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Primary Care Programme Series

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What do Londoners think of their General Practice?

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The King's Fund and the Evening Standard jointly commissioned a study in April 1999 to discover what Londoners thought of their general practice. The report, ***What do Londoners think of their General Practice?*** examines the responses of 1,139 adults in London who were interviewed by NOP earlier this year. The respondents were asked a range of questions aimed at assessing their level of satisfaction with the service provided by their general practice and their knowledge of recent changes brought about in the 'new NHS'.

It found that while the majority of Londoners are satisfied with their General Practitioner (GP) service, a fifth are unhappy about the time they have to wait in the surgery and a quarter are unhappy about the time it takes to get an appointment. People with single-handed practices are more satisfied than those with group practices.

Access

A key objective of recent government reforms is to improve access to services in the National Health Service (NHS). This is particularly important in general practice, where 90% of patient contacts occur. In our sample, 86% of respondents said they had found it easy to register with their current GP and 70% said they had registered with their first choice of doctor.

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Three out of four Londoners (74%) said they would be able to see a doctor of the same sex if they wanted to and just 14% said they would find it difficult. However, nearly three times as many women as men (20% compared to 7%) said it would be difficult to see a doctor of the same sex if they wished. Being registered with a single-handed practice meant that it was even more difficult to arrange to see a general practitioner of the same sex – 23% said they would find it difficult compared to 13% registered with a group practice.

In the last decade, several local and national policies with an emphasis on more flexible working patterns have attracted more women into general practice. An increasing proportion of vocational trainees and medical students are now women and, in London, over a third (36%) of unrestricted principals are women. This is slightly higher than the national average. However, that a fifth of all women in our study said it would be difficult to arrange to see a female general practitioner suggests that there is still progress to be made in both recruitment and retention of women into general practice.

Waiting

One in five (21%) Londoners said they would be able to get a non-urgent appointment on the same day and about the same proportion (18%) said they would be able to get an appointment the next day. However, the majority of people (55%) would have to wait more than two days, and more than a quarter (28%) said that they would have to wait more than three days to see a GP.

The most striking difference in the time it took to obtain a non-urgent appointment, was between Londoners registered with a single-handed practice and those registered with a group practice. Nearly half of patients registered with a single-handed practice (46%) said they would be able to see a doctor on the same day, whereas fewer than one in five (17%) patients registered with a group practice made the same claim. Four times as many patients (32%) belonging to a group practice said they would have to wait more than three days for a non-urgent appointment, compared with fewer than one in ten patients (8%) registered with a single-handed practice.

Patients registered with single-handed practices were more satisfied than those registered with a group practice with the length of time they had to wait in the surgery to see their general practitioner. Equally, they were more confident than group practice patients that they would be able to secure an urgent appointment within an hour of telephoning the surgery. Although group practice is usually considered more desirable, in our study, patients of single-handed practices were more likely to be satisfied.

There was a high level of satisfaction with surgery opening hours amongst Londoners – four out of five (82%) of the people interviewed said that they were satisfied. However, one in five young people aged 18 to 34 years said that they were dissatisfied with the opening hours of their local surgery (19%), compared with only 6% of those aged 55 years and over.

Earlier appointments

We asked whether people in London would be willing to pay £10 to get an earlier appointment and a longer consultation with their GP. One in four said that they would be willing to do so. These were more likely to be men, and those who expressed less satisfaction with the care they received.

We also asked whether patients would be willing to have a same-day appointment with a nurse rather than to wait until the next day to see a doctor. One third of respondents (32%) said it would depend on what the problem was, but of the remainder, 57% said that they would prefer an immediate appointment with a nurse. Younger people, those with children and those working were all more likely to opt for a same-day nurse appointment rather than waiting to see a GP.

Patient satisfaction

Most of the people surveyed were satisfied with the quality of care they received (84%), with more than a third of the total (41%) saying that they were very satisfied. As observed in other areas of the survey, older people, aged 55 years and over, were generally more likely to express satisfaction with their care (90%) than younger people, aged 18-34 years (80%).

Overall, levels of satisfaction with their general practitioner were high – 87% of respondents said they were satisfied with the friendliness and "bedside manner" of their doctor and 82% were satisfied with the amount and quality of information they received from their doctor during a consultation. Despite recent studies showing that the quality of surgery premises in London is highly variable, 92% of respondents were satisfied with the quality of their doctor's surgery premises.

When we asked whether the quality of care at their local surgery had improved, got worse, or stayed the same in the last few years, four out of five people (80%) thought that it had either stayed the same or got better. Just 5% said that it had got worse. Again, those aged 55 years and above were more likely than younger patients to say that there had been improvements.

Complaints

In our survey, around one in six Londoners had considered making a complaint about their GP (16%). Younger women and those with children were more likely than other groups to consider making a complaint. Overall, just 3% of our sample had gone ahead and made a complaint. Despite recent attempts by the government to simplify the complaints procedure, a quarter of all respondents were not confident that the NHS complaints system was either accessible or fair.

