practices received a second detailed report, based on round 2, and also a comparison summary to help show the differences identified between round 1 & 2.

4. Executive Summary

Many of the Islington GP practices have made significant efforts to understand and make appropriate changes to their systems and processes for access and urgent care. Some of these changes are already showing positive signs, although these changes can take time to be understood by patients and reflected in feedback.
It's also recognised that the dynamics can change for GP practices that have higher levels of patient deprivation or language problems; for instance, it's more likely that in these circumstances GP practices may need a higher proportion of same day appointments, compared to elsewhere. However, the principles are the same and it's good to hear from practices that experience these circumstances that they have been positive about the benefits these changes are bringing.

Like any other change, it's often a combination of processes that need review, across the whole GP practice system, and these will need ongoing monitoring and evaluation, rather than just a "quick fix".

During the discussion of the report there were several points of interest raised.

The Committee reported that it had been difficult to find threads of consistency across high and low performing practices and the widespread variation between practices was a big challenge.

. Although there was data on GP performance nationally there was no one solution for GP performance that would work for all practices. The Committee were aware that there was an expectation on practices that they would provide online access to patients from next year but there needed to be a balance of methods of access.

Henry Clay advised that locum issues were relevant when considering the data on GP performance and as part of the review process the Committee should look at how the CCG were helping practices to change the performance statistics as required.

There were draft access standards being prepared for London but they were not yet in place.

Occasionally reception staff felt that the surveys were invasive and it was important that practice managers explained how the surveys would help improve systems for the patients of the practice.

Support had to be given to receptionist teams to help with managing patients with English as a second language. There were existing translation services in place but the take up of these was low and did not seem to work well. Many patients chose to bring a family member or friend with them to translate.

Patients unable to get through to the surgery by phone to access appointments were a major issue. Aiming for targets of 90% of calls being answered in 30 seconds would often diminish complaints. When practices told patients to call back again at the same time tomorrow they were often perpetuating the pressure on phone lines at busy times of day. Resourcing on any given day could be an issue but there could also be more complicated underlying issues.

GP practices have different ways of handling appointments and dealing with emergencies. Some for example employ a telephone triage system, while others continue to rely on a telephone queuing system at the start of the working day. The choice lies between book ahead and managing demand on the day.

There are intelligent ways of planning demand: for example a practice could ask patient groups and vary the mix. This sort of approach may often be well received.

Telephone triage offers a relatively new approach to managing demand on the day. However, if it is to work GPs need to be at the front end of a telephone triage system, either taking or returning the patients calls. This depends on good telephone consultation skills and good safety netting. The criteria for a good triage system are good listening skills, and the ability to ask the right questions.

Instant messaging is being trialled in some practices and the Committee is aware that there are also experiments involving tele-medicine, telecare and skype. Other options open to GP practices include the booking and cancellation of appointments on-line and text reminders to patients. Some patients will always expect face-to-face contact but others may be prepared to consider a choice of telephone, skype or e-consultation.

Repeat appointments were a larger issue for availability. If patients were coming back seven times rather than five times then the practice needed to consider why the extra appointments were needed.

DNAs (did not attend) appointments were often higher when appointments were booked further in advance as the illness had improved by the time the appointment came around. If surgeries made better use of nursing staff so patients could be seen sooner the levels of DNA appointments could improve.

Walk in appointments could help with providing easier access to appointments, particularly to those with English as a second language but it was just one way of service delivery.

There was a drive towards extending access to primary care including into weekends. The shift was inevitable but it was possible that by working with other practices new service models could be developed. The difficulty with this was how to provide continuity of care as a patient's notes and clinical record would need to be accessible.

Continuity and having management plans in place that would explain what would happen when a situation arose were vital.

The Committee had heard evidence of many GPs performing a social support function and undertaking a significant amount of work on benefits assessments, housing applications and sick notes. It was suggested that giving other clinicians access to the system centrally would enable these patients to be seen elsewhere.

As practices grew they would need more resources. Allowing some staff to move round practices and out of hours services to gain experience could be beneficial.

Conclusion

Islington faces very real challenges, in common with many other inner London boroughs. To begin with, there is huge diversity in the local population: 42% of local people were born outside the UK; 20% do not speak English as a first language; and the borough has amongst the highest child poverty rates in the country.

Islington is the most densely populated borough in the UK and one of the five most deprived London boroughs. An average of 40.9% of children under 16 are living in poverty, and the rate of family homelessness is worse than the England average. Child obesity is higher than the national average; 25 % of children aged six are obese in Islington compared with 19 % nationally. The borough has the lowest life expectancy amongst men in London, and the fourth lowest for women.

But there are other significant issues. The GPs whom the Committee have met reported that many of their patients suffer from severe mental health problems, psychosis, and drug and alcohol-related conditions. People with serious psychological conditions such as psychosis represented 1.5% of the total registered population of Islington in 2010/11. This is the highest percentage in England. 10% of the total registered patient population in the borough have a recorded diagnosis of depression – the highest rate in London. Cardiovascular disease and cancer are major causes of early death.

