Access Quality Improvement

Aneurin Bevan University Health Board

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Summary of the Project

- *Access Quality Improvement*
  - *Two phase scheme to enable practices to assess their capacity and demand and to "bid" for funding for innovative solutions*
  - *Understanding demand on GP practices for telephone and face to face contact to enable consideration of system and process changes*
  - *Agreed "principles of access" with the Gwent LMC that underpin safe and effective care to patients*

Why was it chosen

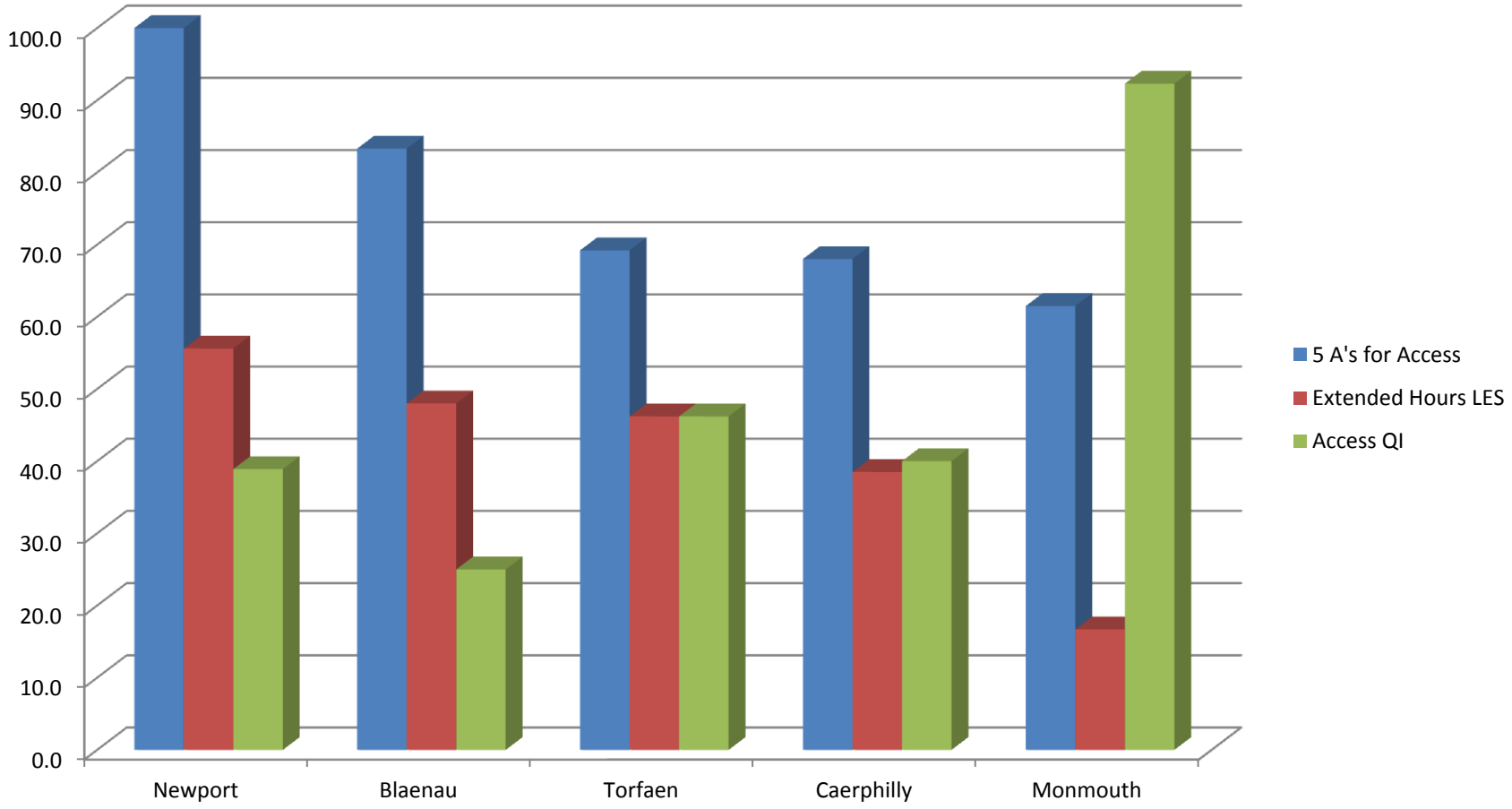
What problem are you trying to solve?

- *improving patient access to GP services*
- *supporting practices to seek new and innovative solutions*
- *supporting sustainability*

What would Success look like?

