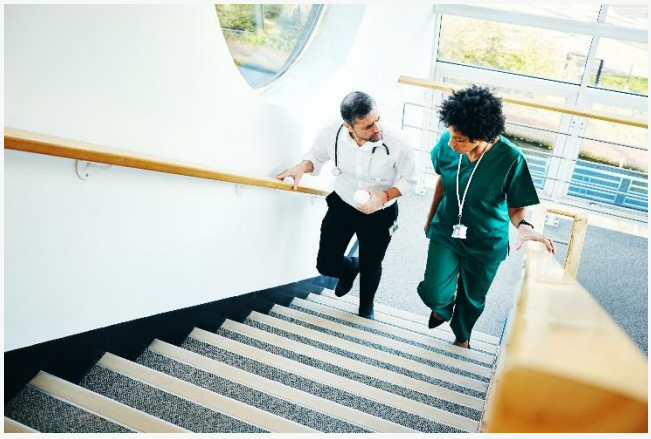
Project 100 – Final Evaluation

Reducing variation and improving outcomes in primary care



Turning a 100-day sprint into a scalable improvement approach

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Purpose of this document

The main purposes of this evaluation document have been set out below:

1. To demonstrate whether P100 achieved its main objective of reducing unwarranted variation in general practice, and improving NHS dentistry performance

2. To provide clarity and insight on the underlying conditions that enable or inhibit improvement.

3. To share what worked well during Project 100, what did not work so well, and provide some key recommendations on how this delivery framework can be adopted more broadly to enable improvement at scale.

Heath Innovation Network acknowledgement (KSS HIN):

"Project 100 offers a constructive, data-led approach to identifying variation and supporting improvement within primary care, demonstrating measurable improvements while strengthening shared intelligence, collaborative working and improvement capability. This is particularly timely for Neighbourhood rollout, where understanding local context, readiness and competing priorities is essential. Data-driven initiatives such as Project 100 support the proportionate deployment of innovation, enabling systems to build on existing strengths while introducing new models where conditions are most favourable for successful adoption."

Executive Summary

NHS England South East

Introduction

Project 100 (P100) was a regionally orchestrated but ICB-owned, time-bound quality improvement initiative designed to tackle the adverse variation in primary care performance across the South East, with a specific focus on general practice and NHS dentistry.

P100 was developed in response to the priorities and ambitions laid out in the 10-Year Health Plan and the Primary Care Delivery Plan, which include improving access, reducing variation, and increasing capacity in primary care, ultimately providing the right foundations for neighbourhood working.

Our approach

The project targeted 104 GP practices in the region, identified through a composite of national and regional performance data as having the highst levels of adverse variation at that point in time. In parallel, the project focused on improving NHS dentistry by rebasing underperforming contracts, reducing the paediatric general anaesthetic backlog, increasing Golden Hello uptake, and implementing NHS Mail accounts for clinical staff. To evaluate the impact of P100, we have used an integrated evaluation approach combinging two levers:

1. **Quantitative**
   - **General Practice:** Tracking movements in data during P100, as well as comparing practice performance to control groups and periods.
   - **Dentistry:** Review progress against the baseline period for the paediatric GA backlog, NHS Mail account development, contract rebasing and Golden Hello uptake.
2. **Qualitative**
   - Capturing ICB and provider feedback on the delivery model, key changes, and what enabled improvement to take place.

Why it mattered:

Project 100 demonstrates a scalable way to deliver national priorities: regional leadership, ICB ownership and local accountability, aligned to clear measures. The model aims to stabilise primary care performance at pace and turn intent into outcomes.

Why we acted

- The NHS 10-Year Plan & the Primary Care Delivery Plan both emphasise the importance of tackling service variation to ensure equitable and consistent access to care. This is fundamental in the development of neighbourhood health models.
- In April 2025, the first Secretary of State GP Outliers Report was released, identifying 38 practices in the SE (425 nationally) that required immediate intervention.
- The region needed a high-intensity delivery model that could quickly restore practice stability, rebuild confidence in data, and align ICBs and the region towards a common goal.

What we did

- Mobilised Project 100 (Aug 2025), a 100-working-day programme to reduce variation across 104 GP practices and priority dental opportunities
- Established an operating model combining ICB ownership with regional leadership and enabling capability to accelerate improvement
- Implemented performance management via a monthly dashboard and structured working groups to maintain grip, resolve barriers and spread learning
- Delivered a coherent support and assurance package, practice improvement offers alongside strengthened contractual levers

What we achieved

General Practice:

- Project 100 delivered a material shift in performance across 104 GP practices: positive indicators rose by 63% (140 to 228) and adverse points fell by 32% (849 to 576). Trend and comparator analysis (prior years and non-P100 practices) suggests this improvement was programme-driven, rather than routine fluctuation.

NHS Dentistry:

- Proved the value of a regionally-led, ICB-owned improvement approach. Designed a scalable delivery model to tackle variation rapidly.

Did it work and why?

General Practice

What went well:

- 66 practices (63%) moved below the original thresholds for P100 (-6 adverse indicators and 0 positive indicators)
- For P100 practices, the average number of adverse indicators per practice (considering monthly data metrics only) between Jun-24 to May-25 was 2.4. Since June-25, this average has fallen to 2.1. The average in Oct-25 fell again to 1.9.
- For the remaining regional practices (678), the average number of adverse indicators per practice between Jun-24 to May-25 was 1.6. Since June-25, the average has remained the same, although the Oct-25 average dropped to 1.5. This suggests P100 did have some positive impact on practice performance.
- Practices valued access to consistent, monthly data, with support from systems to improve data quality/ capture.

What didn't work:

- 21 practices (20%) either regressed or didn't improve during P100.
- P100 was not well received by all practices, particularly those where data was outdated.
- The National GP Dashboard changed regularly, in terms of metrics and thresholds, creating inconsistencies in practice scoring.

What enabled improvement:

- 46 practices improved to -4 indicators or less. These practices generally have a lower IMD score and a lower payment per weighted patient. This suggests deprivation and patient complexities impact performance improvement.

NHS Dentistry

What went well:

- ICBs and the Commissioning Hub identified a £20m contract rebasing opportunity based on NHS BSA calculations and committed to achieving 100 EOIs for local Golden Hello schemes.
- ICBs used P100 as a vehicle to accelerate UDA reallocation and started to address under-delivery before national reform took effect.
- Golden Hello task-and-finish groups and recruitment support addressed coastal and deprived area vacancies.
- Regional Hub oversight created visibility of contract utilisation and urgent-care capacity gaps earlier in the year

What didn't work:

- The timing of P100 coincided with the anticipated payment and contract reforms for 2026/27, impacting the ability of ICBs to confidently rebase contracts and to the recovery levels previously anticipated.
- The national Dental Recruitment Incentive Scheme took longer to pass development and governance checkpoints, creating an implementation delay - recruitment is now underway.
- Regarding the GA backlog, ICB governance changes have created delay, however, some progress made in Kent & Medway, although utilisation of an external provider has not yet been agreed due to operational issues.

What enabled improvement:

- SEDRIG governance oversight provided an existing transformational group to support the P100 workstreams.

Executive Summary

NHS England South East

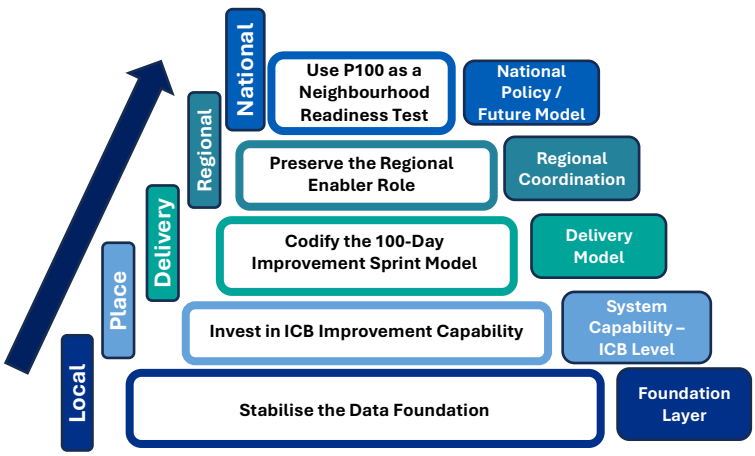
What we learned

Project 100 has brought the region, ICBs and practices closer together, and has made a significant impact on primary care variation. Each partner in the delivery model has a critical role to play, and with the right conditions provided nationally, this approach to improvement can drive tangible outcomes, be scaled appropriately, and adopted simply. The key things we have learnt through P100 delivery are as follows.

There are 6 critical levers for sustained improvement	Project 100 proved that rapid improvement in primary care depends on six critical factors: credible data, ICB and regional orchestration, local accountability, targeted support, and fundamentally, a cultural shift. It's not just what was done, but how. The model shows what conditions must exist to make sustained change possible.
Roles & responsibilities need to be more clearly defined & understood	The region, working with ICBs, has developed a scalable improvement model. Its effectiveness relied upon a shared understanding of complementary roles, with regions convening and accelerating delivery whilst ICBs retained ownership and accountability. These roles were largely held through relationships rather than formal definition.
This way of working tackles Primary Care priorities and supports Neighbourhood Health Models	Project 100 strengthened general practice as the foundation of neighbourhood delivery. By stabilising access and outcomes, clarifying accountability between region and ICB, and building improvement capability within practices, it created the conditions required for neighbourhood working to function in practice. Rather than laying new structures on fragile services, the model reinforces general practice as the stable platform from which place-based integration can scale safely and sustainably.

Our recommendations

Project 100 highlights the value of aligning national priorities (including the SOS list) with robust arrangements for improvement design, enablement and governance. This evaluation sets out six priority actions for national colleagues to help scale and replicate the approach, while retaining local ownership.



Recommendation 1: Protect data stability as a precondition for improvement	Consistent data definitions and protected refresh cycles were critical to maintaining pace. Where metrics remained stable, systems focused on action; where changes occurred mid-cycle, attention shifted to interpretation. National programmes should therefore protect data stability during defined improvement windows.
Recommendation 2: Clarify and codify system roles to enable replication at scale	Improvement accelerated where the respective roles of national, regional and ICB teams were complementary and well understood in practice. For replication, these roles should now be formally articulated, providing clarity on ownership, escalation and accountability whilst reinforcing ICB ownership of delivery and the regional enablement role. Clearer national articulation is required to replicate the model at scale without duplication, hesitation or unintended centralisation.
Recommendation 3: Embed time-boxed improvement cycles within national delivery models	The 100-day format was central to P100's effectiveness. By providing a clear time-box, single priority focus and regular cadence, it created urgency without excessive bureaucracy and enabled early movement that built confidence across systems. National operating models should recognise time-boxed improvement cycles as a legitimate and effective delivery mechanism. These cycles should be supported by clear milestones and proportionate governance. The 100-day format is not however intended to operate as a rolling or permanent cycle, which would risk diluting momentum and placing unsustainable demands on ICB and practice capacity.
Recommendation 4: Make triangulated insight the basis for performance judgement and support	No single dataset adequately explained improvement or deterioration. The most effective decisions were informed by triangulating quantitative metrics with ICB intelligence and practice-level insight. National frameworks should explicitly require triangulated interpretation with regions enabled to reconcile and synthesise insight.
Recommendation 5: Treat leadership culture and digital maturity as foundational enablers	Variation during Project 100 was often driven by leadership stability, cultural readiness and digital configuration, factors not captured in headline metrics but critical to practice's ability to act on improvement support. This includes the role of practice-level change agents, such as partners, practice managers and clinical leads, who were critical in translating improvement activity into routine operational practice and sustaining change beyond the programme. These should therefore be treated as foundational enablers within national improvement programmes, supported through coaching, facilitation and technical support.
Recommendation 6: Position improvement infrastructure as core to neighbourhood delivery	Neighbourhood-based models depend on stable primary care foundations. Project 100 functioned as a necessary precursor by stabilising performance, strengthening collaboration and building shared improvement infrastructure. National policy should recognise this infrastructure as core system capability, essential to the success of neighbourhood health and population based-care.

Purpose and Vision

Purpose of this Paper:

This paper provides a comprehensive evaluation of Project 100, including a clear narrative on what the South-East Region has learned about improvement in primary care. Its purpose is not only to demonstrate whether the original P100 objectives were achieved, but to also offer national colleagues a practical and evidence-based framework for future policy delivery and performance improvement, to help scale and replicate the approach whilst retaining local ownership.

The paper is intended to fulfil three core functions:

Demonstrate whether Project 100 was able to reduce unwarranted variation in primary care and to what extent

It will set out, in clear terms, how practice performance changed during P100 delivery, and will compare practice performance to previous year performance the rest of the South East practice cohort and national data to validate the impact of P100. Data analysis will consider adverse/positive indicator movement, practice rag ratings, and average indicators per practice. For NHS dentistry, delivery will be reviewed against regionally defined baselines for each focus area.
This analysis will determine whether, and to what extent, the SE Region achieved its core P100 objective of reducing unwarranted variation in primary care.

Provide clarity and insight on the underlying conditions that enable or inhibit improvement

To be truly valuable, the evaluation must move beyond describing performance changes and begin surfacing the underlying conditions that either enable or inhibit improvement. Therefore, the data analysis will also group practices according to performance to help us understand what improving sites had in common (locality, leadership, culture, workforce, digital maturity, local support offers etc.) and why some practices saw limited or no movement. This analysis will use both quantitative and qualitative data.

Where definitive conclusions cannot be drawn, we provide plausible, evidence-informed hypotheses, with clear recommendations for further data capture or engagement.

Provide a replicable improvement framework for national consideration

This paper translates the learning from Project 100 into a structured and transferable improvement model. It sets out the critical levers that enabled delivery at pace including data stability, clearly defined system roles, time-bound delivery cycles and targeted support, and defines the operating conditions required to scale this approach beyond a single region.

Vision for the evaluation:

The vision for this evaluation is to provide high-quality, insight-rich and strategically useful narrative that enables Policymakers, regional leaders and system partners to understand not just whether Project 100 delivered change, but how and why that change occurred.

This is not a descriptive retrospective summary. It is a forward-looking assessment designed to surface the underlying conditions that enable improvement to take place, and to translate those insights into practical implications for future policy design and operating models.

What this evaluation examines:

- What the data shows and where its explanatory power is limited
- The consistent characteristics of practices that improved, stagnated or regressed
- The operational, workforce and leadership factors that shaped variation
- The systemic constraints that hinder sustainable improvement
- The relationship between local capability, regional coordination and national levers
- The practical requirements for delivering neighbourhood and place-based models successfully

Given the known limitations of the national datasets (e.g. data volatility, recalibration of metrics, refresh cycle inconsistencies and known anomalies), findings combine quantitative movement, ICB narrative and practice-level insight. Where casual links cannot be fully evidenced, hypotheses are explicitly identified and grounded in triangulated intelligence.

What this evaluation is intended to support:

This evaluation is designed to inform future system design at multiple levels:

- National policy and operating model decisions, by clarifying the conditions under which improvement is most likely to be achieved and sustained
- The design of future improvement programmes, including decisions on scale, cadence, support model and the respective roles of national teams, regions and ICBs
- Identification of areas where further inquiry or capability development is required
- Strengthening system readiness for neighbourhood delivery by clarifying the foundational capabilities required before additional responsibilities are transferred
- Providing a practical reference point for the next iteration of primary care improvement architecture

Background context and project rationale

Background

Patient demand for primary care services continues to rise year-on-year, and although the SE Region is making good progress with national priorities and new approaches to care, e.g. Modern General Practice, patient experience and satisfaction continues to decline, coupled with month-on-month practice closures and contract hand-backs across general practice, dental, and community pharmacy.

