Healthy London Partnership

London General Practice Access Manual

Supporting the London General Practice Access Guide

September 2021

NHS Digital

RCGP Royal College of General Practitioners

EQUiP
ENABLING QUALITY IMPROVEMENT IN PRACTICE

Contents

Executive summary

The London General Practice Access Guide and supporting manual provide general practice teams with the evidence, current best practice, and resources to support general practice access improvements that benefit all Londoners.

The Healthy London Partnership (HLP) Transforming Primary Care team has led the London General Practice Access Guide and the manual's development. HLP's role is to bring together system leaders to support transformation and the HLP Transforming Primary Care Team have worked with general practice leaders and access experts, with input from the Practice Managers Association and Healthwatch, to collate, interpret, and present the material in the London General Practice Access Guide and supporting manual. The guide provides an overview of an inclusive, whole-system approach to general practice access and the manual delivers more detail, guidance, and resources.

An inclusive model of access describes an equitable access system that addresses inequalities to meet all Londoners' needs. A whole-system approach to general practice access brings together the multiple components needed to deliver good access and includes:

General practice activity: how we measure what we do, how patients contact their practice, the appointment types we offer, and matching capacity with need and demand.

Working with patients to improve access: improving patient experience and supporting patients with the correct information to help them self-manage their health needs.

The general practice team: recruiting and supporting general practice teams, how new team members, such as paramedics and social prescribing link workers, can help deliver good access.

Access beyond the practice: how practices' teams can help patients navigate the wider health and social care system to see the right person at the right time.

Making change: the methods and measures that can help implement access improvements.

General practice access is changing and evolving. These documents capture where we are at now, providing a platform to build on as new evidence emerges.

Providing good access takes effort and attention but brings real benefits. Understanding the needs of a practice population and implementing more efficient working methods will improve patient experience and create happier teams. Proactively managing demand can reduce the feeling of being overwhelmed. A systematic approach means teams can dedicate more time to patients with complex needs, work with a safe number of patient contacts, focus on team development, and have control over their working day.

The London General Practice Access Guide is aimed at the whole practice team and engaged patients to identify the specific projects that would help improve access for their population. The London General Practice Access Manual includes a wealth of further guidance and resources aimed at leaders of improvement projects to help them implement change. Commissioners can use both the guide and manual to consider what is needed in their area to support practices and Primary Care Networks (PCNs) to deliver access improvements.

We hope both documents will help your team wherever you are on your access journey.

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Figure 1: Whole-system approach to access

1. The London General Practice Access Guide and Manual

Practical resources to support London general practice in offering the best possible access to their patients, the guide and manual aim to:

- highlight a whole-system approach to achieving the best possible general practice patient access within available resources
- signpost to solutions that address access inequalities
- share good practice and effective access innovations.

We use the term 'general practice access' to include:

- patients registering with a general practice
- patients contacting the general practice team
- patients accessing a clinical or non-clinical contact
- patients receiving reactive or planned care
- patients accessing information to support their care.

The London General Practice Access Guide is aimed at all members of the general practice team, and this supporting manual contains more detail for those leading on access improvements. We hope it will help you understand the complexity and diverse resources general practice teams need to deliver the best possible access to their patients, and the benefits this brings to both patients and practice teams. We recognise that practices cannot achieve good general practice access on their own. It needs focus and support from partners throughout the NHS. As such, the guide and this supporting manual will also be valuable to commissioners, those working across Primary Care Networks (PCNs) and patients and carers working with practice teams to improve general practice access. We include guidance, resources, case studies and signposts to further reading.

1.1 How to use this manual

This manual supports the briefer London General Practice Access Guide – and includes more details, project ideas and resources.

