CHAPTER 3

Better access to general practice
This chapter on primary care services includes:

- helping people register with the GP practice of their choice;
- rewarding responsive providers;
- increasing provision in deprived areas: supporting Primary Care Trusts (PCTs) to attract new providers;
- helping practices to expand by helping with expansion costs and making more money follow the patient;
- reviewing the funding of NHS Walk-in Centres;
- giving people more information on local services;
- new drive to improve the availability and quality of primary care provision in areas of deprivation, so that problems of health inequality and worklessness can be tackled.
Introduction

3.1 When people are asked about their local NHS, they probably think first of their GP. For the last 60 years, GPs have played a vital role in the NHS, acting as the main service provider, first point of contact for most people and the ‘gatekeeper’ to other services. These have always included hospital care and access to social security benefits aimed at helping people with sickness or disability.

3.2 Increasingly, however, a GP-led practice will also involve nurse practitioners and practice nurses and may include other healthcare professionals, such as physiotherapists, drug and alcohol counsellors, mental health counsellors, and therapists. In the future, there may also be specialists to give advice on employment aspects of being sick or disabled.

3.3 At one end of the spectrum is the small practice, owned and run by one or two GPs, possibly assisted by a practice nurse. At the other end is the very large practice – perhaps itself part of an integrated health and social care centre – with a full team of GPs, nurses, therapists and other professionals. New models are also developing, including NHS Walk-in Centres and a few primary care practices that are led by nurse practitioners, with a salaried GP available for those cases requiring a GP’s particular skills. In this chapter, therefore, we refer to ‘primary care practices’ as well as ‘GP practices’.

3.4 Access to high-quality primary healthcare has a vital role in helping people to live longer and healthier lives. Integration of these services with other community and social care services helps to ensure better co-ordinated support and care for each individual, better management of chronic disease, and reduced need for costly and avoidable hospital care. General practice remains best placed to offer patients their usual point of contact for routine and continuing care, and to help patients to navigate other parts of the system.

3.5 By international standards, general practice in England is efficient and of high quality. Indeed, many countries view with envy our system of list-based general practice and some, for example Spain, have sought to copy it.

3.6 We implemented major reforms to primary healthcare in 2003/04. These reforms have been backed by an unprecedented increase in resources. By the end of 2005/06, investment in primary medical care services in England will have increased by well over £2 billion compared with financial year 2002/03. This investment underpins a system of incentives aimed at expanding the range of services provided in general practice, rewarding improvements in clinical quality and patient experience and recruiting and retention of key professionals.

3.7 These reforms are delivering. As a result of the hard work and dedication
of around 160,000 GPs, nurses and others working in and alongside general practice, primary care is now delivering better quality than ever before; and a wider range of specialist services are available. We have recruited 3,950 more GPs since publication of the NHS Plan, including over 2,700 since March 2003 when the contractual changes came into place. Job satisfaction has increased and our GPs are now among the best paid in the world.

3.8 However, while public satisfaction with the services they receive in primary care is generally high, this varies across the country. Services do not always respond to the needs of local communities and individuals, for example by providing services that are appropriate to particular black and minority ethnic groups, nor do they reflect high levels of deprivation. There is also marked variation in how easy people find it to telephone their practice and make a convenient appointment. Access for some people remains difficult in some circumstances.

3.9 In order to improve access and responsiveness we need to put people more in control. If the public could genuinely choose their practice, their needs and preferences would have more impact on shaping services. We need, therefore, to make real the choices that people should have and reward existing practices and other new providers who respond to those choices.

3.10 To ensure that the NHS value of equal access for all is a reality, we must also do more to improve access and build up capacity in poorly served areas. While many people can choose between several high-quality practices, others find there is only one practice in their area with whom they can register. Particular groups of people, such as care home residents, people with learning disabilities, and people who are homeless or living in temporary accommodation, often have great difficulty in finding a GP at all.

3.11 In some places this will mean encouraging or allowing new providers, including social enterprises or commercial companies, to offer services to registered patients alongside traditional general practice. Increased capacity – and contestability – will allow people to choose services that offer more convenient opening times, tailored specialist services or co-location with other relevant services.
Making it easier to register with an open practice

3.12 Since 1948 patients have had the right to choose their GP and primary healthcare provider. This right to choose to register with a practice is a fundamental building block of the NHS:

• it is part of the public’s basic right to access their NHS;
• it establishes the right to care from patients’ chosen practice, supports continuity of care and forms the basis from which practices take responsibility for the wider public health of their registered population;
• it also provides the foundation for the allocation of NHS expenditure across England on a fair basis according to the needs of the local population.