To address the challenges faced in primary care, and the wider healthcare system, the Government launched the 10-Year Plan in early July 2025. At the plan's core are three main ambitions, **hospital to community**, a **move to prevention** and **digital enablement**. Primary Care is at the centre of this plan, as it's recognised that a strong primary care foundation is essential to managing patient flow, integrating care services, and improving patient outcomes.

Our joint focus areas with ICBs ahead of and in response to the 10-year Health plan:

1. **Oversight**: Improving general practice contract oversight, commissioning and transformation.
2. **Modern General Practice**: Supporting Modern General Practice including support and funding for digital tools
3. **Variation**: Priority for practices requiring **targeted support** and identification of the support to be offered
4. **Urgent Dental**: Achieving **UDC allocations**, including the regional share of 700,000 additional appointments
5. **Pharmacy First:** Achieving the updated pharmacy first trajectories for an additional 400,000 pharmacy first consultations

Short Term Focuses

To create the right foundations for Neighbourhood Health Models, there are two distinct opportunities within primary care:

1) **Tackle Primary Care Variation** – We need to target underperformance across the region to create a stable platform for new care models
2) **Pilot New 'At-Scale' Care Models** – whilst we await the broader strategy for NHCs and the required mechanics, there is an opportunity to test new, at-scale care models

Medium Term Focus

It's been well documented and proposed that patients need to be better supported in the community. Neighbourhood health models/ centres have been defined as the mechanism to achieve this, bringing care into local communities, convening professionals into patient-centred teams, ultimately reducing service fragmentation.

Although there are already practical examples of neighbourhood working, this is not a short-term initiative. The development of NHCs will require considerable planning based on local population health and care needs, and contractual mechanisms will need to be developed to support at-scale working (as referenced in the 10-Year Plan).

Secretary of State report

Department of Health & Social Care

The Secretary of State GP Outliers Report was launched in March 2025 to highlight the number of practices in England falling outside the desired performance thresholds.
The report initially did this by ranking all GP practices against 8 metrics. The metrics aligned to the following domains: patient experience, patient access, care quality, clinical workforce, outcomes, vaccinations & immunisations, and medicines management. Where a practice fell below the performance thresholds in 2 or more metrics, they were considered an "Outlier". In July 2025, the GP Outliers Report contained 11 metrics, and a practice was considered an "Outlier" if it flagged for 3 or more metrics. The Secretary of State GP Outliers Report offers an important, data-led perspective on variation, which should be interpreted alongside the wider operational and population context within which primary care services are delivered.

The South East Region ranked second best consistently in these reports. 7% (20) of our practices were considered "Outliers", with Kent & Medway representing around half of the SE total.

Number of Outliers (3+) against total Practices – Mar 2025

South-West	10	521	1.9%
South-East	**20**	**768**	**2.6%**
North-East and Yorkshire	28	920	3.0%
East of England	31	628	4.9%
North-West	34	929	3.7%
London	41	1127	3.6%
Midlands	52	1238	4.2%

The Creation of Project 100

NHS England South East

Upon publication of the first Secretary of State GP Outliers Report in March 2025, the regional Primary Care Transformation team met with each of the 6 ICB teams to establish whether and to what degree the practices highlighted as "Outliers" were already known.

At the time, with 38 practices listed in the report, the consensus was that the true picture could be 3x worse than this, based on known issues across the estate. Regionally, we recognised this required a short term, focussed campaign to reduce adverse variation in primary care across the region

The Project:

The region therefore recognised an immediate opportunity and necessity to:

- Establish a consistent, data-driven method for identifying practices most in need of support
- Strengthen regional and ICB partnership working
- Test whether targeted, time-bound improvement activity would accelerate improvement more effectively than business-as-usual contract oversight
- Build a stronger foundation for neighbourhood health models by reducing unwarranted variation at pace.

Project 100 launched in August 2025 as a 100-working day, regionally enabled initiative involving:

- 104 GP practices most in need of targeted support
- A shared regional dataset of 38 metrics
- A consistent set of improvement principles agreed by all six ICBs
- A dual ambition to reduce variation quickly and create a lasting framework for improvement.

Strategic timing:

P100 was launched at a pivotal moment for primary care:

- ICB operating models for 2026/27 are being redesigned, with expectations that primary care commissioning functions will shift, consolidate or migrate into provider collaboratives.
- The national neighbourhood model is entering design and early testing, requiring a strong general practice base and reliable, accurate data.
- The October GP contract changes and national reporting requirements have put primary care firmly into the 'performance' space.

The evaluation of Project 100 therefore needs to:

1. Articulate and evidence the value of the region and ICBs in delivering improvement at scale to secure future critical primary care improvement functions.
2. Serve as a vehicle to influence national thinking on what structures, capabilities and behaviours are required in the next iteration of system design.

The problem this evaluation is solving:

The challenge before the system is not simply understanding whether practices improved, but understanding:

- Why improvement occurred,
- Why improvement did not occur,
- What underlying system conditions explain variation, and
- What this means for the future architecture of primary care delivery.

National datasets alone cannot answer these questions. Data is volatile, inconsistent, and in some cases inaccurate, with metrics recalculated monthly, data anomalies and thresholds shifting over time.
ICB insight is therefore essential to interpreting the data and uncovering the "real story" behind practice performance.
This evaluation aims to combine the best available quantitative and qualitative evidence to build a credible, strategic and actionable narrative for the region and for national colleagues.

How this supports the future:

The findings from Project 100 provide:

- Insight into the characteristics of improving practices and clear examples of where targeted interventions have accelerated improvement and recognition of where improvement remains stalled and why;
- Practical recommendations for national, regional and ICB roles in developing new operating models; and
- Evidence to support a consistent approach to neighbourhood development.

Approach and Methodology

The evaluation of P100 has been deliberately designed to go beyond a traditional performance review. Given the national significance of P100 and its potential to inform future approaches around reducing service variation, the methodology needed to demonstrate not only what changed, but why it changed, and whether those changes are sustainable. The approach therefore combined rigorous quantitative analysis of national and regional metrics, with qualitative insight gathered directly from ICBs and practices involved in delivery, ensuring the evaluation reflects real-world experience as well as performance outcomes. Where data alone is unable to fully explain the drivers of change, hypotheses have been developed and tested through system feedback and triangulated insight.

To evaluate the success of Project 100, we used an integrated approach spanning two levers that combines:

- Quantitative data to assess changes in performance and delivery, and identify what may enable improvement to take place.
- Qualitative intelligence to understand how the project was received, and whether any shifts occurred in culture, confidence and capability.

Quant

	Focus	What we're measuring	Source	Key KLOEs/ Metrics
GP	• Practice performance/ scoring • Practice variation • Practice characteristics	• Changes in practice-level indicators • Metric changes • Practice demography	• GP dashboard • Regional BI data • ICB returns	• Total number of adverse indicators and positive indicators • Number of practices in P100 (104) falling below the thresholds for P100 (-6 adverse indicators and 0 positive indicators) • Average number of indicators per practice • Comparing practice performance to control periods and groups • Whether high/ low performing practices have similar demographics & setups
Dental	• Dental contracts • Dental GA waits • Recruitment • Accessibility	• Changes in GA waiting lists • NHS mail reports • Golden Hello reports	• Regional CDO team reports	• Golden Hello EOIs against the target per system & performance/access impact • Reduction in 52-week GA waiters from starting point • Value of contracts rebased & redistribution mitigating contract reform • Number of NHS Mail accounts developed vs target

Qual

Focus	What we're measuring	Source	Key KLOEs/ Metrics
• Culture • Collaboration • Capability	• Confidence • Engagement • Impact • Perceived value • Cultural shift	• Surveys • Interviews • Feedback loops	• Has Project 100 improved working relationships between the region, ICBs and practices (e.g. more collaborative, more improvement-focused)? • Did the time-boxed 100-day nature of the project sharpen local focus? • Has Project 100 strengthened ICBs' ability to run performance improvement programmes?

Evaluation Principles

Purposeful

The evaluation must not be for record keeping.
It is to demonstrate impact, understand the how and why, support future case-making, and show accountability to systems and national teams.

To be purposeful, the evaluation needed to:

Demonstrate impact – show whether interventions have led to measurable, positive change across primary care
Generate insight - capture what worked, where and why, to inform the design of future improvement initiatives
Highlight accountability – evidence the value of the regional function designing improvement initiatives and working alongside ICBs to drive improvement
Make the case for change – show how this approach could be adopted more widely across the health and care system.

By following these principles, we ensure that the findings are meaningful and actionable, not simply a record of activity completed.

Consistent and Comparable

To fairly evaluate performance improvement, a baseline period was agreed, and progress was assessed using a consistent methodology through to the end of December.

The Evaluation used a "locked list" model: no practices were added or removed post-baseline, and dental contracts and wait lists were pre-defined
A baseline period (18th June) was agreed by all to show progress from a fixed starting point.

Analysis considered the same metrics and questions at the same point each month. This gives a fair and consistent view on progress.

Where national thresholds and metrics changed, we provided a consistent view against the baseline period by developing our own scores.

Following these principles allowed the Region and ICBs to track, report and learn consistently across the 100-day period.

System-Connected

Evaluation was carried out with system input and feedback. Recognising that sustainability requires local buy-in, reflection, and improvement. Feedback will be shared by all, and with all.

Evaluation needed to be useful for local ICB governance, answering each system's key questions. ICBs contributed directly to the evaluation, providing interpretation of what the data is showing, and insights into what's happening on the ground.

The evaluation reflects system and practice experience, not just the regional team's perspective and analysis.

Following these principles ensures the evaluation report isn't just useful for the region but for future improvement initiatives at all levels of the organisation.

Improvement focused

Recognising the short-term goal is about tackling variation, the intent had to be on sustained improvement. We needed to understand what worked well, and what didn't, and build this into future models to ensure sustained success.

- **What aspects of the support** made the greatest difference
- **Which delivery mechanisms** were most effective (e.g. contract levers, peer support, digital tools
- **What didn't land well**, and why
- **How we might redesign support** for faster or deeper impact next time

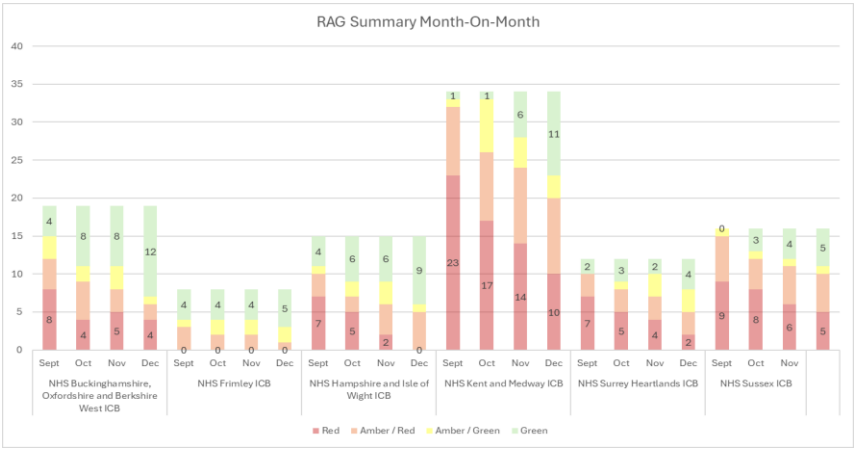
This is especially important in areas like culture change or ICB capability, where improvement takes longer than the 100-day period. We treat these insights as critical evidence when shaping the future role of the region in system support.

Did P100 reduce unwarranted variation? (General Practice)

In summary, the data indicates that Project 100 achieved its primary objective of reducing unwarranted variation in general practice across the participating cohort. During the project period (August – December 2025), there was a continuous decrease in the total number of adverse indicators and a corresponding increase in the total number of positive indicators. There was also a continuous increase in the number of practices moving beyond the original thresholds for P100 (-6 adverse indicators & 0 positive indicators). To ensure that this improvement occurred as a result of P100 activity and not due to ongoing improvement activities, practice scoring was applied back to April 2023. The analysis shows that P100 did have a positive impact on practice performance.

	Jun 18th Baseline	Aug 11th	Sep 11th	Oct 11th	Nov 11th	Dec 12th
Practices qualifying for P100 (at least 6 adverse indicators)	104	73	67	53	49	38
Total number of **adverse indicators**	849	785	757	687	650	576
Total number of **positive indicators**	140	262	264	194	199	228

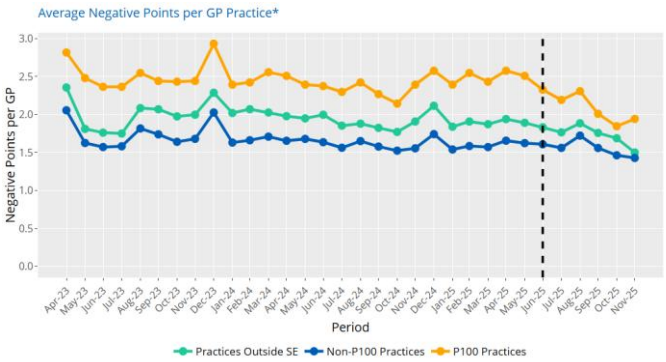
During P100, the number of practices that met the original thresholds for inclusion declined each month. By December 2025, 38 practices out of the original 104 had a score that remained within the thresholds for P100. The total number of adverse indicators reduced from 849 to 576 across the project period, with reductions seen each month. In December 2025, there was a fairly significant reduction that came from a change in how the DPC FTE figure was calculated. The number of positive indicators steadily increased each month, except in October (scores were removed from the Medicines Management domain).

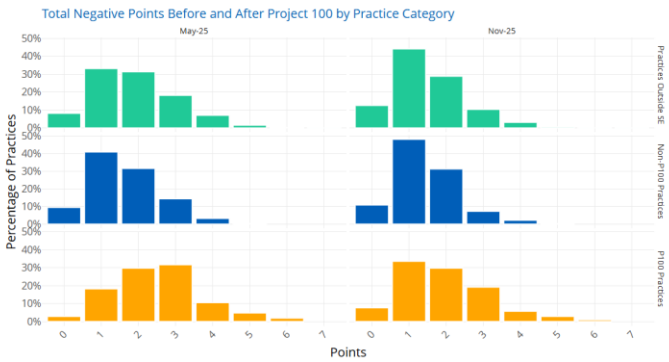


ICB	Jun-25 Av Neg Indicator Per Practice	Dec-25 Av Neg Indicator per practice	% Change
BOB	-7.11	-4.37	-38.52%
Frimley	-7.75	-3.88	-50.00%
HIOW	-7.93	-4.33	-45.38%
K&M	-8.68	-6.53	-24.75%
SHL	-8.58	-5.83	-32.04%
Sussex	-8.44	-6.56	-22.22%

In September 2025, practices were RAG-Rated to help identify practices 'at-risk' versus those that were close to moving beyond the thresholds for P100. The number of Red practices at that time (those that had regressed or flatlined) was 54. By December 2025, this had reduced to 21. Conversely, the number of Green practices increased from 15 in September to 46 in December. The change in the RAG-Ratings can be supported by a clear reduction in the average number of adverse indicators per practice between June and December 2025, with Frimley and HIOW demonstrating the greatest reductions (-50% and -45% respectively).

To determine the impact of P100 on practice performance, practice scoring has been backdated to April 2023 and scores have been calculated for all non-P100 practices in the Southeast, as well as nationally.





- The chart above tracks average number of adverse indicators per GP practice for P100 practices (SE target cohort), non-P100 SE, and outside SE (rest of England). The dashed line marks the launch of P100.
- Before P100, P100 practices had the highest average adverse indicators per practice, and non-P100 SE practices consistently outperformed practices outside the SE.
- Since P100, there's been a sharp decline in the average number of adverse indicators for P100 practices, and the gap has narrowed between Non-P100 practices and P100 practices – this suggests P100 practices have improved at a greater rate.