The guide and this supporting manual are full of access improvement ideas. Each section will highlight:

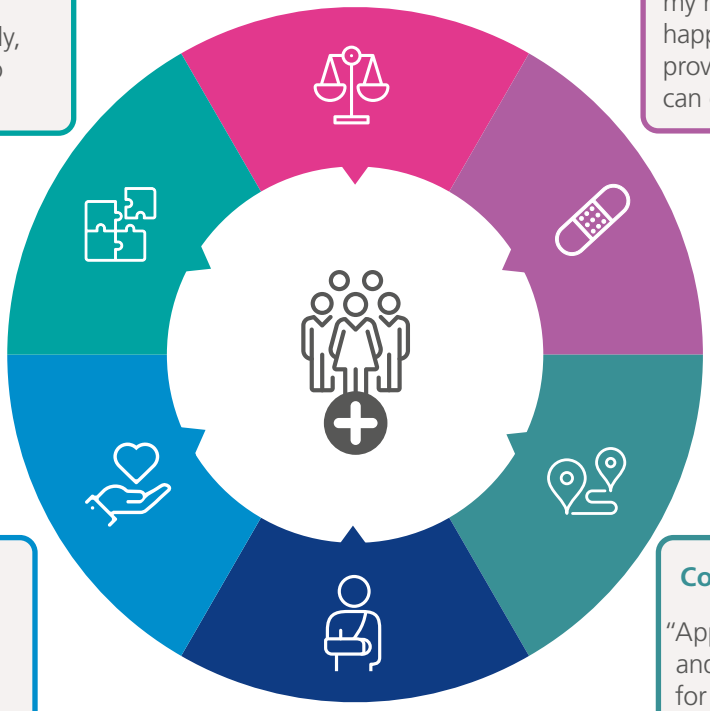
Key messages

Suggested improvement projects

When further resources are available

1.2 An inclusive model of access

Figure 2: An inclusive model of access



Equitable access

"My GP service understands and caters for my needs and preferences."

"The practice team make me feel welcome and at ease."

Balance between reactive and planned care

"I can get help quickly when I have an urgent need."

"I take part in decisions about my health, know what will happen next, who will be providing what and how I can contact them."

Convenience and need

"Appointments are available and held at times convenient for me."

"Most of my healthcare needs are met close to my home."

"I trust my practice team to prioritise patient need over convenience when this is necessary."

Patient choice

"I can choose to be cared for by the same person or people when this is possible and is important for my care."

"I can choose where I register if I am in the practice catchment area."

Balance between support for self-care and practice-delivered care

"I know when to take responsibility for my own health needs and how to find the information and support to do this."

"I know that I can work with my practice to improve not only my own health but that of others in my community."

Balance of established good practice and innovation

"I trust that the care and advice I receive is safe and good quality."

"My practice is proactive and connected, including digitally, to other parts of the NHS to benefit me."

1.3 General practice access in London

- General practice is at the heart of the NHS. It is the first port of call for many Londoners' health needs, with London general practitioners (GPs) providing over 40 million appointments each year.[1]
- A diverse population, wide health inequalities and a high turnover of patients are challenges faced by many London general practices.[2]
- Good general practice access encourages Londoners to use the right service for their healthcare needs and is a good value NHS resource.

1.4 Why a London Access Guide and Manual?

Providing good general practice access is complex and resource-intensive. Every practice is different and should tailor its access approach to local patients and practice needs and preferences. However, there are universal access themes we aim to capture in the London Access Guide and supporting manual.

- General practice is going through a period of unprecedented change. The guide and supporting manual highlight opportunities and help mitigate the risks of change on general practice patient access.
- The guide and supporting manual demonstrate the value and resource requirements of good patient access in London and support the case for better investment from the wider system.
- The guide and supporting manual provide practical support for practices on how they can work effectively and collaboratively to mitigate against health inequalities we see across London.
- London general practices have employed digital services rapidly, including online triage and remote consultations. These achievements need to be fixed and augmented to support the broader NHS strategy to use digital technologies to simplify patient access to primary care.
- The guide and supporting manual aim to complement the National Access Improvement Programme (AIP).