3.13 For most people, choosing a general practice is one of their most important and personal health care decisions:

• on average, each person sees their GP four times a year. When practice nurses, counsellors and other staff are included, this amounts to over 300 million consultations in primary care each year. Fifteen per cent of the population sees a GP in any two-week period;⁴
• 75 per cent of people have been with their general practice for longer than five years;
• nearly one in three people have a long-term condition. People with a long-term condition particularly value continuity of care by someone who understands their problems and whom they know and trust.

3.14 Levels of satisfaction with general practice are consistently high. Yet we know that – for some – problems persist. At times, these problems materially restrict the ability of individuals to register with a practice of their choice.

3.15 Some people, for example, would like to change their practice to another one. This seems a relatively simple right for a member of the public paying for their services through taxation to carry out. Yet it can be difficult to do.

3.16 There is not always good, accessible information on practices and what they offer.⁵ There are not always practices available that are ‘open’ to new registrations – that is, taking on new patients. This needs to be put right.

3.17 Other people would like the option of being able to register with a practice near to where they work, rather than where they live. At the moment many practices do not take on new patients who live outside the geographical catchment area that the practice agrees with its PCT (and which defines the area in which the practice is required to make home visits where there is a clinical need).

3.18 All these factors mean that at present choice of practice in primary care is too often more of a theoretical
proposition than a practical reality. We will put this right. We will ensure that PCTs (as commissioners), practices and new providers respond to the choices and needs of the public as the best way of driving service improvements – not to exhortation from Whitehall.

3.19 We have also considered whether patients should be allowed to register with more than one practice at the same time, increasing convenience, particularly for commuters. This is known as ‘dual registration’. However, this approach would undermine the underlying principles of registration, including continuity of care, and would be difficult and costly to introduce. Nor did this approach receive support during the Your health, your care, your say listening exercise, ranking seventh among options presented in the questionnaire. We are already introducing a range of policies designed to enhance access.

3.20 NHS Walk-in Centres already provide easy access to a range of primary care services to all patients on demand. A new wave of NHS Walk-in Centres in commuter areas are beginning to open. These services should continue to be developed according to local needs, to ensure that people who lead busy lives have equal access to NHS services. For all these reasons we are ruling out dual registration.

Tackling closed lists

3.21 Registration will continue as the cornerstone of list-based general practice. However, we need to ensure that the right to register is a reality for all. In future, patients will be guaranteed acceptance onto an open list in their locality and we will review how we can simplify the process for doing so. Only in exceptional cases of abuse (for example violence) by patients will this not apply.

3.22 We will also simplify the handling of ‘closed’ lists. Although only 3 per cent of practices report operating closed lists, many more are ‘open but full’ – in other words, although they are not formally closed, the practice does not usually accept new registrations. This makes it harder for patients to find a convenient local practice, particularly in areas with low levels of primary care provision. It also inhibits choice and transparency and fails to safeguard against discrimination.

3.23 The existing closed list procedures will be made simpler to operate, in order to provide greater transparency for patients and to offer practices the flexibility they need to manage short-term or longer-term capacity issues. Practices will operate either an open list or a closed list. These changes will ensure that patients choose practices, not the reverse.

3.24 Linked with this, we will clarify the rules on eligibility and streamline the process for patients to register. We will make the access rules more transparent and make the registration process simpler for patients and providers.
3.25 There will be an obligation on PCTs to provide up-to-date, authoritative information to the public on whether a practice is open for new patients, the range of services it provides, its opening hours and so on. We will make it easier for everyone to get the information they need to choose a practice, including via the internet.

Making it easier for responsive practices to expand

3.26 In order to give people more choice of the practice they want, we need to ensure that popular practices benefit from taking on new patients. There are two main barriers:

- the costs of taking on new patients are not fully reflected in the current contract for GP services – money does not follow the patient;
- practices that do want to expand are not helped to do so.

3.27 Our approach is to ensure that there is an effective set of incentives in place that will deliver what patients need and expect. Rewarding responsive providers is the best way to ensure that patients’ needs are taken into account.