- The charts above show the distribution of adverse points per practice across P100 practices, non-P100 SE practices, and practices outside the SE before (May 2025) and after (November 2025) P100.
- Prior to P100, P100 practices were more heavily concentrated in higher adverse points bands, reflecting poorer overall performance compared with both comparator groups.
- After P100, the distribution of P100 practices has shifted 'left', meaning fewer practices in the higher adverse bands and a greater proportion closer to zero. This indicates an overall improvement in performance.
- For all Non-P100 practices, the change is less pronounced, although more practices have visibly moved to 1 adverse point.

Did P100 reduce unwarranted variation? (Dentistry)

A different focus for dentistry - considering variation at a more 'macro-level' – considering overall **contract performance** with rebasing of contracts as the key mitigation, **patient access** with a workforce component of 'golden hello's and tackling the Paediatric General Anaesthetic RTT waiting times. Additionally, a **clinical governance** issue is being tackled through expanding clinical usage of nhs mail/nhs.net

These areas of focus are all national priorities, but at the outset lacked a national steer or clear expectation of delivery. Project 100 facilitated this as the regionally endorsed platform to enable and support moving faster and further to deliver these important dentistry objectives.

Progress has been made against these objectives:

- **Golden Hello's** uptake is on track to exceed the SE share of the national target – all ICBs are participating in the 2nd wave with a locally enhanced offer and recruitment expected through 2026/27 following 38 EOI approvals so far.
- **Rebasing of contracts** formally introduced from 2022 Reforms but was not initially feasible – the focus has now changed from new service investment to a 'churn' of the released funding to increase higher performing contracts offsetting the impact of contract reforms. This is currently live and a longer-term project contingent on implementation of Reforms from April 2026, work is underway but a significant capacity challenge to deliver through 2026/27 as this is likely to affect most contracts, rather than the numbers initially highlighted below.
- **General Anaesthetics backlog** – arose due to Covid-19 where theatre space was prioritised for Acute Trusts RTT service recovery, dentistry GA position was 'hidden' due to a lack of national reporting. The immediate focus is on paediatrics waiting over 52 weeks in Kent and Medway ICB and then 26 weeks in BOB ICB. Weekend work has commenced in Kent and planning commencing in BOB ICB. The intention is to first clear the backlogs and then ensure sustainable and formal agreements are endorsed to avoid future waiting beyond 18 weeks.
- **NHS Mail/nhs.net account development**. Project led by Regional Chief Dental Officer working with the Office of the Chief Dental Officer - 89 NHS Mail accounts have been onboarded versus a target of 100. Plans agreed to incorporate into SE National Performers List application process.

Progress below as at 09/01/2026

These projects are not all suited to delivery within a 100-day period as these are complex issues and most all have interdependencies outside of local commissioner's control. Project 100 has enabled rapid development of plans by raising the profile of these issues which has enabled commencement and earlier progress.

ICBs	Golden Hellos			Contract Rebasing Plan		Paediatric General Anaesthetic Backlog			NHS Mail Accounts
	EOIs Received *@ Dec 25*	EOIs Approved *@ Dec 25*	In Post *@ Dec 25*	Plan Contracts	Plan Contract Value £	Waiters @ June 2025 >18w	>26w	>52w	Number Onboarded (Target 100)
BOB	19	4	0	*TBC*	*TBC*	**110**	**65**	**8**	***89***
FRIM	8	8	0	7	£288,318	**22**	**19**	**4**	
HIOW	32	12	0	38	£8,423,997	**25**	**23**	**1**	
K&M	5	4	0	13	£3,915,622	**40**	**100**	**260**	
SHL	1	1	1	17	£2,369,233	**11**	**8**	**1**	
SUS	14	9	3	14	£4,276,472	**0**	**0**	**0**	
Region	79 79% of plan	38 108% of plan	4 36%	**89**	**£19,273,642**	**217**	**215**	**274**	**89**

What enabled or hindered performance improvement?

NHS England South East

General Practice:

66 practices have improved beyond the P100 threshold

20 improved beyond P100 thresholds	**46 significantly improved** beyond threshold

38 practices remain within the thresholds set for P100

13 regressed	**8** flatlined	**17** improved towards P100 thresholds

Why were 46 practices able to improve significantly?

Practice Deprivation:
- 'Green' practices have an average IMD score of 16.2 vs 22.6 for 'Red' practices. The average IMD score for the practices that moved forward the most (>5 indicator reduction) is 14.9. For those that stayed static or regressed, the average IMD score is 22.1. The data suggests that practices in less deprived areas are more likely to improve at a greater rate.

Contract Type:
- 11 /104 practices are currently on a PMS contract (4 on APMS). 7 of these practices were rated 'Green'. This suggests PMS contracts may have some influence on practice improvement.

Practice Engagement:
- Local ICB intelligence suggests that 'Green' practices were receptive to support offers and quickly onboarded onto available support programmes e.g. GPIP, PAMs, GP Toolkits. This meant improvements were reflected in the data.

Data Quality:
- Sharing data with practices highlighted issues with data quality. Practices that made simple changes to GPAD and NWRS quickly improved their positions. In other areas, such as CQC Ratings, manual adjustments were made where data had a delay.

Why did 21 practices regress or not improve?

Contract Issues & Restructures:
- Local intelligence suggests that 10 / 21 practices have contract-related issues, ranging from single-handed practices and multi-side providers not meeting expectations to changes in partnerships and practice/ PCN mergers.

Practice Payments:
- NHS Practice Payment data for 23/24 shows that 'Red' practices received an average payment per weighted patient of £197.52, whereas 'Green' practices received £155.34. This suggests that 'Red' practices have a more complex patient group, which could impact the practice's ability to enact change.

Practice Size:
- 'Red' practices have an average patient list size of 10,000 vs 18,500 for 'Green' practices. This suggests that appetite for change could be influenced by patient demands/ volumes and the need to generate efficiencies.

Data Lag:
- 6 practices recently developed action plans and/or joined the national GPIP programme. Due to the delay in data, improvements won't be seen until Q4 25/26.

Qualitative Insights from ICBs and practices:

What worked well

ICB
- ICBs working with LMCs to support P100 engagement and rollout
- Development of practice data packs to inform discussions and help steer towards developing practice action plans.
- Supporting practices with data capture and coding to improve reported positions
- Use of PAMs in creating a trusted environment to share challenges and best practice

Region
- Manual data pulls for FTT, A&G, QOF, CQC and LD to further inform our understanding/ scale of progress.
- Manual edits to regional GP dashboard to help keep data consistent
- SME input on specific challenges e.g. GPAD coding
- Connection with wider regional teams e.g. vaccications & immunisations
- Monthly Working Group to discuss best practice and key challenges

What did not work so well

- National GP Dashboard received regular updates, including new metrics and changes to thresholds and weightings. This made practice conversations more difficult, as the 'goal posts' would move month-to-month in the early stages.
- National colleagues were not as heavily involved in the project as expected e.g. additional funding, SME input etc.
- ICBs measured success differently. Some focused on engagement with practices and LMCs, whilst others focused on how many practices had been *moved off* the P100 list.
- Initially some practices felt judged by Project 100 and this damaged relationships between the ICB and practices.
- Improvement is dependent upon appetite for change. If a practice is 'comfortable' with existing operations, there are limited levers available to drive change e.g. single-handed practice.

Key Development Areas

- Agreement on metrics and thresholds from the outset, so practices are consistently measured and data is understood by all.
- Agreement on what success looks like from the outset so monthly monitoring can be tailored appropriately.
- Greater involvement from national colleagues, including attendance at monthly working groups to understand key challenges and offer packages of support.
- Clear communications regarding the purpose and benefits of Project 100 to avoid damaging practice relationships
- National support in identifying and developing additional levers to drive improvement from all practices

National Opportunity

- There are 6091 GP practices across England. The latest national GP Dashboard (Jan-25) suggests that 943 practices have an adverse variation score of at least 6.
- For the 46 practices that improved significantly in the SE, the average IMD Decile was 5 and the average payment per weighted patient was £160.
- Applying this criteria to the 943 practices, there could be around 475 practices with the right characteristics for improvement. Some consideration would, however, need to be given to practice management and contracting arrangements.

What enabled or hindered performance improvement?

NHS England South East

Dentistry:

Golden Hellos

79 Actual EOIs *(to date)*	100 EOI Target

What ICBs were successful and why?
A greater financial incentive and relaxing of the definition of 'area of need' has led to further applications for the scheme. Particularly HIOW and Sussex ICBs have led this second wave in terms of EOIs and recruitment progress.

Contract Rebasing

24 Actual	Initial 100 Target Revised Target TBC *(if criteria met)*

What ICBs were successful and why?
The timing of P100 coincided with the anticipated payment and contract reforms for 2026/27. Rebasing purpose changed once reforms were clarified, likely to affect most contracts now. So far, Frimley, HIOW and Sussex ICBs have rebased some contracts in advance of the reforms, but all will need to progress ASAP.

Paediatric GA Backlog

160 >52 ww Actual Nov-25	274 to zero >52ww Target March-26

What ICBs were successful and why?
Kent & Medway ICB early focus with the greatest backlog have implemented their recovery plan which is tackling the backlog via additional Saturday sessions across two community sites. The senior leadership focus has highlighted the importance of this performance issue.

NHS Mail Accounts

89 Actual *(to date)*	100 Target

What practices/ ICBs were successful and why?
Led by Regional CDO, the NHS Mail Account workstream focused on a single large provider which spans the entire region. This ensured an economies of scale in building towards the target number.

Qualitative Insights from ICBs and practices:

What worked well

The Programme provided a greater focus on Dentistry as a key part of Primary Care; regular governance reporting has highlighted and focussed resources on these performance and improvement initiatives.

1. **Golden Hello's:** Amendments to the national scheme has facilitated a successful second round of recruitment.
2. **Contract Rebasing:** Initially created an aligned approach to defining and identifying contracts in scope by ICB with optimal financial returns outlined.
3. **General Anaesthetic:** Regional data collection & focus on GA has led to expediting of recovery activity in Kent and Medway ICB.
4. **NHS Mail:** Reaching out to a large regional provider facilitated a timely approach to identifying and onboarding a significant number of NHS Mail accounts.

What did not work so well

Each aspect of the workstream had differing leads which made a coordinated delivery approach more challenging, impacting accurate and timely reporting.

1. **Golden Hello's:** ICB schemes all launching at different times risked an uncoordinated timeline and outlook.
2. **Contract Rebasing:** The timing of P100 coinciding with the payment and contract reforms for 2026/27 and its modelled impact created uncertainty and paused much of the planned work.
3. **General Anaesthetic:** Timeline did not allow enough time for project delivery and executive decisions to materially impact the delivery in the 100 days.
4. **NHS Mail:** Account onboarding led by RCDO and OCDO Office, however, limited joint working with regional colleagues.

Key Learnings & Improvement Opportunities

- Future aligned metrics agreed with ICB commissioning teams.
- Better define roles and responsibilities at the outset.
- Understand whether a practice specific targeted approach like General Practice would be possible in a future project?

Identifying the critical levers for improvement

NHS England South East

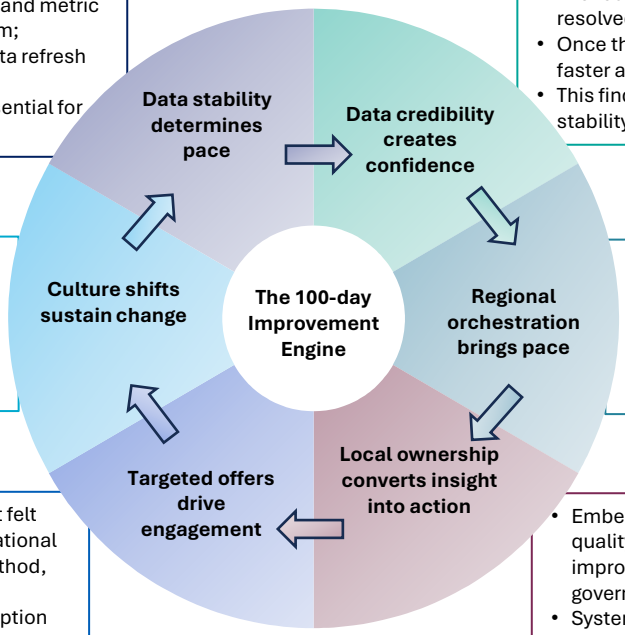
Project 100 was not designed solely as a performance intervention; it was deliberately structured as a test of whether a regionally enabled, locally owned improvement model could accelerate progress against unwarranted variation in primary care. The evaluation therefore sought not only to assess whether outcomes shifted, but to understand how improvement occurred, why it stalled in some settings, and which elements of the delivery approach were critical to success.

The Six Critical Levers for Improvement

Across all domains and systems, six critical levers consistently emerged as the foundations for effective delivery. These levers should be understood not as optional components, but as a minimum operating standard for future improvement programmes

- Frequent national re-weighting and metric changes interrupted momentum; improvement slowed during data refresh weeks.
- Predictable data cycles are essential for sustained change.

- The reconciliation of regional and national data resolved long-standing disputes about accuracy
- Once the numbers were trusted, ICBs acted faster and owned their outcomes.
- This finding reinforces the national need for data stability before accountability.



- The biggest transformation was mindset; practices saw data as a mirror, not a judgement.
- Regional and ICB staff reported higher collaboration and confidence in joint delivery.

- The 100-day format focused energy and visibility, the fortnightly sessions provided oversight without bureaucracy
- With Regional support, it ensured the ICBs had cover to move quickly.

- Practices engaged because support felt bespoke, Peer Ambassadors for relational support, PAMs for improvement method, SPS for technical fixes.
- "Help, not heat" replaced the perception of scrutiny.

- Embedding Project 100 into existing ICB quality and resilience boards meant improvement became part of normal governance.
- Systems invested their own resources once results became visible, a sign of genuine adoption.

Data Stability Determines Pace

A predictable and stable data environment was essential for sustained improvement. Frequent national reweighting of metrics and changes to indicator definitions disrupted momentum and undermined local confidence, particularly where practices were required to adjust operational models at speed.
Where data refresh cycles were predictable and clearly communicated, practices and ICBs were able to plan, test and refine changes with greater confidence. This indicates that pace is constrained less by capability than by uncertainty, and that stability is therefore a prerequisite for meaningful action. Future national programmes should prioritise data stability during improvement windows, with explicit protections against mid-cycle metric changes.

Data Credibility Creates Confidence

In several systems, longstanding discrepancies between regional, national and local datasets had previously undermined trust. Project 100 invested time in reconciling these differences, resulting in a shared understanding of performance position. Once data credibility was established, the nature of engagement shifted decisively: conversations moved from challenge and dispute to action and ownership. ICBs reported greater confidence in prioritisation decisions, and practices were more willing to engage with improvement discussions. Credible, reconciled data should be treated as a foundational investment

Regional Orchestration Brings Pace

Regional coordination played a critical role in aligning effort, reducing duplication and maintaining momentum. The regional acted as a problem solver, enabling rapid escalation of issues that could not be resolved locally and providing assurance for ICBs to move quickly.
Importantly, this orchestration did not dilute local accountability. Instead, it provided clarity of direction and consistency of approach across systems. A clearly defined regional orchestration role is essential for scale. Regions are best placed to hold the system view, broker solutions and maintain delivery discipline.

Local Ownership Converts Insight in Action

Where project 100 was embedded within existing ICB governance structures such as performance boards, improvement activity became part of normal business rather than a parallel initiative. These systems were more likely to invest their own resources once early results became visible, signalling genuine adoption.
Conversely, where ownership remained ambiguous or externalised, progress was slower and less sustainable. Improvement programmes must be ICB-owned by design, with clear accountability and integration into routine governance.