- *Improved Patient experience of access*
- *More Sustainable Practices*
  - *– opportunity to consider different skill mixes*
  - *–improved recruitment/retention of GPs and nurses*
  - *–Increased uptake of Enhanced Services*
  - *•Practices work co-operatively through new structures or processes*
  - *–Greater local leadership & ownership of problems/ solutions*
  - *–Development of Hubs, Federations, Mergers*

Picture of Access



What are your Process Measures?

Access QI

- *Support to practices for capacity/demand review*
- *Standardised data collection*
- *Single patient satisfaction survey*
- *Ability to analyse data at an individual practice level*

What will be your Outcome Measures?

Access QI

- Review of capacity and demand pre-Phase 1 and post Phase 2
- Patient satisfaction pre-Phase 1 and post Phase 2
- Practices moving to 5A accreditation as a result of participation
- >50% of practices participating in the Access QI scheme

What will be your Outcome Measures?

Access QI

- 51% practices participated in P1 (C1)
  - 17 practices successfully bid for funding from P2 (C1)
  - 5 practices have 4a and 1 practice 3a accreditation
  - 26 provide the Extended Hours ES
  - More patients using MHOL on to book appointments (41.9% - telephone:7.8% MHOL)

What will be your Outcome Measures?

Practice	Issue	Change	So What?
A	Identified a surge in demand for telephone access.	More reception staff working at peak times. Purchased cordless headsets for reception staff	Patient compliments about the running of the practice and the appointment system
B	Identified a need to change the appointment system	Changed the appointment system and use MHOL appointment booking; Self check in screen has been purchased	Patients happier with "booked" rather than "open" appointments; good uptake of MHOL appointments; 60% of patients attending the practice are using the self check in
C	Identified peak times for patient contact	More reception staff working at peak times; Using digital board to display important health messages	Patients have given positive feedback about the digital information and the practice has noticed an increase in uptake of the Shingles vaccine as a result
D	Ongoing need to monitor access and demand.	Practice has continued to use analysis tools and reviews third available appointment every week and is discussed at monthly partner meetings. Self check in system purchased	Patients are giving positive feedback about the self check in system rather than waiting at Reception
E	Demand outstripping capacity	Additional sessional GP has increased appointment capacity; Purchased an appointment card printer; improved information to patients about access	Patients providing written compliments on access to appointments; DNA rate has decreased from >200 to <150 per month

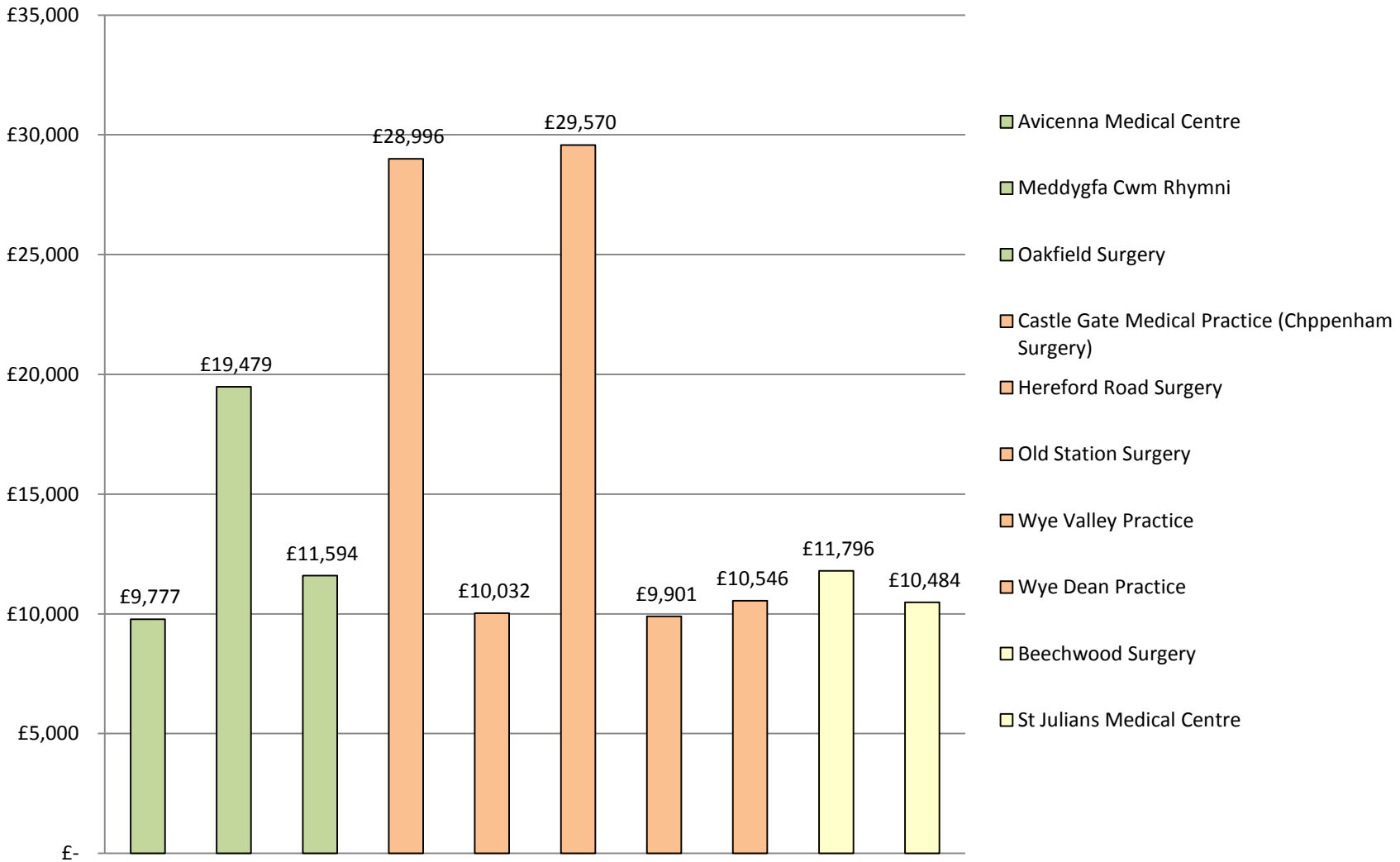
Will you have any Balancing measures?