3.28 The way we invest in general practice goes some way towards ensuring money is allocated on the basis of need and that it follows the patient. However, less than 70 per cent

---

**Figure 3.1 General practice contract types**

<table>
<thead>
<tr>
<th>General medical services</th>
<th>Personal medical services</th>
<th>Alternative provider of medical services</th>
<th>Primary Care Trust medical services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nationally agreed contract between the Department of Health (or bodies acting on behalf of the Department of Health) and the British Medical Association.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recent negotiations led to an overhaul of the contract, which included practice-based rather than GP-based payments, stronger quality incentives, and more flexibility to increase range of services provided.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Alternative to GMS, in which the contract is agreed locally between the practice and the PCT.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Designed to encourage local flexibility and innovation and a focus on local population needs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Many of the developments in the new GMS contract have also been adopted in PMS.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Route for provision of primary medical services where PCT may contract with the independent sector, voluntary sector, not-for-profit organisations, NHS Trusts, other PCTs, Foundation Trusts, or even GMS and PMS practices.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PCT-provided medical services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Route to provision of primary medical services where PCT employs the GPs, nurses and others in the primary health care team.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Has been used as a lever for providing care where it has not proved possible to attract GPs to open practices.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Department of Health
of payments to practices on the national contract transfer with a patient when they move, and local Personal Medical Services (PMS) arrangements are open to local negotiation. In addition, premises funding stays with the original practice and most General Medical Services (GMS) practices are protected by a Minimum Practice Income Guarantee (MPIG). This was introduced to ensure that practices did not face a fall in income in moving to the new GMS contract in 2004. This reduction in income has not happened – indeed, most practice incomes have risen substantially.

3.29 One of the aims of both the PMS and GMS was to invest in practices and their populations based on patient need.

3.30 For GMS, a review of the funding formula is due to report in time for implementation in 2007/08. This will inform the next round of discussions between NHS Employers and the General Practice Committee (GPC). On the back of the substantial additional investment in general practice between 2003 and 2007, and a need to have more money following the patient, we will also ask NHS Employers to consider the MPIG and its impact on equity when discussing incentives for 2007/08 and beyond.

3.31 We will also undertake a fundamental review of the financial arrangements for the 40 per cent of practices on local PMS contracts. Many have developed innovative new services.

### CASE STUDY

#### Innovative GP services

The James Wigg Practice in Kentish Town – an inner-city London neighbourhood with high levels of disadvantage and health inequalities – is demonstrating the range of services that can be provided by primary care. The practice has GPs and nurses, of course, but it offers so much more.

Visiting specialists include an alcohol counsellor, a drug counsellor, an adult psychologist and psychiatrist, an ophthalmologist and a rheumatologist. Clinics are run by practice nurses for many ongoing conditions, including diabetes, asthma, hypertension and quitting smoking.

The practice makes extensive use of information technology. This means that patients can order repeat prescriptions using the internet. This emphasis on information technology has led to the practice being awarded beacon status. Patients can also conduct telephone consultations with doctors if they need advice or want to ascertain if they need to make an appointment.

3.32 However, providers are not always rewarded for attracting new patients to take advantage of innovative services. We would like all practices – whatever their contract type – to have a real incentive to take on new patients, where this is what people choose.
3.33 The second barrier to practices expanding are the steep extra costs. We will ask NHS Employers to consider the case for establishing an Expanding Practice Allowance for practices that have open lists which are growing significantly and that offer extended opening hours. Aside from such developments, we will expect PCTs to prioritise expanding practices when allocating strategic capital monies.

3.34 We will also review the arrangements for funding NHS Walk-in Centres and for paying for services provided by general practice to unregistered patients. The aim will be to ensure that all providers have the right incentives to deliver care to patients while away from their registered practice.

3.35 PCTs’ existing duty to inform local residents of the services available will be extended to include information on the establishment of new services and expanding practices. This will mean that the public are better informed about the choices open to them.

Health inequalities

3.36 These changes will make registration easier for most. But there are persistent and particular problems in deprived areas which have long been under-served. We intend to increase provision in areas that are not well served – which are typically the most needy areas – to increase the equity of provision and to ensure that everyone has a real choice.