Targeted Offers Drive Engagement

Practices engaged most strongly where support felt practical, relational and enabling. Peer Ambassadors, hands on facilitation and targeted technical support were repeatedly cited as more effective than generic guidance or performance management.
The framing of support as "help, not heat" was a critical factor in shifting practice behaviours and willingness to experiment with new models. Targeted, practice-specific support offers should be a core component of national improvement approaches, not optional.

Culture Shifts Sustain Change

The most durable changes observed during P100 were behavioural rather than structural. Practices that adopted a mindset of data as improvement intelligence, rather than judgement demonstrated greater resilience and sustained progress.
Cultural readiness also explained variation where quantitative data could not. Leadership stability, staff confidence and collective problem solving emerged as key determinants of success. Leadership and culture should be treated as explicit improvement domains, supported through coaching and facilitation rather than assumed to develop organically.

Key Findings & Lessons Learned

Roles and Responsibilities

Whilst project 100 demonstrated the effectiveness of a regionally enabled, locally owned improvement model, the evaluation also highlighted the need for clearer articulation of roles and responsibilities if the approach is to be replicated at national scale.

During delivery the respective roles of regions, ICBs and practices evolved pragmatically in response to need. This flexibility enabled pace and responsiveness, but it also meant that responsibilities were sometimes implicit rather than formally defined. In particular, national colleagues observing the programme externally did not always have clear sight of where accountability sat for data reconciliation, prioritisation decisions, escalation and practice engagement.

Before this model can be adopted as a national blueprint, there is a need to codify roles across the system.

Including:

- The role of regions as convenors, brokers and holders of system-wide insight
- The role of ICBs as owners of improvement delivery and accountability to practices
- The expectations placed on practices as active partners in improvement rather than passive recipients

Clarifying these roles would not diminish the flexibility that made Project 100 effective. Rather, it would provide a shared operating framework that supports consistent application, particularly as improvement activity becomes embedded within routine operating models.

For national adoption, this model requires an explicit role framework that is understood consistently across national, regional and ICB teams, enabling pace without ambiguity.

Primary Care Priorities and Neighbourhood Models

Project 100 was not explicitly designed as a neighbourhood health programme. However, the project has demonstrated that it laid much of the operational and cultural groundwork required to support neighbourhood-based models of care.

Specifically, the programme contributed to:

- Stabilising primary care performance, reducing extreme variation that would otherwise undermine neighbourhood delivery
- Strengthening system collaboration, particularly between practices, PCNs, ICBs and regional teams
- Developing improvement infrastructure, including shared data understanding, regular cadence, and cross-system problem-solving

These elements align closely with the enabling conditions required for effective Neighbourhood Health models, where delivery depends on collaboration, trust, shared intelligence and the ability to act at pace across organisational boundaries.

Attempting to implement neighbourhood health at scale without first addressing these foundational issues risks embedding variation and fragility into models of care. In this sense, P100 functioned as a necessary precursor, creating the conditions in which neighbourhood approaches can be realistically sustained.

From Improvement Programme to Operating Model

These findings reinforce that Project 100 represents more than a time-limited intervention. The project has demonstrated the core components of a viable improvement operating model that can be applied beyond the immediate objectives of reducing variation over a 100-day period.

Specifically, P100 has shown that improvement at scale is most effective where there is clear alignment between regional enablement and ICB ownership. The programme clarified, in practice if not always formally, the complementary roles of different system levels: regions acting as convenors, brokers and holders of system-wide insight, and ICBs owning delivery, prioritisation and accountability to practices. This alignment enabled pace without undermining local ownership and created confidence for systems to act decisively.

This way of working strengthens system readiness for neighbourhood delivery. By stabilising core primary care performance, building shared understanding of data, and normalising cross-system collaboration, Project 100 addressed many of the foundational issues that would otherwise constrain neighbourhood models. In this sense, the programme functioned as a necessary precursor, creating the operational and cultural conditions required for more integrated, population-based approaches to succeed.

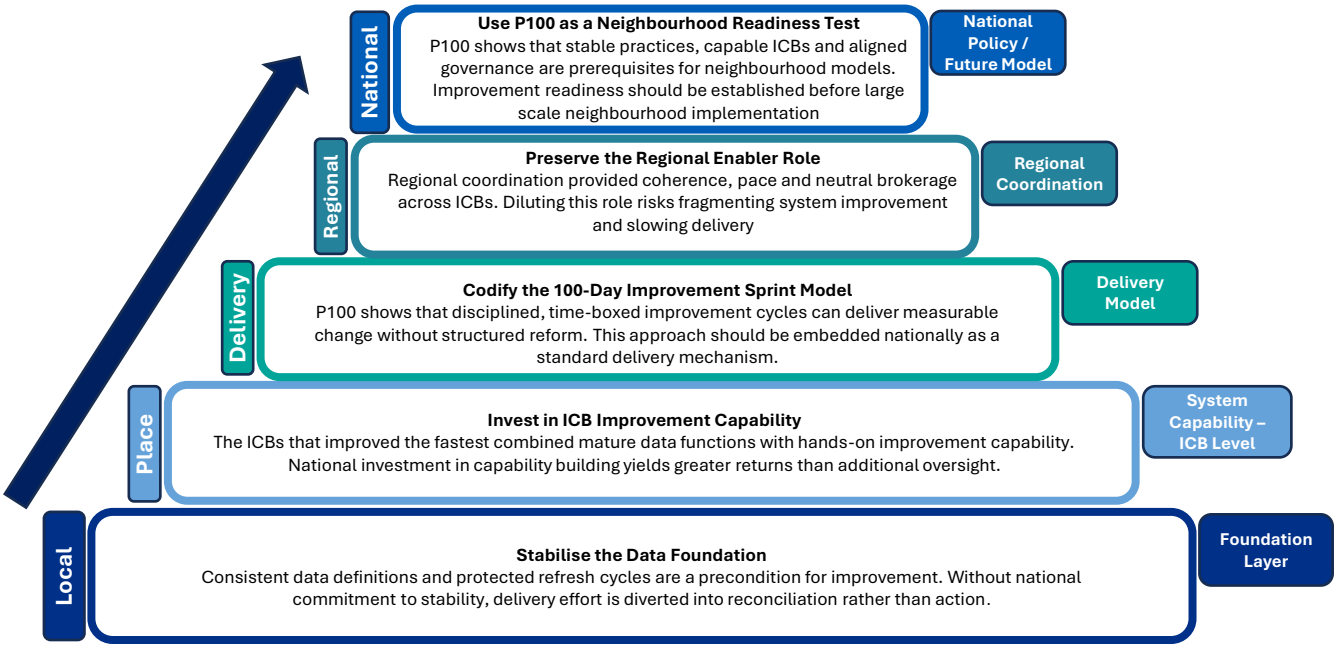
Importantly, P100 aligned short-term operational improvement with longer-term policy ambitions, including neighbourhood health, population health management and reduced unwarranted variation. The focus on leading metrics as shown throughout the report (such as access, workforce, vaccinations, outcomes), combined with triangulated insight and relational support, enabled early movement whilst laying the groundwork for more sustained change.

However, it is clear that transitioning from programme to blueprint is not automatic. Replicating this model at scale will require deliberate design choices to formalise what emerged organically during delivery. In particular clearer national articulation of roles, accountability and expectations will be needed to ensure consistency, reduce ambiguity and support replication across different contexts. At the same time, this must be achieved without eroding the local ownership and relational trust that underpinned engagement and progress during Project 100.

Recommendations for future adoption

The synthesis of findings from Project 100 highlights that the project's success was driven less by novelty and more by the deliberate alignment of system roles, data conditions and delivery discipline. To translate this learning into a sustainable and scalable operating model, a number of implications for national policy and operating arrangements emerge.

The recommendations set out below are not intended to introduce additional layers of policy or oversight. Rather, they focus on codifying and protecting the conditions that enabled improvement to occur, whilst preserving the local ownership and flexibility that underpinned engagement and pace during Project 100. Below shows a diagram of how recommendations can build on each other and how each recommendation links back to each building block of the diagram.



Recommendation 1: Protect data stability as a precondition for improvement	A consistent finding across P100 was data stability is a prerequisite for pace. Where metric definitions and thresholds remained stable, systems were able to focus on improvement action. Where changes occurred mid-cycle, attention shifted to interpretation and reassurance, slowing progress. National programmes should therefore explicitly protect data stability during defined improvement windows. Where changes to metrics or methodology are unavoidable, they should be clearly signalled and phased to minimise disruption to delivery. This approach would strengthen confidence in performance and enable system to focus on action rather than explanation.
Recommendation 2: Clarify and codify system roles to enable replication at scale	P100 demonstrated that improvement accelerated where respective roles of national, regional and ICB teams were complementary and well understood in practice. Regions acted as conveners and brokers of system-wide insight, whilst ICBs retained ownership of delivery and accountability. However, this role emerged organically rather than explicitly through national articulation. For replication at scale, national colleagues should formally codify these roles, providing a clear and consistent framework that sets expectations while allowing flexibility in local application. This would support: • Faster escalation and resolution of issues • Reduced duplication across system levels • Great confidence for ICBs to act decisively Crucially, such codification should reinforce, not dilute the principle of ICB ownership of delivery, with regions positions as enablers rather than alternative centres of control.
Recommendation 3: Embed time-boxed improvement cycles within national delivery models	The 100-day format was central to P100's effectiveness. By providing a clear time-box, single priority focus and regular cadence, it created urgency without excessive bureaucracy and enabled early movement that built confidence across systems. National operating models should recognise time-boxed improvement cycles as a legitimate and effective delivery mechanism. These cycles should be supported by clear milestones and proportionate governance. Time-boxing should be understood not as a substitute for long-term improvement, but as a catalyst that unlocks momentum and readiness for sustained change.
Recommendation 4: Make triangulated insight the basis for performance judgement and support	P100 reinforced that no single dataset can adequately explain improvement or deterioration. The most accurate understanding emerged when quantitiatve metrics were triangulated with ICB intelligence and practice-level insight. National performance frameworks should therefore move beyond reliance on headline metrics alone and explicitly require triangulated interpretation as standard practice. Regions are well placed to hold the reconciliation role, synthesising multiple sources of insight to inform proportionate decision-making
Recommendation 5: Treat leadership culture and digital maturity as foundational enablers	Variation observed during P100 was often explained by factors not directly visible in quantitative data, particularly leadership stability, cultural readiness and digital configuration. These elements consistently shared whether practices were able to absorb support and sustain change. National improvement programs should therefore treat leadership capability, culture and digital maturity as explicit and foundational enablers. This requires investment in coaching, facilitation and technical support alongside performance monitoring. Recognising these enablers formally would improve the realism and effectiveness of future improvement initiatives
Recommendation 6: Position improvement infrastructure as core to neighbourhood delivery	Neighbourhood-based models of care depend on stable primary care foundations. P100 functioned as a necessary precursor by stabilising performance, strengthening collaboration and building shared improvement structure. National policy should recognise improvement infrastructure of this kind as a core system capability, rather than discretionary programme activity. Investment in delivery discipline and data reconciliation should be seen as essential to the success of neighbourhood health and population-based care. Attempting to scale neighbourhood models without addressing these foundations risks embedding fragility and variation into new structures.

Part 2 Evaluation

Domain Breakdown and Metric Analysis

How Improvement Behaved Across Domains

Summary

Across Project 100, improvement followed a consistent pattern: domains respondedd differently to the same intervention, but in predictable ways shaped by practice readiness, operational stability and system support.

What the cross-domain evidence shows:	Reviewing performance across Access, Workforce, Vaccinations, Outcomes, Patient Experience, Digital Maturity, Leadership and Culture and Population context reveals that improvement did not occur uniformly. Instead, domains behaved in distinct but interrelated ways, reflecting their position in the delivery system. • **Operational Domains:** (access, digital maturity, vaccinations) were the most responsive within the 100-day timeframe, particularly where practices implemented early, practical changes. • **Enabling Domains:** (workforce, leadership & culture) did not shift quickly themselves, but strongly shaped whether improvement occurred elsewhere • **Lagging Domains:** (outcomes, patient experience) showed limited immediate movement, but improved where upstream conditions were stabilised • **Contextual Factors:** (population demographics and inequalities) influenced the pace of improvement, but did not determine whether improvement was possible. This pattern was consistent across ICBs and repeatedly evidenced in practice-level commentary across the highlight reports.
What differentiated practices that improved from those that did not:	Across all domains, the clearest differentiator was practice readiness to implement change, rather than exposure to the programme or volume of support offered. From the practices that improved below are the shared common characteristics: • Stable leadership and workforce • Willingness to redesign operational processes • Ability to act on data and feedback • Engagement with hands-on support Practices that did not improve were more likely to experience: • Leadership or staffing instability • Reliance on legacy models • Deferred implantation of agreed actions • Compounding operational and population pressures These patterns explain why the same improvement model produced different outcomes across practices, without implying differences in effort or intent
How domains interacted:	Throughout the review of highlight reports and evidence collected, we identified that domains did not act independently: • Access redesign acted as a catalyst for improvement in patient experience and outcomes • Digital maturity amplified improvement where configuration issues were resolved early, but constrained progress where unresolved • Workforce stability and leadership acted as foundational enablers, shaping whether operational changes could be embedded • Vaccinations responded well to focused operational effort, particularly where data quality and recall processes were addressed • Outcomes and patient experience improved where stabilisation allowed proactive care to resume, rather than through direct intervention
What this tells us about the improvement model	Taken together, the evidence indicates that Project 100 was effective not because it targeted every domain simultaneously, but because it created the conditions under which improvement could occur. The model worked where data was sufficiently trusted to act upon, roles between regions and ICBs enabled pace and ownership, and support was practical and relational. We also found that if expectations were realistic within the time-limited window practices and ICBs were more receptive to the model. Where these conditions were absent, practice improvement stalled, even where there may have been motivation to improve and engagement was present.
Implications of the synthesis between domains	The evidence we have collected confirms that: • Improvement is driven by conditions, not compliance; • Time-limited interventions can unlock progress if foundational issues are addressed • Practice-level variation is explained by readiness and stability, not just programme design alone These findings underpin the case for treating Project 100 not as a one-off intervention, but as a replicable improvement operating model, with clear implications for national design and neighbourhood delivery.

ICB Perspectives: What Enabled (and Constrained) Improvement

Summary

ICBs consistently described Project 100 as an accelerator of improvement driven by delivery focus and ways of working rather than the introduction of new priorities.

What ICBs told us worked

ICBs reported that Project 100 was most effective where it created clarity, pace and shared visibility around improvement activity. Whilst priorities such as access and workforce were already nationally defined (including through the SOS list), P100 provided a structured mechanism to focus effort, sequence actions and maintain momentum.

ICBs consistently highlighted the value of a shared data view in enabling more constructive conversations with practices, particularly where time was invested in explaining metrics, reconciling discrepancies and building confidence in the data. Where data was stable and trusted, it supported quicker decision-making and more targeted support.

Relational ways of working were repeatedly cited as critical. Practice visits, PAM input, GPIP/SPS support and regular regional ICB touchpoints were described as more effective than remote performance management alone, particularly in practices facing operational or cultural changes.

> ***P100 as an accelerator, not a priority***
>
> *"Project 100 didn't introduce new priorities, but it created the focus and momentum we needed to move faster on things we already knew we had to address"*

> ***Value of shared data when trusted***
>
> *"Having a shared dashboard improved the quality of conversations with practices, particularly once time was taken to explain the data and reconcile discrepancies"*

What constrained impact?