National Access Improvement Programme aims[3]

Increase the number of appointments in general practice by 50 million nationally
An improved appointments dataset
New patient experience measures
Targeted support to struggling practices
Single combined extended hours and extended access service delivered by PCNs

- London has a history of implementing effective access initiatives and was the first English region to deliver access 8am to 8pm, seven days each week. The guide and supporting manual build on London general practice successes to support practices to provide further improvements for patients.
- Emerging evidence suggests that effective quality improvement (QI) methods help practices deliver access improvements.
- The London Access Guide and Manual focus on core hours' of general practice. Access beyond this core offer is dealt with in Access beyond the practice, section 5.

Core hours general practice[4]

All practices must provide services during the core hours of Monday to Friday, 8am-6.30pm (excluding Good Friday, Christmas Day and bank holidays)
Each practice must provide essential services to meet patient need, whether the patient believes themselves to be ill, has a chronic disease or is terminally ill. Services must be delivered in discussion with the patient
Practices should also look to: • ensure arrangements are in place to access services in case of emergencies • demonstrate engagement with their Patient Participation Group (PPG) • meet the reasonable needs of the patients and address areas of concern

[1] NHS Digital (2020). Appointments.
[2] NHSE/IPSOS Mori (2020). General Practice Patient Survey
[3] BMA and NHSE (2020). Update to the GP contract.
[4] BMA. GP access, meeting reasonable needs.

1.5 Resources: General

Access requirements for GP practices
Update to the GP contract agreement 2020/21-2023/24
BMA GP access, meeting the reasonable needs of patients
GP Contract: NHS guidance and links to support General Medical Services (GMS) contract
Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan, January 2019
The NHS Long Term Plan, 2019
Next Steps on the NHS Five Year Forward View, March 2017
Next Steps to the Strategic Commissioning Framework: A vision for strengthening general practice collaboration across London, 2018
General Practice Forward View, April 2016

Understand your patient population
Patient experience and satisfaction
GP Patient Survey results: 2020
Public satisfaction with the NHS and social care in 2018: Results from the British Social Attitudes survey, The King's Fund, March 2019
Patient experience of GP surgeries: it's getting in that's the problem, The King's Fund, 2017

2. General practice activity

How we set up our appointment systems, measure what we do and respond to patient demand and need enables an effective and equitable access system.

This section helps by describing:

- the benefits of capturing activity data
- how to capture activity data
- how to match activity to demand and need
- how to use this data to improve patient access.

Activity data alone cannot deliver improvements and needs to be part of a system change. The Making change section of this manual looks at ways to use your data to deliver improvements.

"For an important part of what GPs do, such as managing uncertainty, there may be no reliable or valid measures but these nevertheless need to be valued."

RCGP (2017). 'Position statement on quality in general practice.'[5]

Figure 3: Mapping your activity

Each of these groups can be subdivided into more specific activities

[5] RCGP (2017). Position statement.

2.1 Measuring your activity

English general practices have historically used more than 400,000 different appointment types and codes, which evolved over time and were determined by individual practice appointment books. This variation limits the helpfulness of general practice activity data (GPAD) and has led to national appointment categories being developed, an important step towards consistency in activity measures within and between practices.[6]

NHS England definition of a general practice appointment: [7]

An appointment is a discrete interaction between a health or care professional and a patient, or a patient's representative

The roll out of the programme of Improving GP Appointment Data in 2021 includes a requirement for practices to map their appointments to national appointment categories. This should bring benefits to practices and PCNs looking to make access improvements.