Figure 3.2 Bottom 10 per cent of PCTs with the fewest doctors

<table>
<thead>
<tr>
<th>Rank</th>
<th>PCT</th>
<th>GPs (WTE) per 100,000 weighted population</th>
<th>Spearhead PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NORTH MANCHESTER PCT</td>
<td>40.6</td>
<td>S</td>
</tr>
<tr>
<td>2</td>
<td>WYRE PCT</td>
<td>43.2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>ASHFIELD PCT</td>
<td>43.6</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>TRAFFORD NORTH PCT</td>
<td>43.8</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>SWALE PCT</td>
<td>43.8</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>OLDHAM PCT</td>
<td>44.0</td>
<td>S</td>
</tr>
<tr>
<td>7</td>
<td>MANSFIELD DISTRICT PCT</td>
<td>44.1</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>DONCASTER WEST PCT</td>
<td>44.2</td>
<td>S</td>
</tr>
<tr>
<td>9</td>
<td>WALSALL PCT</td>
<td>44.3</td>
<td>S</td>
</tr>
<tr>
<td>10</td>
<td>KNOWSLEY PCT</td>
<td>44.5</td>
<td>S</td>
</tr>
<tr>
<td>11</td>
<td>WOLVERHAMPTON CITY PCT</td>
<td>44.7</td>
<td>S</td>
</tr>
<tr>
<td>12</td>
<td>DONCASTER EAST PCT</td>
<td>45.0</td>
<td>S</td>
</tr>
<tr>
<td>13</td>
<td>ASHTON, LEIGH AND WICAN PCT</td>
<td>45.1</td>
<td>S</td>
</tr>
<tr>
<td>14</td>
<td>BURNLEY, PENDLE AND ROSSENDALE PCT</td>
<td>45.1</td>
<td>S</td>
</tr>
<tr>
<td>15</td>
<td>BARKING AND DAGENHAM PCT</td>
<td>45.2</td>
<td>S</td>
</tr>
<tr>
<td>16</td>
<td>BLACKPOOL PCT</td>
<td>45.3</td>
<td>S</td>
</tr>
<tr>
<td>17</td>
<td>NORTH STOKE PCT</td>
<td>45.5</td>
<td>S</td>
</tr>
<tr>
<td>18</td>
<td>EASTERN HULL PCT</td>
<td>45.5</td>
<td>S</td>
</tr>
<tr>
<td>19</td>
<td>WIDNESBURY AND WEST BROMWICH PCT</td>
<td>45.7</td>
<td>S</td>
</tr>
<tr>
<td>20</td>
<td>TENDRING PCT</td>
<td>46.3</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>BARNSLEY PCT</td>
<td>46.4</td>
<td>S</td>
</tr>
<tr>
<td>22</td>
<td>EASINGTON PCT</td>
<td>46.5</td>
<td>S</td>
</tr>
<tr>
<td>23</td>
<td>SHEPWAY PCT</td>
<td>46.5</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>HASTINGS AND ST LEONARDS PCT</td>
<td>46.7</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>NORTH KIRKLEES PCT</td>
<td>46.9</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>SOUTHPORT AND FORMBY PCT</td>
<td>47.3</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>SOUTH TYNESIDE PCT</td>
<td>47.4</td>
<td>S</td>
</tr>
<tr>
<td>28</td>
<td>OLDBURY AND SMETHWICK PCT</td>
<td>47.5</td>
<td>S</td>
</tr>
<tr>
<td>29</td>
<td>HARTLEPOOL PCT</td>
<td>47.5</td>
<td>S</td>
</tr>
<tr>
<td>30</td>
<td>BLACKBURN WITH DARwen PCT</td>
<td>47.5</td>
<td>S</td>
</tr>
</tbody>
</table>

A PCT is under-doctored if its number of whole time equivalent GPs (excluding GP retainers, GP registrars and locums) per 100,000 weighted population is less than the national average.

Source: Department of Health General and Personal Medical Services Statistics, March 2005
3.37 The distribution of general practice has been uneven since the beginning of the NHS. Research also shows that those areas with poorest health outcomes are also those with the fewest GPs. The variation is quite large. The PCTs that had the most GPs per 100,000 weighted population had more than double that of the least.

3.38 GPs are one indicator of capacity. There has been a change in emphasis in delivery of primary care, with more team-based approaches involving nurses and other professionals. Although there have been improvements in the overall number of primary care professionals, there has been no significant narrowing of inequalities in provision. Areas with insufficient provision tend to have below average health outcomes and lower levels of patient satisfaction.

3.39 Increasing the quantity and quality of primary health care in the areas of greatest need is one of the most important ways in which this Government can tackle health inequalities. It can improve services for all, so as to guarantee universal access to high-quality primary care services across all parts of the country, appropriate to the local population, and based on need. The issue of quality in primary care is considered further in Chapter 8.