ICBs were clear that data volatility limited confidence and, at times, undermined improvement conversations. Changes to metrics or delays in refresh created uncertainty for practices and made it harder to evidence progress within the 100-day window.

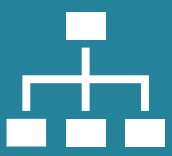
Several ICBs also noted that improvement could not be driven by metrics alone. Local intelligence, including workforce context, leadership stability, estate constraints and population complexity was essential to interpret data meaningfully and prioritise support.

In a small number of cases, inclusion in Project 100 initially increased anxiety amongst some practices, reinforcing the importance of supporting framing and hands-on engagement.

> ***Limits of data volatility***
>
> *"Changes to metrics and delays in data refresh created uncertainty for practices and made it harder to evidence improvement within the programme timescale"*

> ***Relational support mattered more than monitoring***
>
> "Practice visits and regular touchpoints were far more effective than remote monitoring alone, particularly where practices were anxious or under pressure"

What this means for replication



From an ICB perspective, Project 100 is replicable provided certain conditions are met:

- Metrics are available, clearly defined and supplemented by qualitative insight
- The 100-day improvement cycle is clearly scoped and time-bound
- Roles between national, regional and ICB teams are explicitly articulated
- Improvement support remains practical, relational and locally owned

ICBs were clear replication should preserve local ownership of delivery with regions acting as enablers rather that alternative centres of control.

> ***Conditions for replication***
>
> *"This approach is replicable, but only if metrics are stable, roles are clear, and local systems retain ownership of delivery"*

Measuring Success in our Domains - Access

Access improvement was driven by early operational redesign rather than increased capacity alone

NHS England South East

Summary

Across successive highlight reports, practices that improved access consistently redesigned triage, care navigation and appointment models early in the programme. Practices that did not improve were more likely to retain traditional access models, often due to workforce instability or leadership change. This suggests that access outcomes reflect practice readiness and willingness to implement structural change, rather than exposure to the programme alone.

Quantitative Analysis

What the data shows:

1) Overall reduction in adverse indicators between July and December for P100 practices

July Baseline	August	September	October	November	December
-236	-229	-219	-248	-210	-196

Number of adverse indicators decreased by 17% between July and December. The increase in October was mainly attributed to GP Appnts per 1k population (caused by seasonal variation).

2) Reduction in adverse indicators for P100 practices vs non-P100 practices (*August – December period for data consistency)

August	December	Difference	August	December	Difference
-229	-196	-14%	-624	-601	-4%

P100 practices mainly saw reductions across two metrics, with the remaining metrics remaining stable across the period. Non-P100 practices saw reductions in the same two metrics, however, three other metrics had fairly significant increases.

3) Metric(s) that had the largest reduction in adverse indicators (P100 practices only, August compared to December)

GP Appnts per 1k Population
30 indicator reduction ↓

Rate of OC Submissions per 1k Population
8 indicator reduction ↓

Qualitative Analysis

What the data shows:

Access metrics demonstrated meaningful yet uneven improvement at practice level. Whilst aggregate dashboards showed an overall reduction in adverse access indicators, highlight reports consistently indicated that this masked significant variation between practices. Some practices moved quickly from sustained adverse indicators into stabilised or improved positions, whilst others showed little movement over the same period despite comparable system-level support.

Review of the highlight reports showed that practices demonstrating improvement tended to do so early in the programme, often within the first two reporting cycles, whereas practices that had not begun to change by mid-programme rarely showed material improvement by the end of the 100-day period. This suggest that access improvement was not simply a function of time or exposure to the programme, but of practice readiness and willingness to implement operational change.

Hypothesis – Why we think this happened and which factors drove the change:

The highlight reports suggest that access outcomes were driven primarily by how practices managed demand, rather than by the absolute level of demand or the volume of appointments offered. Practices that improved were consistently described as having reconfigured front-door processes, including triage pathways, appointment templates and care navigation roles.

In contrast, practices that did not improve were frequently reported as retaining traditional appointment models, often due to workforce instability, leadership turnover or a reluctance to change established ways of working. In these settings, additional support was often focused on reassurance and monitoring rather than redesign, limiting the programme's ability to influence access metrics within the 100-day timeframe.

What is emerging as a consistent behaviour

Across successive highlight reports, a clear set of behaviours distinguished practices that improved access from those that did not. Practices showing sustained improvement consistently:

- Undertook early redesign of triage and care navigation processes, reducing reliance on GP-led front door decision-making
- Actively configured Online Consultation (OC) tools to reflect local capacity and prioritisation, rather than operating default settings
- Adjusted appointment templates to better align clinician skills mix with demand type
- Used practice-level data to monitor access patterns and iterate changes rapidly

By contrast, practices that remained in sustained adverse access positions were commonly characterised by:

- Ongoing leadership or workforce instability
- Limited engagement with triage redesign or care navigation
- Reliance on short-term capacity increases rather than structural change
- Delayed implementation of agreed actions multiple ICBs

Where future support offers are required

Whilst highlight reporting provides strong qualitative insight, further quantitative data would strengthen the evalauation. In particular, practice-level data on appointment utilisation, triage outcomes, and demand segmentation and continuity would allow more precise attribution of which access changes were most effective.

In addition, follow-up data beyond the 100-day period is required to assess whether early access improvements were sustained or whether practices reverted to previous models once intensive support was withdrawn.

What this could mean for national operating models

The access findings indicate that improvement is most effectively driven through supported operational redesign, rather than through performance management or capacity expansion alone. National operating models that emphasise headline access metrics without equivalent focus on front-door design risk driving superficial compliance rather than sustainable change.

These findings support the case for national frameworks that explicitly enable and encourage practices to rediesgn access models, supported by time-limited improvement cycles and hands-on facilitation.

What this implies for practice support

Practices facing workforce instability require different forms of support to those with stable teams. The evaluation suggests that improvement activity is most effective where workforce support, leadership development and operational redesign are addressed in parallel, rather than sequentially.

Hands on facilitation and flexible timelines were particularly important in practices experiencing staffing disruption.

*Between June & August, 2x metrics were added to the dashboard (ACS admissions and Emergency admissions) and 5 metrics had their lower threshold increased

Measuring Success in our Domains - Workforce

Workforce stability consistently differentiated practices that improved from those that did not

Summary

Across successive highlight reports, practices with stable leadership and staffing were able to implement and sustain improvement actions, whilst practices experiencing churn, vacancies or heavy locum reliance struggled to embed change despite similar support offers. This indicates that workforce is not a parallel issue to improvement, but a foundational condition that shapes what practices are able to deliver.

Quantitative Analysis

What the data shows:

1) Overall reduction in adverse indicators between July and December for P100 practices

July Baseline	August	September	October	November	December
-216	-194	-185	-181	-172	-122

Number of adverse indicators decreased by 44% between July and December. The significant drop in December was attributed to a change in the DPC calculation (figure was adjusted to PCN level)

2) Reduction in adverse indicators for P100 practices vs non-P100 practices (August – December period for data consistency)

August	December	Difference	August	December	Difference
-194	-122	-37%	-348	-218	-37%

Both P100 and Non-P100 practices saw reductions across all workforce metrics. However, the bulk of the reduction can be attributed to the change in the DPC calculation – 147 adverse indicators for DPC metric in August vs 11 in December.

3) Metric(s) that had the largest reduction in adverse indicators (P100 practices only, August compared to December)

Registered Patients Per DPC FTE	Patients Per Fully Qualified GP FTE	Patients Per Nurse FTE
35 indicator reduction ↓	10 indicator reduction ↓	7 indicator reduction ↓

Qualitative Analysis

What the data shows:

Workforce metrics did materially change within the 100-day period; where movement was observed, this largely reflected data recalculation or quality improvement rather than structural workforce change. The differentiator identified through Project 100 was leadership stability and management capacity rather than short-term staffing expansion.

Workforce stability emerged as one of the clearest differentiators between practices that demonstrated improvement and those that did not. Highlight reports from the start of the programme to the end showed that practices with stable clinical and managerial teams were more likely to progress agreed actions, move through P100 phases, and sustain improvement across multiple reporting cycles.

Conversely, practices experiencing ongoing recruitment challenges, leadership turnover or high reliance on locum cover frequently remained within P100 for the duration of the programme, with limited movement across access, outcomes and patient experience indicators.

Hypothesis – Why we think this happened and which factors drove the change:

Practice level-commentary across the highlight reports suggests that workforce instability constrained improvement in two interrelated ways. First, practices facing staffing gaps lacked the operational capacity to redesign systems whilst maintaining safe day-to-day delivery. Second, changes in leadership disrupted continuity of decision-making, resulting in delays to, or reversal of agreed improvement actions.

In these settings, improvement activity often shifted from implementation to reassurance and monitoring, limiting the programme's ability to influence performance within the 100-day timeframe.

What is emerging as a consistent behaviour

Practices that improved consistently demonstrated:

- Stable clinical and practice management leadership
- Clear role definition and deployment of MDT and ARRS staff
- Willingness to adjust rotas and skill mix to support new ways of working
- Active engagement with workforce-related support offers

However, in contrast, practices that did not improve were frequently described as:

- Experiencing repeated GP or practice manager turnover
- Relying heavily on short-term locum cover
- Lacking clarity on ARRS role utilisation
- Deferring improvement actions due to staffing pressures

Where future support offers are required

Whilst highlight reports provide strong quantitative insight, further quantitative data would strengthen the understanding of workforce impact. In particular, information on vacancy rates, leadership tenure, ARRS deployment models and rota patterns would enable more precise comparison between improving and non-improving practices.

Longer-term follow-up data is also required to assess whether workforce stabilisation achieved during P100 translated into sustained improvement beyond the programme period. The upcoming new Long Term Work Place will be key to future direction.

What this could mean for national operating models

The workforce findings indicate that improvement must explicitly account for workforce conditions. National operating models assume that baseline workforce stability risk overestimating the pace and scale of change practices can realistically deliver.

These findings support treating workforce stability as a foundational dependency within improvement design, rather than as a parallel issue to be addressed separately.

What it implies for practice support

Practices facing workforce instability require different forms of pacing of support to those with stable teams. This suggests that improvement is most effective where workforce support, leadership development and operational redesign are addressed in parallel.

Hands-on facilitation and flexible timelines were particularly important In practices experiencing staffing disruption.

Measuring Success in our Domains - Vaccinations

NHS England South East

Vaccination performance improved where practices combined operational focus with targeted population outreach, rather than relying on passive recall alone

Summary

Vaccination performance showed early and uneven improvement across Project 100, with gains most evident where practices actively addressed call-and-recall processes, data accuracy and targeted outreach. Where vaccination metrics did not improve, this was often linked to workforce constraints, population complexity or limitations with recall systems rather than a lack of engagement. This indicates that vaccination improvement responded best to focused operational action within stable practice environments.

Quantitative Analysis

What the data shows:

1) Overall reduction in adverse indicators between July and December for P100 practices

July Baseline	August	September	October	November	December
-99	-66	-66	-66	-76	-76

Number of adverse indicators decreased by 23% between July and December. There was no change in thresholds between July & August, so the reduction of 33 indicators was due to data updates, mainly across all Child Imms metrics

2) Reduction in adverse indicators for P100 practices vs non-P100 practices (August – December period for data consistency)

August	December	Difference	August	December	Difference
-66	-76	+15%	-226	-198	-12%

The increase in adverse indicators for P100 practices was mainly attributed to the Child Imms DTaP/IPV/Hib/HepB and Child Imms Hib/MenC booster metrics. For the non-P100 practices, there was a decrease in indicators for the Child Imms Hib/MenC booster and Child Imms PCV Booster metrics, which will require discussion with wider regional colleagues to understand whether some practices were receiving targeted support.

Qualitative Analysis

What the data shows:

Vaccination metrics demonstrated variable improvement at practice level, with some practices showing clear progress whilst others remained static. Dashboards indicated modest overall improvement, but across highlight reports from August to December revealed significant variation beneath this headline picture.

Practices that improved vaccination performance tended to show movement relatively early in the programme, often following targeted recall activity or data quality work. Practices that did not improvement frequently remained static across multiple reporting cycles, particularly where vaccination delivery competed with access pressure or workforce instability.

Hypothesis – Why we think this happened and which factors drove the change:

The evidence suggests that vaccination performance improved where practices treated vaccination delivery as active operational priority, rather than a background process. Practices that improved were more likely to review recall lists, validate eligibility data and deploy staff time specifically for vaccination activity.

Where practices did not improve, vaccination delivery was often deprioritised due to service pressures, limited staffing capacity or challenges engaging specific population groups. In these settings, improvement activity focused on maintaining baseline delivery rather than achieving measurable gains within the 100-day timeframe.

What is emerging as a consistent behaviour

Practices that improved vaccination performance consistently demonstrated:

- Early validation and cleansing of vaccination registers
- Targeted call-and-recall activity for specific cohorts
- Clear allocation of responsibility for vaccination delivery
- Use of non-GP staff to support vaccination outreach and administration

In contrast, practices that did not improve were frequently described as:

- Relying on routine or passive recall processes
- Experiencing staffing constraints that limited proactive outreach
- Struggling to engage hard to reach or transient populations
- Deferring vaccination improvement activity in favour of access pressures

Where future support offers are required

Further analysis is required to understand variation in vaccination improvement across population sub-groups, including deprivation, ethnicity and mobility. More timeline access to cohort-level data would also strengthen understanding of which recall and outreach approaches were most effective.

Longer-term follow-up is needed to assess whether early improvements observed during Project 100 were sustained across subsequent vaccination cycles.

What this could mean for national operating models

The vaccination findings indicate that improvement is most effective where vaccination delivery is treated as a focused operational process, supported by data quality, clear ownership and protected capacity. National operating models that rely primarily on passive incentives or reporting may struggle to achieve consistent improvement, particularly in complex populations.

These findings support the use of time-limited, targeted improvement approaches for vaccination delivery, aligned to population need.

What this implies for practice support

Practices benefited most where support included practical help with data validations, recall processes and workforce deployment, rather than performance monitoring alone. Support that enabled practices to prioritise vaccination activity alongside other pressures was particularly effective.

This reinforces the importance of hands-on facilitation and flexible support models for vaccination improvement.

Measuring Success in our Domains - Outcomes

NHS England South East

Outcomes improved where practices translated operational change into sustained delivery, rather than through short-term performance recovery alone

Summary

Outcomes showed measurable improvement for a subset of practices during Project 100, particularly where operational and workforce stability enabled consistent delivery of care. Where outcomes did not improve, this was commonly linked to access instability, workforce disruption or data quality issues, rather than absence of effort or engagement. This suggests outcomes improvement was contingent on underlying system readiness, rather than driven by outcomes-focused intervention in isolation.

Quantitative Analysis

What the data shows:

1) Overall reduction in adverse indicators between July and December for P100 practices

July Baseline	August	September	October	November	December
-290	-283	-274	-192	-192	-182

Number of adverse indicators decreased by 37% between July and December. The significant drop in October was mainly due to QOF updates, which are annual figures (change from 23/24 figures to 24/25), as well as an update to the LD Health Check measure.

2) Reduction in adverse indicators for P100 practices vs non-P100 practices (August – December period for data consistency)

August	December	Difference	August	December	Difference
-283	-182	-37%	-825	-433	-48%

Both P100 and non-P100 practices had a significant reduction in adverse indicators within the Outcomes domain. The majority of the reduction came from the LD Health Checks metric (55 indicator reduction for P100 practices vs 366 for non-P100 practices). However, for P100 practices, there were reductions across multiple other indicators.