Table 1: Potential benefits of mapping appointments to national categories

Practice benefits	Local benefits	National benefits
Better understanding of our daily activity (see figure 3: Mapping your activity)	Help inform and understand demand and pressures in general practice	Actively capture and demonstrate the sheer scale of general practice activity
Share data and learning with other practices and PCNs to support improvement	Identify areas which do not have enough clinical resources and inform service planning, including new services and new service models	Demonstrate and make the case for extra investment in general practice
Help develop services at practice and PCN level that best meet patient needs and deliver best value	Understand the use of new roles to ensure optimum take-up and use across practices (Additional Roles Reimbursement Scheme (ARRS)). See 4.2.1 in The general practice team section	Give insight about different ways of working and variation across the country
Clear and consistent appointment names will make it easier for patients using online booking, including using the NHS App[8]	Support business continuity planning if a practice has to temporarily close for any reason, such as flood, fire, utility failure, sickness, or COVID-19 (Operational Pressures Escalation Levels)[9]	
Meets national requirements for appointment mapping		
Identify potential pressure points enabling flex of capacity to times of peak demand		
Plan best-value deployment of team members and skill mix		

[6] NHS Digital. Improving GP appointment data.
[7] NHSE, NHSI, BMA. More accurate general practice appointment data.
[8] NHS Digital. The NHS App.
[9] Nuffield Trust Blog. Black Alert?

Table 2: Description of national appointment categories

NHSE Appointment description[7]			
✓	**All healthcare professionals** Includes an interaction with any health or care professional	✗	Excludes purely administrative interactions between practice staff and patients including non-clinical/automated triage or administrative signposting
✓	**All modes of contact** Includes all modes – face to face, telephone and remote interactions	✗	Excludes work undertaken by a health or care professional that does not involve patient contact, for example Multi-Disciplinary Team (MDT) meetings, case conferences, reviewing results, audit, training, supervision
✓	**All settings** Includes an interaction at any primary medical care setting (including the practice, patient's home, community, care home, group consultations, local GP extended access hub)	✗	Excludes all clinical administration activity, including writing referral letters and repeat prescriptions, audit, training, supervision

There is guidance on how to map your appointments to the national appointment categories[10] and practices are required to record all appointments in this way. System specific guidance and tips have been developed with NHS Digital.[11] This is an evolving landscape, so keep an eye out for changes.

Table 3: Example of mapping appointments to national categories (EQUIP)

Slot type	Service setting	Context type	National slot category
Telephone triage	GP practice	Care-related encounter	Triage
GP face to face	GP practice	Care-related encounter	General consultation acute
Antenatal	GP practice	Care-related encounter	Scheduled/planned clinical activity
Chronic disease management	GP practice	Care-related encounter	Scheduled/planned clinical activity
Walk-in	GP practice	Care-related encounter	Walk-in clinic
Blood test	GP practice	Care-related encounter	Scheduled/planned clinical activity
Adult safeguarding	GP practice	Care-related activity	Multidisciplinary team meeting/ patient collaboration meeting
Protected learning time	GP practice	Admin and practice staff activities	Training/mentoring/supervising

[10] Standardised GP appointment categories

[11] Appointments in General Practice report – NHS Digital

Tips for appointment mapping
By following a standard process, appointment mapping should take 1-2 hours
Using a tool like Edenbridge can make this process more straightforward
Archive unused slots in advance to make process quicker
Breaks should be categorised as admin and practice activities – break, and made non-bookable so they are not counted as unused appointments
Activity such as Continuing Professional Development (CPD) commitments should be recorded and categorised, such as under the category Receiving training and/or being the mentee.
Record Did Not Attend (DNA) appointments
If a patient cancels at short notice and there's no time to offer the appointment to another patient, it is a DNA
Use a double screen or print out the national categories list to match to your appointment groups
Use different colours for different appointment types to make things clearer
Don't use special characters such as* – they compromise data extract
Clear and consistent naming of slot types helps patients understand what appointment they are booking when booking remotely – online and from the NHS App
Focus on frequently used appointments and sessions – don't get distracted by exceptions

Once your practice has mapped its appointment book to the national categories, you will be in a better position to understand your appointment activity and use this understanding to decide which areas to improve.