3.40 Part of the new contract deal endorsed by GPs was the creation of new contractual freedoms for PCTs to bring in additional provision (see Figure 3.1). In the next stage of reform these freedoms will be used systematically to reduce inequality in primary care provision.

3.41 On their own, PCTs have not always had the size or clout to develop enough new provision in their locality to tackle inequalities. The Department of Health is currently assisting six PCTs in procuring services from a diverse set of suppliers for communities that have previously been poorly served. Now we will help all PCTs in under-served areas to draw upon national expertise to attract new providers of sufficient size to fill these gaps in provision.

3.42 We will do this by ensuring that PCTs actively commission additional practices, reflecting the needs and expectations of their local populations. Change will be driven locally, with local authority input, and co-ordinated nationally in a series of procurement waves. This is an urgent priority if we are to make equal access for equal need a reality.
3.43 We will ensure that both new and existing providers are allowed to provide services in underserved areas. Social enterprises, the voluntary sector and independent sector providers will all make valuable contributions in the longstanding challenge of addressing inequalities. The voluntary and community sectors often have strengths and experience in delivering services to those people who are not well served by traditional services. This will be the basis of the new Fairness in Primary Care procurement principles.

3.44 PCTs will retain full control of their proposed contract specifications, in order to ensure services are tailored to meet local needs, and they will, of course, be responsible for awarding and signing contracts.

3.45 The first wave of nationally supported procurements must address those areas with the most significant inequalities of access to primary care. The Department of Health will assist health communities with the poorest levels of general practice provision. Future waves will be shaped more broadly around the ongoing needs of local populations, ie based on the trigger mechanisms outlined in Chapter 7. They will take into account the broader set of measures, such as patient surveys, patient assignments, closed lists, and unresponsive services. We will ensure that local authorities have the opportunity to input into relevant tender specifications.
Better access to general practice

New providers in primary care services

The current small business model of GP partnerships is likely to remain very popular. To complement this, larger organisations can bring capital and new management techniques to deliver innovative solutions, such as larger one-stop shop primary care centres, offering a wider range of services, including diagnostics and minor surgery, and convenient opening hours. Some examples include:

Entrepreneurial GPs or nurse practitioners forming large organisations

The organisations would continue as providers under GMS and PMS contracts, however they would be organised into larger units, or be based around networks, allowing the pooling of resources and the delivery of a broader set of services. Practice Based Commissioning is likely to be the prime driver for practices working more closely together.

Co-operatives

There are already 20 GP out-of-hours co-operatives, known as ‘mutuals’. Mutuals are not-for-profit organisations where members are entrusted with their social ownership and governance. They can be large enough to enjoy economies of scale and have long-term horizons, yet maintain a local responsive touch in the delivery of patient care. Mutuo is leading the development of such organisations. Some out-of-hours co-operatives may be interested in providing a round-the-clock service, based at one or more primary care practices.

Independent sector

The for-profit corporate sector has just begun to provide services in primary care via the use of the Alternative Providers of Medical Services contract. More broadly, Boots are offering chlamydia testing in some high street stores in London, and a number of organisations will run commuter-focused Walk-in Centres close to train stations, on behalf of NHS patients.

Mercury Health Primary Care (the primary care arm of an independent sector organisation) has formed a strategic alliance with Chilvers and McCrea, a company established four years ago by an NHS nurse and a GP, with 18 general medical practices in England. The alliance brings together the size and capital of a corporate body with the specialist expertise of a small entrepreneurial organisation. Mercury also has an affiliation with Frome Medical Practice, one of the largest in the country with 29 GPs.
3.46 The approach to the first wave of the Fairness in Primary Care procurement principles is as follows:

**First wave of Fairness in Primary Care procurement principles**

1. The Department of Health will begin immediately to identify the localities that are significantly under-provided, especially those in deprived areas.

2. Where PCTs are unable to provide robust plans for rapidly reducing inequalities of access to services, they will be invited to join the national procurement process.

3. There will be a competitive tendering process, which will provide a level playing field and ensure fairness. PCTs will purchase and contract manage the new services.

4. PCTs will draw up specifications for the new services they will procure. These must include arrangements for convenient opening hours, open lists, a practice boundary, if any, very broadly defined, as well as quality incentives comparable to those in the GMS/PMS contract.

5. The Department of Health will manage the procurement process on behalf of PCTs, ensuring the principles of contestability and value for money are realised under a fair, transparent and consistent process.