3) Metric(s) that had the largest reduction in adverse indicators (P100 practices only, August compared to December)

LD Health Checks	Total QOF Points	Dementia Patients with Care Plan Review
55 indicator reduction ↓	16 indicator reduction ↓	14 indicator reduction ↓

Qualitative Analysis

What the data shows:

Outcomes metrics demonstrated modest but observable improvement at practice level, with aggregate dashboards showing a reduction in the number of adverse outcome-related indicators. However, the highlight reports indicate that this improvement was unevenly distributed, with some practices demonstrating sustained progress whilst others showed limited movement over the same period.

Practices that improved outcomes were more likely to show consistent progress across successive reporting cycles, whereas practices that remained under sustained monitoring often showed stagnation across outcomes alongside continued challenges in access, workforce and leadership stability.

Hypothesis – Why we think this happened and which factors drove the change:

The evidence suggests that outcomes improvement during Project 100 was rarely the result of direct intervention on outcomes metric alone. Instead, outcomes improved where practices were able to stabilise delivery sufficiently to embed changes in clinical processes, recall activity and proactive care.

Where practices continued to experience operational disruption, outcomes activity was frequently deprioritised in favour of managing immediate access or staffing pressures. In these settings, improvement activity focused on maintaining safe delivery rather than driving measurable gains, limiting the programme's impact on outcomes within the 100-day timeframe.

What is emerging as a consistent behaviour

Practices that demonstrated that outcomes improvement showed:

- Sustained implementation of agreed actions over multiple reporting cycles
- Greater stability in clinical leadership and workforce
- Improved use of data to monitor performance and prioritise activity
- Alignment between access models and proactive care delivery

Practices that did not improve outcomes were frequently described as:

- Experiencing ongoing access or workforce instability
- Struggling to sustain recall and long-term condition management activity
- Focusing on short-term delivery pressures rather than embedding change
- Revisiting agreed actions without progressing implementation

Where future support offers are required

Whilst dashboard metrics provide a useful overview, further practice-level data would strengthen attribution between specific interventions and outcomes improvement. In particular, clearer visibility of baseline versus follow-up performance, and longer-term trend data, would support more robust assessment of sustainability.

Additional follow-up beyond the P100 period is also required to understand whether early outcomes improvements were maintained once intensive support was withdrawn.

What this could mean for national operating models

The outcomes findings indicate that improvement initiatives should avoid treating outcomes as a standalone domain. National operating models that prioritise outcomes targets without addressing access, workforce and leadership conditions risk limited impact.

These findings support a model where outcomes improvement is positioned as a product of system stability and delivery maturity, rather than as an isolated performance objective.

What this implies for practice support

Practices benefited most where outcomes improvement was supported through integrated delivery support, linking access redesign, workforce stability and proactive care. Support focused solely on outcomes monitoring was less effective in practices experiencing operational disruption.

This reinforces the importance of coordinated, multi-domain support rather than single-issue intervention.

Measuring Success in our Domains – Patient Experience

Patient experience shifted where operational change reduced friction for patients, rather than through standalone activity

Summary

Patient experience improvement unevenly across Project 100 and was closely linked to changes in access models. Practices that redesigned the front-door processes and improved patient messaging were more likely to see early positive signals, whilst practices where operational change lagged saw limited movement in experience indicators. This suggests patient experience acted as a downstream indicator of system change, rather than a domain that shifted independently.

Quantitative Analysis

What the data shows:

1) Overall reduction in adverse indicators between July and December for P100 practices (GPPS Overall Experience)

July Baseline	August	September	October	November	December
-108	-90	-90	- 90	-90	-90

Number of adverse indicators decreased by 17% between July and December. The decrease between July and August, the only decrease, was due to an update in the data (23/24 data moving to 24/25). The lower threshold also increased to 65%. If the threshold remained constant, the number of indicators would have reduced to 58 in August.

2) Reduction in adverse indicators for P100 practices vs non-P100 practices (August – December period for data consistency)

August	December	Difference	August	December	Difference
-90	-90	0%	-172	-170	-1%

The GPPS Data is annualised, so the data only changed between July and August. The decrease in Non-P100 practices was likely due to a practice closure or dataset error. The impact of P100 will only be seen in 25/26 GPPS data (August 2026).

Qualitative Analysis

What the data shows:

Patient experience metrics showed limited movement at aggregate level, reflecting the inherent lag in national datasets such as GP Patient Survey (GPPS). However, practice-level commentary within the highlight reports indicates emerging variation in patient experience trajectories, closely aligned with changes in access, triage and communication processes.

Practices that implemented early operational changes frequently reported improvements in patient feedback themes, reduced complaints, or increased confidence that patient experience would improve once national metrics were refreshed. Conversely, practices that did not progress operational change reported persistent adverse patient experience, often linked to access frustration and communication issues, with little evidence of improvement over the programme period.

Hypothesis – Why we think this happened and which factors drove the change:

The evidence suggest that patient experience outcomes during Project 100 were driven less by direct engagement activity and more by indirect effects of operational change. Where practices improved access flow, clarified routes of contact and set clearer expectations for patients, experience was perceived to improve even before this was reflected in formal metrics.

In contrast, where access models remained unchanged or unstable, patient experience issues persisted. In these settings, practices often focused on managing complaints rather than addressing underlying system drivers, limiting the programme's ability to influence experience indicators within the 100-day timeframe.

What is emerging as a consistent behaviour

Practices that improved patient experience consistently demonstrated:

- Early alignment between access redesign and patient communication, including clearer messaging on websites and online consultation platforms
- Active use of feedback (complaint themes, FFT where available) to inform operational changes
- Greater confidence among staff in explaining access processes to patients, reducing frustration at repeat contact
- Willingness to test and iterate changes based on patient response

By contrast, practices that did not improve patient experience were frequently described as:

- Experiencing persistent access-related dissatisfaction from patients
- Relying on reactive complaints management rather than system change
- Lacking clarity on consistency in patient-facing communication
- Differing patient experience improvements until access or workforce pressures were resolved

These patterns were observed repeatedly in practice-level commentary across multiple ICBs.

Where future support offers are required

Patient experience evaluation is constrained by the timeliness of national datasets. More frequent access to real-time or near real-time feedback, including FFT trends and local complaints data, would enable clearer attribution between operational changes and experience outcomes.

In addition, follow-up beyond the 100-day period is required to assess whether early qualitative improvements translated into sustained improvements in GPPS and other national measures.

What this could mean for national operating models

The patient experience findings indicate that national improvement approaches should avoid treating experience as a standalone domain. Instead, experience improvement should be framed as a consequence of effective access design, communication and system stability.

National operating models that focus on experience metrics without addressing underlying operational drivers risk encouraging superficial fixes rather than meaningful improvement.

What it implies for practice support

Practices benefited most where patient experience was addressed through practical operational support, rather than isolated engagement activity. Support that helped practices redesign access pathways, clarify patient messaging and build staff confidence in explaining changes was more effective than remote monitoring of experience metrics alone.

This reinforces the value of integrated support across access, digital and communication.

Measuring Success in our Domains – Digital Maturity

Digital maturity amplified improvement where foundations were in place, but constrained progress where configuration and capability issues persisted

Summary

Digital maturity did not act as a standalone driver of improvement during Project 100, but strongly shaped the extent to which practices could benefit from other interventions. Practices with well-configured digital systems were better able to redesign access, manage demand and communicate with patients, whilst practices with unresolved digital issues experienced friction that limited progress across multiple domains. This suggests digital maturity functioned as an enabling condition rather than a primary lever for change.

Quantitative Analysis

What the data shows:

1) Overall reduction in adverse indicators between July and December for P100 practices (Rate of OC Submissions)

July Baseline	August	September	October	November	December
-14	-13	-14	-19	-13	-5

Number of adverse indicators decreased by 64% between July and December. The data was fairly static between July and September, before increasing in October. The significant reduction in December could be attributed to the GP Contract changes for 25/26, which came into effect in October (OC has 2-month data time lag).

2) Reduction in adverse indicators for P100 practices vs non-P100 practices (August – December period for data consistency)

August	December	Difference	August	December	Difference
-13	-5	-62%	-41	-28	-32%

There was a significant reduction in the number of adverse indicators for P100 and non-P100 practices regarding the Rate of OC Submissions. As the GP Contract Changes for 25/26 impact all practices, we would expect an improvement in OC compliance and usage. However, the 62% reduction across P100 practices suggests some additional OC support was provided to practices.

Qualitative Analysis

What the data shows:

Digital maturity indicators showed limited direct movement at aggregate level. However, all throughout highlight reports digital configuration and capability are referenced as factors influencing performance in access, patient experience and workforce efficiency.

Practices described as digitally stable were more likely to progress agreed actions and show improvement across related domains. In contrast, practices with unresolved issues relating to online consultation configuration, websites or data flows frequently remained under monitoring, with digital friction cited as a barrier to wider improvement.

Hypothesis – Why we think this happened and which factors drove the change:

The evidence suggests that digital maturity influenced improvement by reducing operational friction, rather than driving change directly. Where digital systems were well configured, practices were able to manage demand more effectively, communicate clearly with patients and use data to inform decision-making.

Where digital configuration issues persisted, practices experienced increased workload, patient confusion and data inaccuracies. In these settings, improvement activity often focused on addressing technical problems before broader operational change could be implemented, limiting the programme's ability to influence performance within the 100-day timeframe.

What is emerging as a consistent behaviour

Practices that progressed more effectively consistently demonstrated:

- Early resolution of online consultation configuration issues
- Clear and accurate patient-facing digital information
- Alignment between digital tools and local access models
- Willingness to adjust digital processes in response to demand patterns

Practices that did not improve were frequently described as:

- Operating with poorly configured of default digital settings
- Experiencing patient confusion driven by inconsistent online messaging
- Facing data flow or reporting issues that masked true performance
- Deferring digital changes due to competing operational pressures

Where future support offers are required

More consistent assessment of digital maturity at practice level would strengthen understanding of its impact. In particular, clearer segmentation of practices by digital configuration, capability and support needs would enable more targeted intervention.

Additional insight into how digital improvement interact with access, workforce, and patient experience over time would also support stronger evaluation.

What this could mean for national operating models

The digital maturity findings indicate that national operating models should avoid assuming a uniform digital baseline across practices. Digital enablement needs to be treated as a foundational enabler, address early to prevent it becoming a bottleneck to improvement.

National approaches that focus on deploying digital tools without sufficient attention to configuration, usability and local fit risk limited impact.

What it implies for practice support

Practices benefited most where digital support was practical and targeted, focusing on configuration fixes rather than system replacement. Early technical support enabled practices to progress with access redesign and communication improvement more rapidly.

This highlights the value of timely, hands on digital support aligned to wider improvement objectives.

Measuring Success in our Domains – Leadership and Quality

Leadership stability and improvement mindset consistently shaped whether practices were able to translate support into sustained change

Summary

Leadership and culture emerged as one of the main cross-cutting enablers of improvement during Project 100. Practices with stable leadership and a willingness to engage with improvement activity were more likely to implement agreed actions and sustain progress, whilst practices experiencing leadership churn or limited readiness for change struggled to embed new ways of working. This indicates that leadership and culture were not abstract concepts, but practical determinants of delivery capability. This aligns with the Messenger Review and the Fuller Stocktake, both which emphasise leadership, culture and team readiness as foundational enablers of sustainable improvement

Quantitative Analysis

What the data shows:

1) Overall reduction in adverse indicators between July and December for P100 practices (Rate of OC Submissions)

July Baseline	August	September	October	November	December
-78	-81	-81	-75	-75	-75

Number of adverse indicators decreased by 4% between July and December. The data was fairly static across the P100 period, considering the monthly updates. It was quickly recognised that the available CQC dataset was not providing an accurate and up to date picture on practice quality.

2) Reduction in adverse indicators for P100 practices vs non-P100 practices (August – December period for data consistency)

August	December	Difference	August	December	Difference
-81	-75	-7%	-36	-27	-25%

Some reduction was seen in the number of adverse indicators for CQC Ratings for both P100 and Non-P100 practices. Interestingly, CQC Ratings does not seem to be impacted by IMD Decile – of those P100 practices requiring improvement, the average decile is 7. Through local intelligence, it's understood that some practices have had a recent review and are waiting for the data to be updated, whilst others are in the process of a review. CQC data will be tracked to determine the full impact of P100.

Qualitative Analysis

What the data shows:

Leadership and cultural factors repeatedly appeared in highlight reports as explanatory drivers of variation between practices. Whilst leadership and culture are not directly captured in national metrics, practice-level commentary across the reports consistently linked progress to leadership stability, engagement and openness to change.

Practices that demonstrated improvement were more likely to be described as having engaged leadership teams, clear internal communication and confidence in implementing change. Conversely, practices that remained under sustained monitoring were frequently associated with leadership turnover, uncertainty or reluctance to alter established ways of working.

Hypothesis – Why we think this happened and which factors drove the change:

The evidence suggests that leadership and culture influenced improvement by shaping decision-making speed, confidence and follow-through. Where leadership was stable and improvement-oriented, practices were better able to act on insight and sustain implementation across reporting cycles.

Where leadership was unstable or risk-averse, improvement activity often slowed or stalled. In these settings, agreed actions were more likely to be deferred, revisited or partially implemented, limiting the programme's impact within the 100-day timeframe.

What is emerging as a consistent behaviour

Across successive highlight reports, practices that improved consistently showed:

- Stable clinical and managerial leadership
- Willingness to engage openly with performance data
- Confidence to test and adapt new ways of working
- Clear internal communication and shared ownership of change

Practices that did not improve were described as:

- Experiencing leadership turnover or absence
- Demonstrating limited readiness for change
- Requiring repeated reassurance before implementing actions
- Revisiting decisions without progressing delivery

Where future support offers are required

More structured assessment of leadership capability and improvement readiness would strengthen the evaluation of this domain. Qualitative insight from practice teams, alongside indicators such as leadership tenure and engagement levels would support a more systematic comparison between practices.

Longer-term follow-up would also help assess whether leadership and cultural shifts observed during Project 100 were sustained beyond the programme period.

What this could mean for national operating models

The leadership and culture findings indicate that improvement programmes cannot assume uniform readiness across practices. National operating models that focus solely on technical levers risk limited impact where leadership confidence and cultural readiness are not in place.

These findings support explicitly recognising leadership and culture as foundational enablers within improvement design, rather than treating them as implicit conditions.

What it implies for practice support

Practices benefited most where support addressed leadership confidence and improvement capability alongside operational change. Coaching, peer learning and facilitative support were particularly important in practices facing uncertainty or transition.

This reinforces the value of relational, trust-based support models in enabling improvement.

Measuring Success in our Domains – Population Demographics and Inequalities

Population complexity influenced the pace of improvement, but did not determine whether progress was possible

Summary

Population characteristics shaped how quickly practices were able to demonstrate improvement during Project 100, particularly in areas of higher deprivation, population mobility or complexity. However, highlight reports indicate that practices serving complex populations were still able to make progress where support was appropriately targeted and expectations were realistic. This suggests population context affected pace, not potential.

Quantitative Analysis

What the data shows:

Green	Amber/ Green	Amber	Red
4 adverse indicators or less	5 adverse indicators	A reduction from start point but at least 6 adverse indicators	Practice remained static or regressed
46 practices	11 practices	26 practices	21 practices
IMD Decile 7	IMD Decile 8	IMD Decile 6	IMD Decile 5
Average Payment Per Weighted Patient = £155	Average Payment Per Weighted Patient = £148	Average Payment Per Weighted Patient = £154	Average Payment Per Weighted Patient = £197

The data shows that Green practices, on average, have a lower IMD score than Red practices, and a lower payment per weighted patient.
This suggests that deprivation and complex patient groups can impact a practice's ability to make improvements.

Qualitative Analysis

What the data shows:

Practices serving more deprived or transient populations were more likely to remain under sustained monitoring and showed slower movement across some metrics. However, throughout the highlight reports from August through to December, evidence showed that population factors alone did not explain variation in improvement.