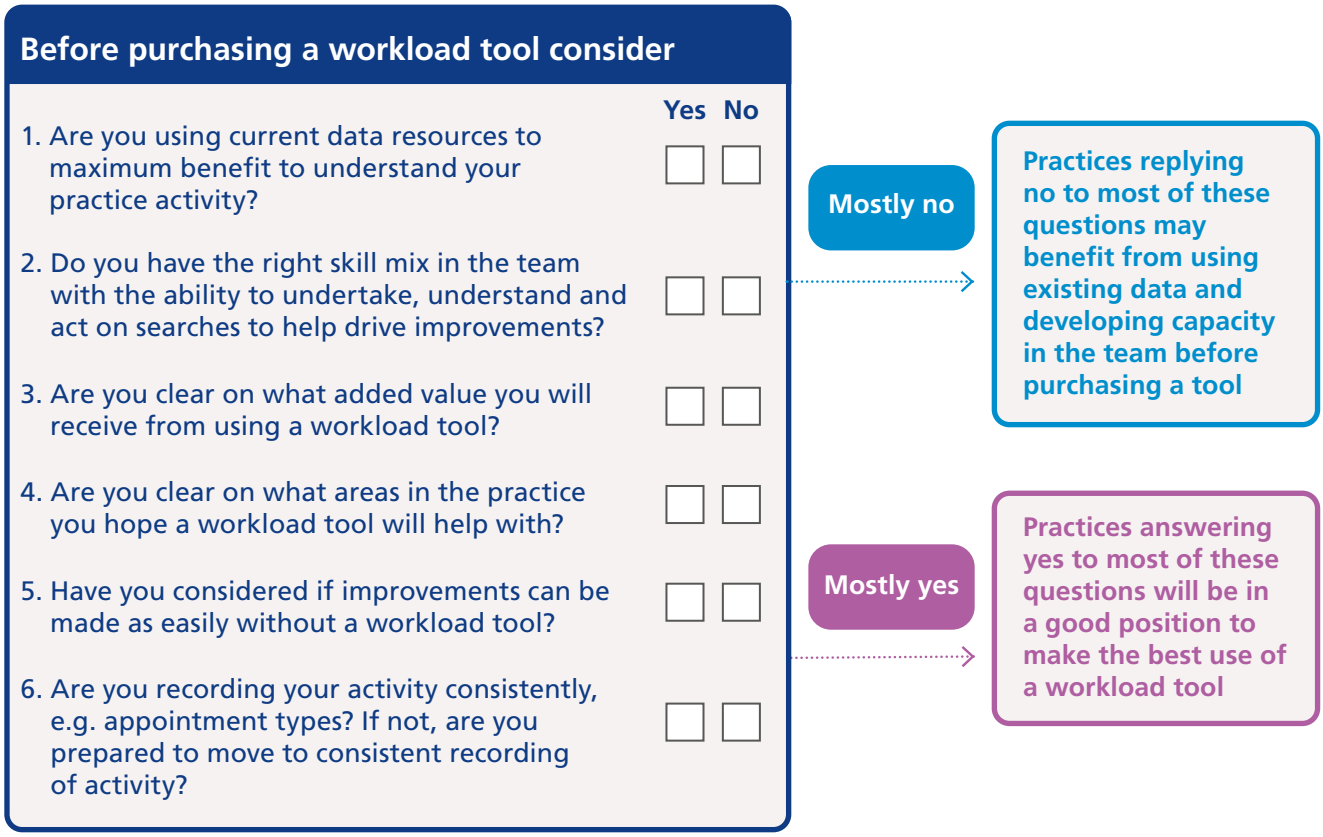
2.2 Tools to measure activity

Workload tools can help pull your appointment data out of your system and present this back to you in a way that helps you plan.

For best use of a tool to help with access improvements teams needs to categorise and consistently record their appointment activity.

Before considering buying a tool, work through figure 4: Considerations before purchasing a workload tool to check your needs.