6. All providers that pre-qualify to quality standards during the tendering process will be put on an accredited list of primary care suppliers, to ensure that in the future commissioners can procure GP services faster.
Making it easier to get care at the right time

3.47 Registration is not an end in itself. Registration ensures free access to a primary care professional and is the gateway to other services. We want people to register with a practice that provides them with the care that they want. Once a patient is registered, when they need to see a primary care professional, they expect to be seen at a convenient time and quickly.

3.48 The NHS Plan set a target of patients being able to see a practice nurse within 24 hours and a GP within 48 hours. This target has led to significant improvements in access to primary care and largely ended the problem of people waiting a week or more to see a GP.

3.49 But it has created new problems. A growing minority of practices stopped offering advance bookings. This is a particular problem for people who want to organise their time ahead or whose need is less urgent. It assumes that the public’s time is free. Action has been taken to address this and the problem is diminishing, but more needs to be done.

3.50 The public, quite reasonably, expects both to be able to see a primary care practitioner quickly, and to have the opportunity to book an appointment in advance. Your health, your care, your say showed that this is a high priority.

3.51 In response to Your health, your care, your say, we have agreed with the British Medical Association (BMA) a new general practice contract framework for 2006/07 that already makes progress on ensuring better access. It sets practices objectives to offer patients:
- the opportunity to consult a GP within 48 hours;
- the opportunity to book appointments in advance;
- easy telephone access;
- the opportunity for the patient to consult their preferred practitioner (while recognising that this may mean waiting longer).

3.52 It is our intention to ensure that people have both the ability to get fast access when they need it and to book ahead. We will use our contracts to deliver this, together with public information on practices not complying, to enable people to make informed choices.

3.53 PCTs will be expected to provide information to all patients on the performance of all practices in an area in offering fast access and advanced booking. This information will list other local practices that are open to new registrations and are meeting the target fully. This will enable them to make informed decisions about the care and services they are receiving.
Ensuring practices are open when the public wants

3.54 Ensuring that services are open when the public want to use them is fundamental to improving access. It was one of their highest priorities in the *Your health, your care, your say* listening exercise. We will tackle this with the professions through a variety of means.

3.55 At present, practices set their own surgery opening hours and have the ability to change these without PCT agreement. There are few incentives to offer opening times that respond to the needs of patients. We will change this.

3.56 First, it will be easier for people to choose which practice they register with. This will enable them to choose practices that offer access that fits with their lives. Practices that offer opening
hours that the public want will gain new patients, and the money that follows them; those that don’t, won’t.

3.57 Second, we will directly ask the public how easy it is to get into their practice to see a GP and will reward those whose patients are satisfied. From this year, practice patient surveys, which will be standardised and independently conducted, will ask registered practice populations whether their surgery offers convenient opening hours, including an early morning, evening or Saturday surgery.

3.58 Third, in the future, opening hours should reflect patient preferences and will be agreed with PCTs. We will seek to use the various primary care
contracts to provide more incentives for new and existing providers to offer better opening hours.

3.59 Fourth, PCTs will also ensure convenient opening hours across a range of other alternatives. These alternatives include:

CASE STUDY

Opening longer for patients

People told us that more convenient opening hours was the most important thing for us to tackle to improve access to GPs. They also told us that they didn’t want this to mean that staff simply worked longer hours. From late November 2004, two practices in Waltham Forest, North London, piloted extended opening hours to meet their patients’ needs. They also restructured staff working hours and engaged additional staff. Here’s how it feels for both their patients and people working at one of the practices.

Neil Collins, a 64-year-old retired social worker, has been a patient at Forest Road Medical Centre for three years. “The longer hours scheme was piloted at my surgery for six months last year. I think it could have been advertised a bit better, but once I found out about it, it was great. I found the flexibility very useful and it meant there were more appointments, so it was easier to get to see the doctor at a time that was convenient. For example, one Friday evening I had what I thought was an infected foot. Previously, if this had happened on a Friday night, I would not have been able to get an appointment before Monday and I’d have had to go to the Walk-in Centre or Accident and Emergency. This time I was able to ring and get an appointment for Saturday. I’m also a mental health services user and I suffer from an anxiety disorder, so I tend to worry more about certain things and the flexibility of the appointment system also helped to ease my anxiety, because I knew I could get an appointment if I needed it.”