- Improvements in patient access resulting in reduction of patient complaints
- Increased uptake of Enhanced Services

What did you Learn ?

- *Access and sustainability are intrinsically linked*
- *Dedicated project management to Access QI to drive it forward and to provide direct support to practices*
- *Able to share data collection tools and methodology; PCOST Service Level Agreement*
- *Underpins ministerial priorities for sustainable primary care*
- *Access QI is labour intensive; would be difficult to support roll out across Wales in current format until Audit+ is widely available*
- *Inverse Care Law applies – those practices that come forward are those that are already doing "well"*

Access Q1 Expenditure – Cohort 1



Ministerial Priorities

- *Improved sustainability and service provision in practices*
- *Greater (timely) access to services for patients*
- *Prudent healthcare principles adhered to*
- *Efficient systems that eliminate waste*
- *Professionals working to the top of their license*

Next Steps

Access QI

- *Review of applications from cohort 2 of practices participating in Phase 1*
- *Support those practices through Phase 2*
- *Re-evaluate the impact of changes made by practices in cohort 1*
- *Final review of data January 2017 to inform any future remodelling*
- *Consider including Access QI as a key function of PCOST intervention to ensure that those "hard to reach" practices are supported*

Discussion – 21st Sept 2016

- Standardised data collection to database; aggregate to give overview
- Patient satisfaction features heavily in reported outcomes - good model
- Care needs to be taken to avoid inverse care law - ie practices that need it most often not applying for scheme
- Importance of good project management, with sufficient time to prepare . AB have criteria for project manager to share
- Strength of this model is the 'capacity and demand' analysis – model developed for capacity and demand analysis; IT solutions are essential
- Benefits of an 'accreditation' model
- Need to link service with demand, building capacity in areas identified. Simple technology can help with demand, eg self-service machines at front door; learning from patient feedback
- Assessment of prof skills needed to cope with demand; how best use existing staff –careful analysis of demand and skill-mix required
- Doing things differently – eg LA, vol sector, telephone-first services
- Professionals need to be empowered and trained appropriately for effective triage
- Question over how access is defined. Is there patient involvement in definition?
- Clarity on actual changes to improve access - should come from Phase 2 evaluation. Detail would be valuable. CHC involvement
- Survey is based on NHS England survey – validated model
- Risk of focusing on in-house staffing changes rather than changes ‘upstream’ to prevent pts going to ED, etc- more joined up work on capacity and demand needed
- Fragmented aspects of funding unhelpful - ie other pots of funding are being used for other aspects of demand, with disconnected work on capacity and demand
- Importance of having the right resource in the right place to effect change
- Reference to the patient survey as a resource