Bunhill and Clerkenwell are amongst the most densely populated wards in the borough and a large number of patients have severe mental health issues and high levels of depression and anxiety. It is difficult to imagine that these issues could easily be dealt with by GPs in 10 minute consultations. The Committee note that a report was specifically commissioned to look at the issues of population increases in Bunhill and Clerkenwell and the impacts this will have on services.

Capacity appears to be a major issue for GP practices. The Committee heard that many patients have long-term conditions such as respiratory problems, heart disease and diabetes, all of which used to be dealt with in hospital. More than 35,000 people registered with a GP in the borough have one or more long-term conditions. If they are to respond effectively and manage the increased demand, both volume and complexity of cases, GPs have told the Committee that at the very least they need long-term continuity and certainty of funding for their business plans.

It seems that GP practices are struggling to manage demand, due partly to the size of their patient lists and partly to the complex nature of the conditions of some patients particularly those with significant mental health problems. This situation is not helped by the numbers of patients presenting with minor ailments which might just as easily be dealt with by a visit to the local pharmacy, and by patients who make appointments simply to ask their doctor for a letter to assist them with a housing application, or those sent by a local school to get a doctor's sick note for their child when the proper course might have been for the parent to look after the child at home.

All patients should be able to register with their GP practice and should have a standard experience. GP patient lists are reviewed at regular intervals, typically every two or three years. This is important bearing in mind that the funding of GP practices is geared to patient numbers and inactive 'ghost' patients can misrepresent the size of the workload.

The Committee has been advised that many practices' patient lists turn over by up to 30% a year. As an example the Committee heard that one local practice had taken over a depleted list comprising 2,800 patients 14 years ago, which had since increased year on year to around 7,000. A 30% churn is typical and might involve registering 50 new patients in a week which understandably would have a disruptive effect on any practice.

There is evidence to suggest a large degree of inconsistency between GP practices on their appointment systems. There are a number of different approaches amongst GP practices, dictated in part by the size of the practice, the patient population, and the range of options available for booking appointments e.g. online booking, book ahead, book on the day or the day before**.** The evidence we have heard has also shown little consistency between patient satisfaction and appointment systems. Two practices operating the same appointment systems can have vastly differing patient satisfaction rates and this makes it hard to identify one "best practice" approach. In the Committee's view there is not any one system that can operate for all practices to the satisfaction of all patients.

Core hours in the GPs contract are from 8.30am to 6.30pm subject to variation by local agreement. In Islington 27 out of the 37 GP practices operate an enhanced service i.e. provide a service outside of the core contracted hours. Although this is intended to help people in work, access at these times is not in any way restricted.

Many practices are juggling priorities. Some practices operate 'walk-in', same day appointments but this may deter those patients who are not prepared to wait for an unscheduled appointment. The Committee heard from one practice which was doing its best to provide high quality services, and help patients to see their GP on demand.

The perception locally is that patients are generally dissatisfied with the arrangements for accessing their GP. The impression is that the service is not as accessible as it should be and that people in work in particular find it difficult to make an appointment. It was this that prompted the Committee to carry out a review with clear but tightly focused objectives. The intention is to make some best practice recommendations which add value and which make sense in practice.

The review has looked specifically at the demand for GP appointments in Islington which has 37 registered practices some of which are small single-handed practices whilst others have multiple partners, nurses and health care assistants, and very large patient lists. It has also looked at their capacity to meet demand, having regard to the challenges posed locally and wider considerations such as public expectations and the changing interface between acute and primary care, and the move towards integrated care which is being pursued by Whittington Health and others.

In light of the evidence received the Committee have formulated their key recommendations that they consider will help to improve access for patients and look to alleviate pressure on GPs.

APPENDIX A –

SCRUTINY REVIEW INITIATION DOCUMENT (SID)
Review: GP Appointment Systems
Scrutiny Review Committee: Heath Scrutiny Committee
Director leading the Review: Director of Public Health
Lead Officer: Alison Blair, Islington CCG
Overall aim: To assess the performance of GP appointment systems and the service provided to residents.
Objectives of the review: To assess how effective urgent and non-urgent appointment systems are and how these vary across the borough. To examine GP appointments against current targets and identify any under-performing areas. To collect evidence of patient experiences and assess any unmet needs.
How is the review to be carried out: (Use separate sheets as necessary for 1-4 below) Scope of the Review Types of evidence will be assessed by the review: (add additional categories as needed) Documentary submissions: It is proposed that witness evidence be taken from: GPs Patient Groups ii) Commissioners Visits
Additional Information:
Extract from Minutes of HSC held on 16/10/2012 In the discussion the following points were made:
Objective one should be amended to read “to assess how effective urgent and non-urgent appointment systems”. Objective two be amended to read “To examine GP appointments against”. That the Chair and LINk member meet with the CCG to discuss how the scrutiny could effectively explore this area. The Committee requested any data available on GP performance by practice.