Dr Dinesh Kapoor, a GP at Grange Park Practice, said his patients reacted very positively. “They were so pleased that we were no longer saying ‘Sorry, there are no appointments for two weeks’ but rather, ‘You want to be seen? Come now!’ The new system also enabled the practice to increase the length of appointments so, as Dr Kapoor explained, “patients were getting around 50 per cent more time. Immediate access and a longer consultation time with the doctor or nurse were obviously beneficial, particularly for those suffering from chronic diseases.

“The Saturday morning service was particularly popular and it meant that fewer of our practice patients were turning up at the out-of-hours services in the local hospitals. So it contributed to saving costs at the A&E and NHS Walk-in Centres. I believe some patients have transferred to our practice as a result of the scheme.”
• bringing in new providers offering more convenient opening hours (see paragraph 3.46);
• allowing out-of-hours providers to do evening surgeries, take booked appointments and take on registered patients;
• developing new NHS Walk-in Centres and allowing existing sites to take booked appointments.

Choosing your primary care professional

3.60 Patients also want to be able to see the GP of their choice within the practice. Women often prefer to see a female GP. Relationship continuity is very important. It is better for both the patient and practitioner if the patient’s history and needs are shared and understood, particularly if the patient has ongoing needs.9

3.61 Research also shows that where a practitioner has an ongoing professional relationship with a particular patient, they tend to be more committed to the patient as a person.10 This is one of the reasons why small practices are popular and will remain an essential part of general practice.

3.62 At present, patients can state their preferred GP. If a particular GP is especially popular, this will inevitably mean that the patient cannot see them within 48 hours. It will then be for the patient to decide whether to wait, or instead to see a different GP within 48 hours.

3.63 The public does not always want to see a GP. At the national Citizens’ Summit in Birmingham in 2005, over 40 per cent of people picked having a trained nurse as a first point of contact in primary care as one of their top three priorities. We will encourage existing practices and new providers – particularly through the review of urgent care services – to make best use of the first contact skills of nurses. In addition, NHS Walk-in Centres and NHS Direct are already offering this option and the further expansion and development of these services will extend this.
As well as increasing the accessibility of GPs and nurses, it is important that access to other primary care professionals is improved where waiting lists exist, such as access to allied health professionals. While many services already operate a self-referral system where patients can access these services themselves without the need to see a doctor, we will be piloting this approach with a comprehensive evaluation (see Chapter 4).

Nurse triage, perhaps using the telephone, has the potential to reduce pressure on GPs while enabling people to talk to a clinician straight away. We will encourage primary care practices to explore the potential of both nurse triage and telephone consultations, particularly if a practice's survey reveals support for these innovations.

Technology could improve access in primary care. Use of the internet could be made for the booking of GP appointments, for ordering prescriptions from GPs on-line and even, potentially, for registering with a practice on-line. We would encourage practices to explore the potential for technology to improve access and we will work with NHS Connecting for Health on the practicalities for this, as well as learning from examples of best practice.

If the public has a choice of practices, then those that offer the most appropriate and responsive services will attract more patients. Practices will have to identify and meet the cultural and demographic needs of the population they serve – they will have to design services around the user in order to attract them.

Some practices will wish to expand and take on more patients outside their current boundaries, thereby increasing choice. In these circumstances they will continue to be free to agree a larger area with their PCT. Other practices or providers may, however, prefer to concentrate on delivering high-quality services to their existing patients or list size.

We also expect that some existing practices will wish to combine extended boundaries and extended opening hours for maximum coverage for people. We will expect new providers in particular to offer this option to patients.

PCTs will work closely with their local authority partners to ensure that the associated social care implications of different practice boundaries are taken into account.

Responsive primary care practices should work within an integrated set of community and local services. In the next chapter we will look at the wider
set of services with which primary care practices link.

References

1 Starfield B. Primary care: balancing health needs, services and technology, Oxford University Press, 1998

2 The NHS Plan: A plan for investment, a plan for reform (Cm 4818-I), The Stationery Office, July 2000


4 Professor Sir Denis Pereira Gray, A dozen facts about general practice primary care, St Leonard’s Research General Practice, University of Exeter; Emeritus Professor of General Practice

5 Marshall M, Noble J, Davies H, Walshe K, Waterman H, Sheaff R, Elwyn G. Producing information about general practice services that makes sense to patients and the public, National Primary Care Research and Development Centre, 2005


7 Recent Glasgow University study, plus also Department of Health workforce census figures