Knowledge about changes to the NHS

Almost nine out of ten Londoners (89%) said that they had not been consulted about changes to their local surgery, or its relationship with the rest of the NHS. When asked if they had heard of Primary Care Groups (PCGs), only one in five (21%) said they had heard of them,

but the majority of these people knew little or nothing about them (65%). Only 7% of Londoners said they knew 'a great deal' or 'a fair amount' about PCGs. That people are so ill-informed about PCGs is not surprising – after eight years of fundholding, only a third (34%) of the Londoners we spoke to knew whether their GP was a fundholder or not.

Summary

The 1990s have seen fundamental changes in the field of primary care. A wide range of new initiatives to increase access to primary care services, such as Personal Medical Services pilots, NHS Direct and Walk-in centres, are being piloted across the country.

The findings of this study revealed that overall levels of satisfaction were high. These results echo those of other patient satisfaction surveys, in which patients, and in particular older patients, tend to express high levels of satisfaction with the services they receive.

However positive the overall results of this survey are, many Londoners still see scope for improvement, and this was apparent in the proportion of patients who had considered making a complaint. The recent flood of White Papers and ministerial announcements heralding change in the NHS appears to have largely passed the general public by. Most people said they had not been consulted about changes to their local surgery, only one in five people had heard of PCGs, and fewer than one in ten knew anything about them.

The majority of Londoners thought that the quality of care provided by their local surgery had either improved or stayed the same over the last few years. Just one in twenty felt that there had been a lowering of standards over the same timescale. As Peter Kellner of the Evening Standard observed 'Perhaps too many of us tolerate second best services. Perhaps we are too grateful that London's general practitioner service keeps going to notice its defects. Or perhaps the capital's family doctors do a first rate job. Whatever the explanation, a huge majority of Londoners think highly of the primary care they receive' (Evening Standard, 1999).

Other publications in the King's Fund Primary Care Programme Series 1999

- **Developing Health Improvement Programmes: lessons from the first year** by Shona Arora, Anne Davies and Sarah Thompson [published jointly with the Public Health Programme].
- **The Health of Refugees: a guide for GPs** by Ros Levenson with Naaz Coker.
- **Quality in general practice** by Trisha Greenhalgh and John Eversley.
- **Personal Medical Services Pilots in London: rewriting the Red Book** by Richard Lewis, Clare Jenkins and Steve Gillam.
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Developing primary care in London: from 1990 to PCGs by Dominique Florin et al (in press)

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Developing Health Improvement Programmes

Lessons from the first year

Summary

Health Improvement Programmes (HImPs) are a key innovation in the Government's health policy. They are intended to bring together the main statutory and voluntary bodies in each health authority area, to plan and deliver measures to improve the health of the local population. The first round of HImPs was completed by April 1999. The next is due for submission by September 1999.

What can be learned from the first round? What worked well and what problems have arisen? The King's Fund carried out a rapid appraisal early in 1999, exploring the experiences of selected London-based health authorities, local authorities and primary care groups. They were asked about their perceptions of HImPs, the structures and processes involved in developing partnerships, approaches to priority setting and health inequalities, and public involvement and accountability. The following themes emerged from the study as a whole.

A positive response

Across all three sectors, there is good will and enthusiasm for the concept of HImPs, especially the new commitment to tackling health inequalities, to partnership working and to addressing the wider determinants of health. There is optimism that HImPs will encourage new ways of working that have potential to improve health. However, those working in the public sector, particularly in the NHS, are at risk of being overwhelmed by the pace of change

Changing roles and responsibilities

The future of health authorities is uncertain as primary care groups develop. This has implications for their partnership with local councils, which is intended to be central to the development of HImPs. The role and location of public health expertise is also called into question. If HImPs are to function properly as strategic frameworks for commissioning services, able to influence patterns of expenditure, they must not come to be seen merely as the property of public health departments. But public health could play a key role in ensuring that evidence on effectiveness and efficiency is collected and used to inform action generated by the HImP.

Working in partnership

Successful partnerships require tangible outcomes and positive engagement of all partners. There must be a clear, shared vision of what health improvement means in each locality, well-defined roles and responsibilities, respect for cultural differences between partners, and agreed procedures for setting priorities. Sharing information is important but raises ethical difficulties, which can be a stumbling block. It is important that partnership processes do not become an end in themselves. Leadership of the HImP process may not remain with health authorities indefinitely – it may become appropriate for local authorities to assume leadership of health improvement in some localities. But it is less likely that PCGs will be suitable lead agents in a district wide strategy. The balance between local and national priorities may be a source of potential conflict.