Several practices serving complex populations demonstrated progress where stabilisation and target support were prioritised. Conversely, some practices serving less complex populations showed limited improvement where workforce or leadership instability persisted.

Hypothesis – Why we think this happened and which factors drove the change:

Evidence suggests that population complexity influenced improvement primarily by amplifying operational pressure, rather than by limiting engagement or intent. High demand, language barriers, mobility and health inequality increased workload intensity, making short-term gains harder to achieve.

Where practices where able to stabilise delivery and target specific cohorts, improvement was still possible. Where instability persisted, population pressures compounded existing challenges, slowing the progress of the Project 100 timeboxed 100-day timeframe.

What is emerging as a consistent behaviour

Throughout highlight reports, practices that improved consistently demonstrated:

- Early focus on stabilisation rather than the broader design
- Targeted interventions for specific cohorts
- Close alignment with ICB support officers
- Realistic prioritisation of improvement actions

Where practices did not improve they were often to referred to as:

- Experiencing compounded access and workforce pressures
- Struggling to prioritise improvement alongside reactive demand
- Requiring longer timeframes to demonstrate measurable change

Where future support offers are required

More granular population segmentation data would strengthen understanding of how deprivation, ethnicity and mobility interact with improvement outcomes. Longer-term analysis is also required to assess whether practices serving complex populations sustain improvement over extended timeframes.

What this could mean for national operating models

The findings indicate that national improvement approaches should avoid uniform expectations for pace across all population contexts. Operating models that recognise population complexity and allow flexibility in timelines and support intensity are more likely to deliver equitable improvement.

This supports differentiated improvement approaches rather than one-size fits all models.

What it implies for practice support

Practices serving complex populations benefited most where support was tailored, sustained and realistic. Short-term performance pressure without accompanying stabilisation support was less effective.

This reinforces the need for equity-informed improvement support models.

Annex

Case Studies

Project 100 Case Study Synopsis

The following case studies highlight how practices participating in Project 100 have translated targeted support into meaningful change. Despite differing sizes and challenges, each practice demonstrates how focused transformation activity can deliver improved access, stronger performance and better experiences for patients and staff.

Modality Mid Sussex

Modality Mid Sussex, a large multi-site GP practice serving nearly 30,000 patients, used Project 100 support to address performance variation, workforce pressure and poor patient experience following an Inadequate CQC rating.

Through targeted ICB engagement, co-designed improvement planning and the rapid introduction of digital access solutions, the practice transformed access, quality and operational resilience. Key changes included digital triage, extended online consultation hours, strengthened leadership and community engagement, and renewed in-house extended access provision.

As a result, Modality Mid Sussex achieved measurable improvements in CQC outcomes, GP Patient Survey experience, QOF performance, appointment availability and workforce stability demonstrating how focused system support and collaborative improvement can deliver sustainable recovery in challenged practices.

Sydenham House Medical Centre

Sydenham House Medical Centre, a large multi-site practice in Kent & Medway, used a structured, data-led improvement approach to address access pressures, rising demand following Total Triage, and variable patient experience.

Through facilitated on-site PLS and FIR sessions, demand and capacity analysis, and transparent use of call and triage data, the practice prioritised system wide changes to patient flow and care navigation. Interventions included revised DNA processes, GPAD slot mapping, strengthened Pharmacy First referral coding, ongoing Total Triage monitoring, and proactive CVD reviews delivered via an external provider.

This delivered clear, measurable impact, including substantial reductions in call volumes and abandoned calls, alongside increased online consultations and Pharmacy First utilisation. The case highlights the value of facilitator support and sustained data monitoring at scale.

Thorkhill Surgery

Thorkhill Surgery, a small single-handed GP practice in East Elmbridge PCN, worked with Surrey Heartlands ICB through Project 100 to address persistent access pressures, workforce challenges and patient experience concerns.

Using data-led insights and flexible primary care support, the practice introduced total triage, strengthened operational processes through AccuRx training, refreshed GPAD reporting, and implemented patient-feedback-driven improvements.

These changes enabled safer online access throughout core hours, improved patient flow, and more reliable decision-making despite the constraints of a small practice model. The work demonstrates how tailored, relationship-based ICB support can deliver measurable improvements in access and experience while laying the foundations for sustained service transformation.

Project 100 Case Study

Modality Mid Sussex

NHS England South East

What was required?

This approach was implemented to identify and address any specific needs of the practice where adverse variation had been identified and understand whether this variation could be explained, and where appropriate identify any areas for further improvement.

The practice was written to outlining the P100 programme, principles, areas of variation identified and our approach locally to supporting practices. A virtual visit was then scheduled with the ICB team with representatives from the Primary Care Team and GP Clinical Leads who met with the practice. During the meeting the areas of adverse variation were discussed, and a practice action plan was developed which was then shared with the Practice with further follow up from the ICB teams as appropriate i.e digital and workforce leads

What were the aims?

The practice was identified through the Project 100 programme, which was launched to address key areas impacting both staff and patients. These areas include Access and Patient Experience, GP Workforce, Clinical Outcomes and Care Quality, as well as Vaccinations and Screening.

The ambition of the programme was to engage with those Practices that have been identified as having a number of areas where adverse variation exists, working with those Practices by offering a programme of support and creating best practice examples to drive peer learning across local systems.

This was facilitated through individual practice discussions understand and where possible explain the areas where adverse variation had been identified through the GP Dashboard metrics.

Modality Mid Sussex was initially given a adverse variation score of 10 based on the July 2025 baseline data. The metrics associated with the adverse variation are outlined below:

- Percentage of patients describing their overall experience of contacting their GP practice on this occasion as "very good" or "good"
- Number of registered patients per Direct Patient Care (DPC)
- CQC Overall Practice Rating
- Overall QOF achievement
- Percentage of patients diagnosed with dementia with care plan review
- Percentage of patients with COPD on the register, who have had a review in the preceding 12 months
- Percentage of patients on the QOF Learning Disability register (aged 14 years or over) who received a learning disability health check between the start of the financial year and the end of the reporting period

This collaborative approach enabled both parties to openly assess the practice's present circumstances and identify any ongoing or anticipated challenges where the ICB's support could prove beneficial.

What was the solution?

Prior to each visit an internal ICB pre-meet took place to review scope, purpose and planned outcome, and review action plan in preparation for the meeting.

The initial meeting with the ICB and Practice Team led to an understanding of the practice's current circumstances, and together an action plan was co-designed, considering achievable improvements and appropriate timescales. Additionally, the meeting provided an opportunity for the practice to identify areas where ICB support would be most beneficial, ensuring a supportive and partnership-based approach to improvement.

The following areas were highlighted by the practice:

Managing demand and capacity
The practice continues to focus on aligning capacity with patient demand, demonstrating a proactive and responsive approach to service delivery. The team has significantly enhanced communication with patients and established a dedicated Digital Transformation Group, reflecting their forward-thinking ethos. The implementation of the Rapid Health digital triage system enables timely and effective assessment of urgent cases, ensuring that patients receive the care they require without delay. In addition, the practice operates their Online Consultation service from 6am, to improve accessibility and convenience for patients.

Patient Engagement
The practice actively engages with the wider community, including holding a regular monthly segment on Meridian Radio's 'Health Matters' and recently hosting a highly successful Family Health & Fun Day at Judges Close Surgery, East Grinstead. These initiatives foster community engagement and promote health awareness.

The practice is working closely with the ICB Communications team and Healthwatch to seek expert support and continuously enhance the quality of services provided to patients and the wider local population.

Improving Digital Inclusivity
The practice has reached out to the ICB Digital Team to explore opportunities for a digital inclusion project, ensuring equitable access to digital health services.

Strengthening resilience
Collaboration with the ICB Workforce team is also underway to strengthen workforce resilience and stability, safeguarding continuity and high standards of care.

It is important to recognise that the practice has demonstrated a strong commitment to continuous improvement in advance of the ICB's engagement and subsequent support through Project 100. These examples provide a comprehensive overview of the wide-ranging enhancements the practice has proactively pursued to reach its current position, as well as the additional advances achieved as a result of collaborative efforts during the Project 100 practice visit.

What was the impact?

The practice have made a number of improvements in the quality of patient care:

- Enhanced communication channels and proactive service delivery ensure patients receive timely and appropriate care, particularly through the Rapid Health digital triage system.
- Online Consultation services, available from 6am, improve accessibility, making it easier for patients to seek help outside traditional hours.
- Community engagement initiatives, such as radio segments and health events, promote health awareness and strengthen relationships between the practice and local residents.
- Commitment to digital inclusion ensures all patients, regardless of their digital skills or resources, have equitable access to health services.
- The provision of extended access was brought back in-house to deliver services during evenings and weekends, improving access and offering patients more appointment options for both acute conditions and chronic disease reviews.
- Separately, the practice delivered group consultation sessions for a range of conditions, including diabetes, pre-diabetes, and menopause, supported by their health coaches, and more recently the Obesity Local Commissioned Service (LCS).
- Investing into the above improvements resulted in some cost and time savings as well
- Digital triage and extended online consultations reduce bottlenecks and pressure on reception staff, especially during peak times, leading to more efficient use of resources.
- Streamlined processes support quicker patient assessment and allocation, saving time for both staff and patients.
- Proactive community outreach and dissemination of best practices may reduce unnecessary appointments and improve preventive care, potentially lowering overall costs.

The positive impact on staff has been noticeable:

- Enhanced workforce resilience and stability through collaboration with the ICB Workforce team, supporting continuity of care and reducing staff turnover.
- Reduced administrative pressure due to improved digital solutions, allowing staff to focus more on patient care rather than routine tasks.
- Access to expert support and ongoing professional development opportunities boosts staff confidence and job satisfaction.
- Increased opportunities for partnership working and innovation foster a positive, forward-thinking work environment.

Project 100 Case Study

Sydenham House Medical Centre

NHS England South East

What was required?	Practice are currently undertaking NHSE PLS Programme. They are currently 8 sessions through their 15 session programme and are due to complete 25/02/2026. NB as part of the PLS Programme, the practice have completed the AT MGP assessment tool to identify areas of support.
What were the aims?	The practice was identified for the Kent and Medway FIR project. The transformation team have worked with their delivery partner Xytal to develop a programme incorporating the GPIP PLS aims, and K&M FIR aims. The practice will receive a minimum of 15 on site visits with a facilitator and 3 group sessions. The practice is provided with a data pack with focused aims identified from the ICB and will work with the facilitator using their local data and ATMGP to identify areas for improvement they wish to work on. Projects Identified by P100 and FIR: • Pharmacy first referrals • CVDs • Patient Experience Improvement areas identified by practice as part of GPIP • Reduce DNAs • Review and ongoing improvements following move to Total Triage
What was the solution?	The practice continues to work on the KM PLS/FIR project and are 8 sessions into this work, using the programme they have worked on a number of areas. P100 & FIR Aims; • Pharmacy first referrals are now being coded by admin staff who complete the referral on behalf of the triage GP. A review of referral figures showed an increase from an average of 14 per month, to 38 (3/11/25 – 3/12/2025) since change has been made to referral process ensuring activity is captured. • CVD Planned work for the new year. CVD – Interface have been commissioned by the practice to undertake reviews with their CVD patients. In particular, they will be focussing on pro-active care reviews and intervention around BPs and cholesterol reduction. • Patient Experience- expected as improvements continue and specific activities to review and measure this in the new year, Practice Aims; • Reduced DNAs - With a monthly count of 342 DNAs, the practice would like to see at least a 50% reduction in DNAs over time with the implementation of their revised DNA policy. The revised DNA policy has been shared across the group of practices, with feedback being that the cost to write to all DNA patients will be too costly, as well as take up too much staff time. • The majority of DNAs are within the nursing team, and the suggestion that nursing staff use the wasted appointment time to contact patents is being taken to the nurse lead next week. If nurses were to contact patients by phone, it is planned they could identify the reason for non-attendance (or not brought in the case of children or vulnerable patients), provide clinical advice and guidance to patients around the clinical need to attend their appointment, to offer a follow-up appointment, and also to advise the patient or carer of the practice's DNA policy (possible removal with continued DNA patterns). Other DNA appointments maybe contacted via text or email but will be documented in the patient records and coded, to ensure DNA searches run true. Missed appointments for children will be followed up with a letter, in line with the practices safeguarding policy. • Total Triage –Call data updated and added to the weekly monitoring spreadsheet which now covers 8 weeks of data. Weekly calls down by an average of 72.53% since before moving to total triage. An 89.89% reduction in calls in the first hour also since moving to total triage. Abandoned calls have reduced by 72.38 (87.90% in the first hour) and online consultations are up by 58.72% since moving to total triage. The practice will continue to monitor this data throughout GPIP. Data is being reported on at operational meetings. • GPAD- Reviewed slot types to ensure they align with national slot types and are picked up by GPAD. Change made where appropriate.
What was the impact?	The practice expects these interventions to equate to improved QOF scores, CVD targets and improvements to patient satisfaction. They have not yet been able to measure these longer-term outcomes as the programme has yet to be completed and the nature of the aims and subsequent impact requiring more time to be measured.