APPENDIX B –

Background

Roles and Responsibilities

NHS England is responsible for commissioning GP, dental, pharmacy and optometry services and for carrying out contractual compliance and performance monitoring.

It is however a jointly agreed objective of the Clinical Commissioning Group and the NHS Commissioning Board that local patients should have easy access to safe, high quality and accessible services.

The Clinical Commissioning Group (CCG) commissions the majority of health services for patients in the local area. This includes acute care, mental health services and community services but not GP services or specialist services such as heart transplants. CCGs do however have a role in driving up the quality of primary care in their area, and a duty to collaborate with NHS England to improve the quality of services.

GP practices operate as independent businesses and develop services in line with patients' needs. Their interests are represented to the NHS by local committees of NHS GPs, known as local medical committees.

The GP contract was determined nationally in 2004. The important points relating to GP appointments and access to GPs by patients may be summarised as follows:

(a) All practices must publish details of how patients can access a GP for a consultation. Many practices produce a leaflet.
(b) The number of appointments that should be offered is not specified, nor is the type of appointments system.
(c) Practices are required to 'meet reasonable needs of patients'. There are no limits on the number of patients that may be taken on by any one practice, nor on how many staff (doctors, nurses, receptionists) a practice may employ.
(d) The targets on speed of access were removed in 2010. It is no longer a requirement that a patient must be able to see a GP within 48 hours.

As part of the process of annual contract review, each GP practice is required to complete a detailed document for submission to the NHS contracts team, part of which specifies the clinic times offered to patients. The BMA recommends 4.6 appointments per patient per annum as a guide. Where it appears that a practice has fallen below this guideline figure it is asked to draw up an action plan which might propose an increase in the number of appointments per GP, the appointment of more GPs, or additional nursing time, or a combination of all of these inputs to ensure that more appointments are offered to patients.

The Committee has examined a number of factors which have a bearing on access to GP appointments and the patient experience. These include:

(a) Demand and GP Appointments and the capacity of GP practices to respond

- The number of patients registered with each practice;
- The number of GPs and other staff (i.e. practice nurses and receptionists);
- The number of appointments offered;
- Opening hours;
- The appointments system (e.g. same day booking, advance booking)

- The telephone system;
- Do not attend patients;
- The extended hours offered by each practice.

(b) Patient feedback on Access to GPs and Appointments

In London patients can also use the My Health London website to give feedback to their GPs www.myhealth.london.nhs.uk/.

(c) Patients' Complaints related to GPs Appointments

Under the new NHS structures complaints are part of the responsibility of primary care development at Clinical Commissioning Group level. All GP practices have patient participation groups and wider groups to collect patient feedback. GPs cannot turn away patients and data could be gathered from formal complaints.

The data on GP appointments for June 2012 shows significant variations from practice to practice and this should, as far as possible be reduced to ensure a positive experience for all patients.

STRATEGIC RESPONSIBILITY FOR COMMISSIONING

NHS England has responsibility for strategic decisions on the provision of additional GP practices and improvements to premises etc. and for bringing interested parties together as part of the decision-making.

NHS 111 SERVICE

It may be necessary to factor in NHS 111 which has recently replaced NHS Direct as the single number for urgent care advice. (The Service is provided locally by London Central & West Unscheduled Care Collaborative (LCW).) If the review wants to look at the entrance points to medical advice and health care, NHS 111 is one of them, alongside GPs and A&E.

Can NHS 111 cope with demand at peak periods? Is it contributing to the increased demand at A&E (too wide a subject for our review?)

To date there has been no evidence to suggest that NHS 111 has contributed to any increase demand in A&E attendances. Islington CCG are carefully monitoring LCW's ability to deal with peaks and troughs in activity. They receive weekly reports on this and are working with LCW on their plans for the winter period when they can expect to get more calls. NHS 111 also provides a directory of services whereby patients are signposted to the most appropriate services based on the need including primary care – GPs, community pharmacy, community services where appropriate etc.

A&E

It has been suggested that some patients present at A&E instead of making an appointment with their GP. See Tables 1 and 2 below. These six practices were selected because between them they account for the highest numbers of patients reporting to A&E at either Whittington or UCLH during the six month period from September 2012 to February 2013. It should be stressed however

that these practices have the largest patient lists in Islington and between them have more than 60,000 registered patients.

Table 1Whittington Hospital

GP Practice	Whittington	% of Total
Goodinge Group Practice	933	5.8
Northern Medical Centre	1,029	6.4
St John's Way Medical Centre	1,684	10.5
Total	**3,646**	**23**

Table 2 University College London Hospitals

GP Practice	UCLH	% of Total
Killick Street Health Centre	1,020	9.1
Ritchie Street Group Practice	1,106	9.8
St Peter's Medical Practice	743	6.6
Total	**2,869**	**25**

Sources: NHS Choices and Islington CCG Database