Public involvement

This can help to improve responsiveness to local needs, to build the capacity of local communities and to strengthen public sector accountability. Problems include: presenting information in accessible ways, showing willingness to act on the public's views, and deciding whom to involve and how. Opportunities for involving the public as citizens, rather than just as service users, remain inadequate. 'User fatigue' is a danger and there is a strong case for one partner co-ordinating public involvement on behalf of the HImP partners. Local councillors, suitably prepared, could play an enhanced role in health improvement, working closely with PCGs, and could help make the process more accountable.

Resources

For HImPs to work, resources must be channelled into appropriate activities, including those beyond health and social services. Tighter links between the HImP and the planning cycles of other programmes would facilitate the redistribution of core resources. Since acute trusts currently command the lion's share of health resources, their co-operation is needed if funds are to be redistributed, but their traditional priorities must not be allowed to dominate. There is often a significant financial shortfall within health budgets, which will, in any event, limit the scope for funding HImP-related activities. The problem of transferring funds between health and local authorities remains unresolved. Strong political signals that health improvement is as much a priority as, say, waiting lists, could help. But leadership from the centre must not crowd out local ownership and flexibility.

Measuring progress

The HImP must be capable of translation into practical action if those in the front line of service delivery are to share 'ownership'. Each of the partners must be able to demonstrate progress. A range of indicators, including process and outcome measures, as well as health and social factors, will be needed. Some indicators can be shared across professional and sectoral boundaries. Evaluation must be a means to an end, not an end in itself, and findings should be presented to the public as a health promotion opportunity. Public understanding, support, and engagement is vital to the HImPs' success.

Key findings

Responses from interviewees in the three settings are described and analysed in the report and summarised here. These include: concerns about HImPs in general, opportunities, problems and challenges, and recommendations for action for each of the sectors involved in the study.

Opportunities provided by the HImPs

For health authorities, local authorities and primary care groups

- to spread the public health agenda more widely, not only through the health sector but also beyond it
- to share responsibility between organisations for improving the health and well being of local populations
- to address the wider determinants of health beyond the health service, tackling deep-seated social as well as health problems
- to tackle health inequalities and inequities in access to health and other services
- to extend partnership working beyond joint work between health and social services departments

In addition, HImPs provide an opportunity:

- for *health authorities* to aid the development of primary care
- for *local authorities* to develop a new role in the formulation of health strategy and to extend the scope for community development
- for *primary care groups* to improve multi-professional working, move resources from secondary to primary health care, and to improve the quality of primary care

Problems and challenges presented by the HImPs

For health authorities

- ownership across the authority – the HImP may be marginalised within the public health department
- use of resources needs to be influenced by the HImP as well as by acute service pressures
- tension between the need for strategic vision and for 'quick wins'
- possible conflict between national and local priorities
- how to involve the public effectively

For local authorities

- how to convert strategy into action
- how to engage the authority corporately, not only through social services departments
- finding social indicators relevant to the contribution the boroughs can make
- performance management and measuring progress towards agreed targets
- identifying resource implications of local authorities' role in implementing the HImP
- limited scope for diversion of funds to pursue HImP objectives – new initiatives other than social services are so far dependent on 'slippage' in existing budgets
- engaging public support – how to consult the public effectively and avoid wasteful duplication of time and effort
- developing a constructive role for elected representatives in the health improvement partnership

For primary care groups

- overload – too many changes to implement simultaneously in too short a time
- minimal infrastructures affecting the capacity to deliver – most board members have other jobs
- lack of resources to implement change
- need to measure and demonstrate progress
- developing ownership of the HImP across the whole primary care team
- limited public accountability – the need to engage with the wider community on whose behalf commissioning takes place

Action required

By health authorities

- develop a clearer vision of health improvement throughout the authority as well as with partner organisations
- develop public health capacity in partner organisations
- introduce more systematic priority setting processes
- make the links between HImPs and resources more explicit, and at an earlier stage
- develop processes that extend the sense of ownership of the HImP to partner organisations such as local authorities, trusts and PCGs
- identify appropriate performance indicators for the HImP process

By local authorities

- incorporate health improvement objectives in all areas of policy for which local authorities have responsibility
- conduct health impact assessment of local authority policies where appropriate
- rapidly acquire the necessary public health expertise to participate fully in the partnership and avoid risk of domination by the 'acute service' perspective
- establish links with PCGs
- obtain some 'quick wins' to demonstrate the value of partnership in HImPs
- pool resources with health authorities, e.g. information systems, premises, personnel, consultation mechanisms
- find a meaningful role for elected representatives (councillors), possibly linking with PCGs

By primary care groups

- develop a greater shared understanding of health improvement locally, including the roles and responsibilities of different agencies
- ensure that perspectives other than those of GPs can be expressed
- strengthen basic structures and processes, e.g. consultation, priority setting, public involvement
- use existing information from primary and community care to identify local needs and inform priorities
- involve the whole primary care team in the delivery of HImP
- develop meaningful indicators, process as well as outcome-based, to monitor progress
- use professional development opportunities to enhance both multi-professional and multi-sectoral working
- work with health and local authorities to develop and complement strategies for public participation and accountability

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