Project 100 Case Study

Thorkhill Surgery

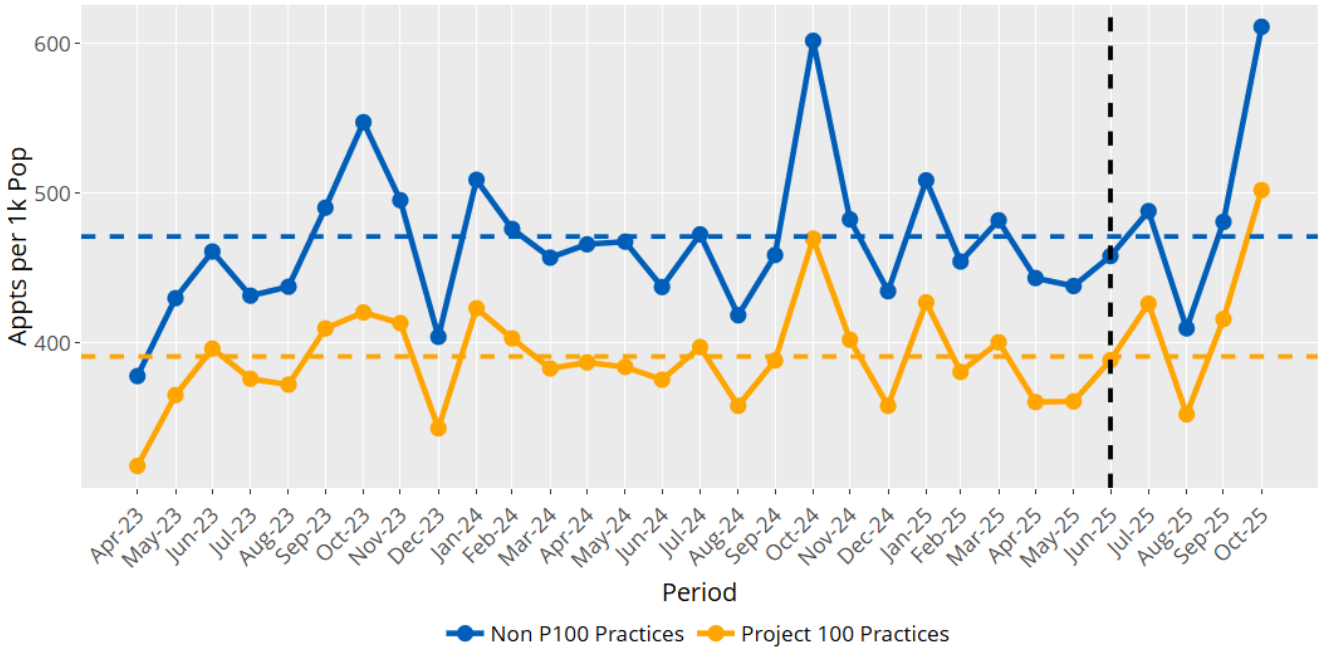
NHS England South East

What was required?	This approach was implemented to address specific needs within the practice that had been flagged through the Project 100 approach. The practice engaged with local ICB primary care team, work within the internal practice team and support from outside organisations.
What were the aims?	The practice was identified through the Project 100 programme, which was launched to address key areas impacting both staff and patients. These areas include Access and Patient Experience, GP Workforce, Clinical Outcomes and Care Quality, as well as Vaccinations and Screening. The programme aims to drive long-term service transformation by continuing to collaborate with the practice, building on the strong and trusted relationships established over time.
What was the solution?	The practice undertook transformation work by participating in the Surrey Heartlands ICB GP Development Toolkit which focused on improving continuity of care for patients, practice efficiency and outcomes for patients. The ICB team have been keen to continue conversations with practices around improvement following on from the Toolkit, in a way that is tailored to particular areas of focus. In the case of Thorkhill, access and patient experience were considered. To improve access and patient experience, the practice implemented a series of changes supported through four key areas: **1. Flexible PLS Support via Xytal** Working with Xytal, a delivery partner through the national PLS programme adapted for Surrey, we conducted appointment audits in May and December, alongside a manual review of peak times. These audits highlighted high demand during mornings and on Mondays and Fridays, informing the introduction of total triage. Staff planning meetings and Patient Participation Group engagement ensured a smooth transition, with an overlap in appointment booking until the new system was embedded. **2. AccuRx Six-Week Training Programme** To support the implementation of total triage, the team completed a structured six-week AccuRx course. This training strengthened operational processes and helped embed digital tools effectively, improving patient flow and responsiveness. **3. Accurate Data Capture and GPAD Refresh** Robust data was essential for monitoring progress. The ICB team provided support to refresh GPAD appointment mapping, ensuring accurate reporting and enabling better decision-making. Training was delivered to staff to maintain consistency in data capture. **4. Patient feedback** Patient feedback highlighted previous delays linked to staff turnover and training gaps. While reception staff GP contact remains above average, a targeted training plan has been introduced to address these issues and sustain improvements.
What was the impact?	The process has allowed the safe introduction of online access throughout core hours for patients. The transition to online access must be carefully considered, particularly for smaller practices and has been successful due to the additional thought and time required to ensure sustainability. The percentage of patients describing their overall experience of their GP practice as ‘very good’ or ‘good’ increased from 53% in 23/24 to 72% in the 24/25 GPPS survey results The percentage of patients describing their overall experience of contacting their GP practice on this occasion as ‘very good’ or ‘good’ increased from 49% in 23/24 to 59% in the 24/25 GPPS survey results. The practice showed improvements in a number of QOF indicators, highlighted in the GP Dashboard, for 24/25.

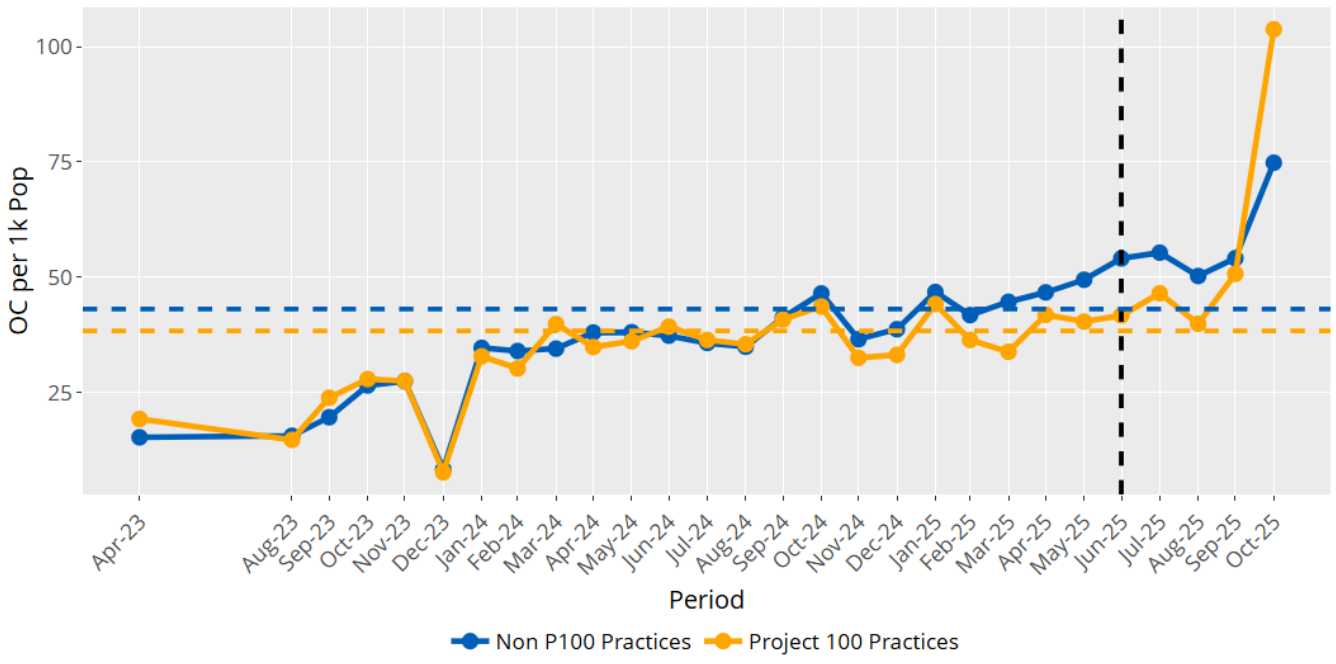
Annex 2

Data Graphics & Visualisations

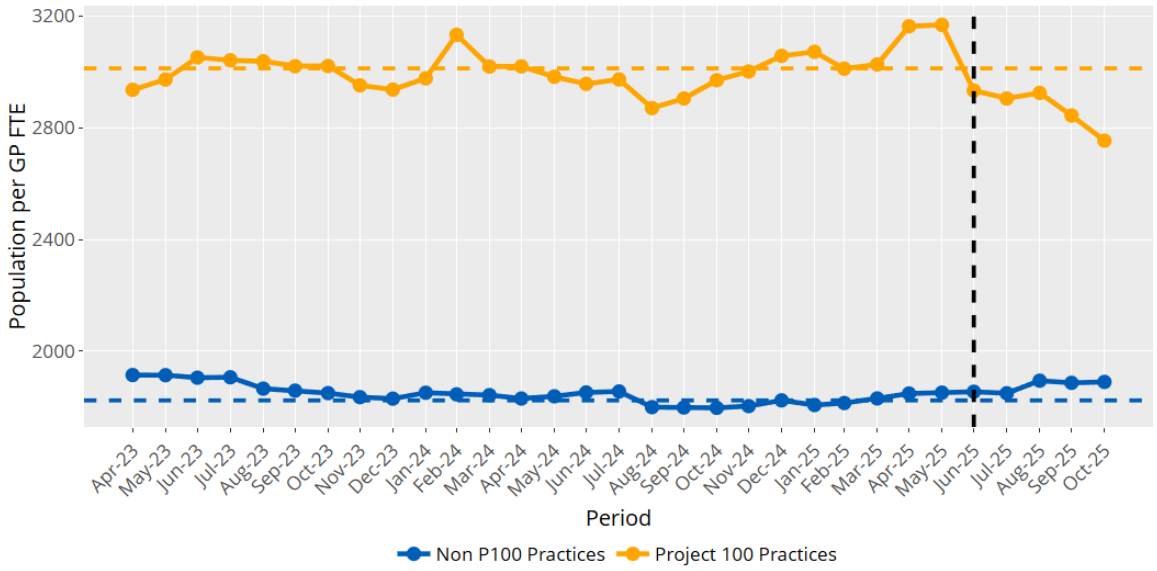
Practices Median: Monthly GP Appointments per 1k GP Registered Population



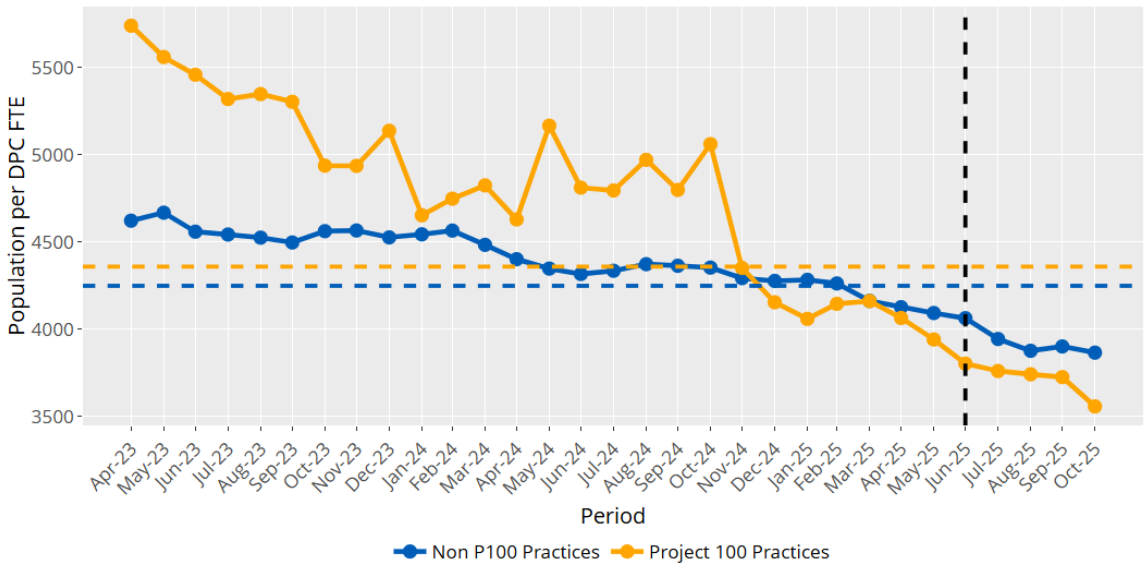
Practices Median: Monthly Online Consultations per 1k GP Registered Population



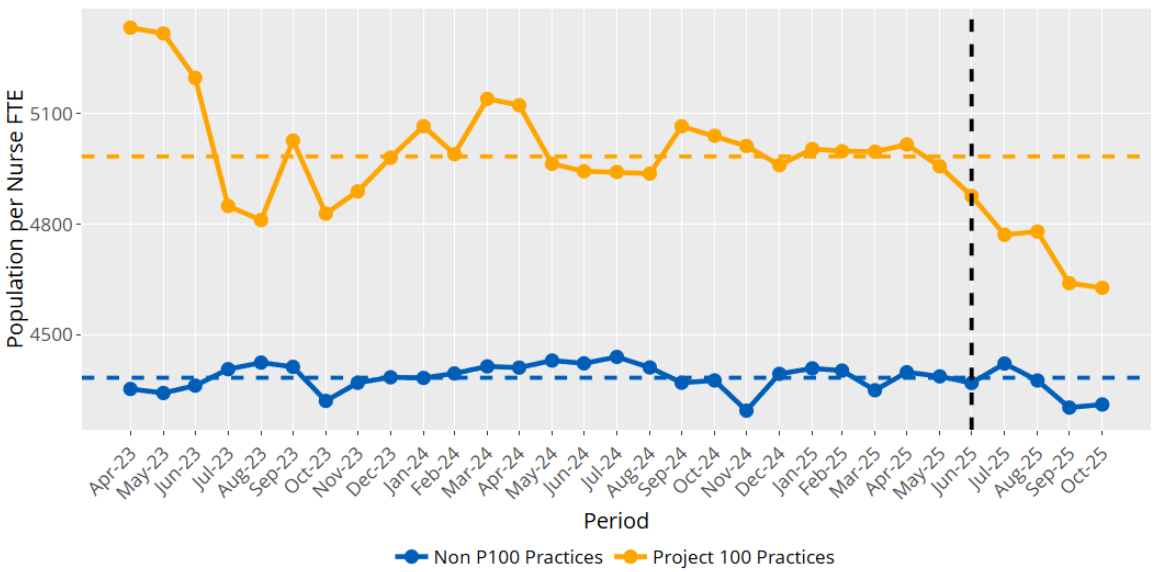
Practices Median: GP Registered Population per GP Full-Time Equivalent

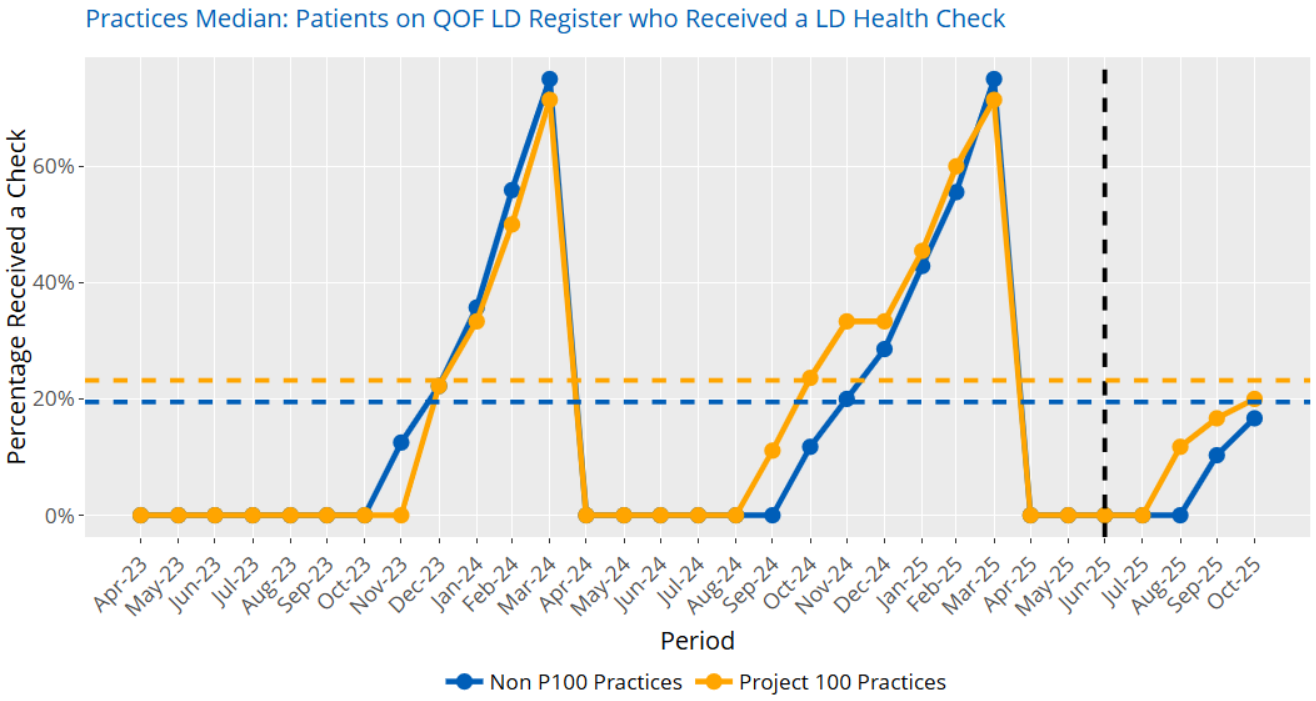


Practices Median: GP Reg Pop per Direct Patient Care Full-Time Equivalent



Practices Median: GP Reg Pop per Nurse Full-Time Equivalent




Practices Median: Patients on QOF LD Register who Received a LD Health Check
Percentage Received a Check
60%
40%
20%
0%
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Period
Non P100 Practices
Project 100 Practices