Figure 4: Considerations before purchasing a workload tool



2.3 Need, demand and capacity

Patients with health needs do not always present to health services. Those who may benefit from general practice care may present in other parts of the system less able to meet their needs.

Matching capacity to need, as well as demand, is critical for effective and equitable access and a particular challenge for the many London practices serving deprived populations.[12]

The best appointments systems are flexible and constantly refined in response to data and staff and patient feedback, balancing capacity between demand, need, on-the-day and planned care, episodic and continuity of care.

A good place to start is by mapping your current appointment system processes, ideally with input from patients and carers, reception team members and clinicians. This will identify bottlenecks, constraints, problems and opportunities – see figure 30: Process mapping in the Making change section of this manual.

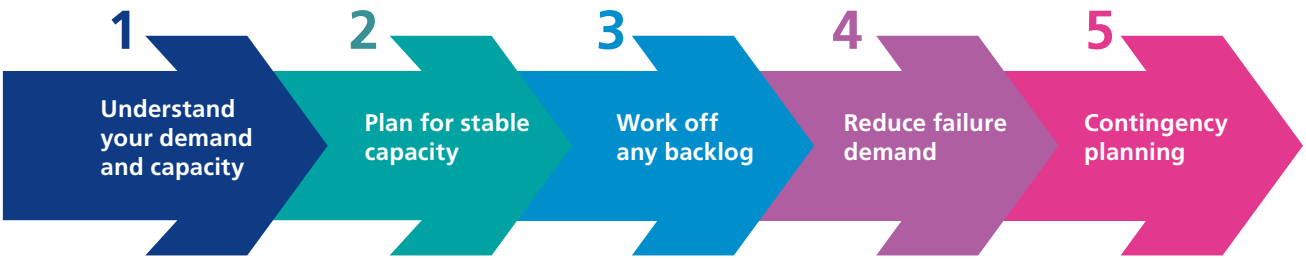
If your practice struggles to meet patient needs within your available resources, share data and learning with your PCN colleagues and seek further support from your commissioners or Local Medical Committee (LMC).

[12] Julian Tudor Hart (1971). Inverse Care Law.

Table 4: Terms and definitions[13]

Recognised terms	Definitions	Notes
Need	The capacity to benefit from healthcare	**Expressed need:** patients with real and perceived needs who seek help. This need may be met in general practice or by, for example, self-help **Unexpressed need:** patients with needs who do not present to health or other services
Demand	What patients ask for	This is, or can be, a form of **expressed need**
Supply	The healthcare provided	Also termed **activity/utility**
Capacity	What we could be doing	1. Care related: patient contact 2. Care related: non-patient contact 3. Admin and practice staff activities See figure 3: Mapping your activity
Activity/utility	What is actually being done (equivalent to **supply**)	
Backlog (queue)	Build-up of uncompleted work: backlog = no of days wait for a routine appointment x appointments offered over that no of days	If demand exceeds capacity or variation in demand is not met with matching variation in capacity, a backlog will develop
Failure demand	Duplication, waste and inappropriate use of time	"The demand placed on the system, not as a result of delivering value to the 'customer', but due to failings within the system." J. Seddon[14]

Steps to matching need, demand and capacity



[13] Wright J and others (1998). Development and importance.

[14] Downham, Nick and Cressbrook Ltd. Sources of Failure Demand.

2.3.1 Understand your capacity and demand

Table 5: Understanding your capacity and demand

Capacity	Demand
Use appointment naming described above	Demand audit over a minimum of two weeks at different points of the year
Count appointments offered by type and clinician	Set standard patient appointments/week and see if this meets demand
Review appointment distribution over the week and year	Use historical demand to inform standard
Include all patient contacts and consider using a tool to help	Undertake a Primary Care Foundation 'Potentially Avoidable Appointment Audit'[15]
Review capacity in both your clinical and non-clinical teams	Align to continuity: what percentage of contacts would benefit from continuity with a clinician?
Understand your DNA rate	What is unmet demand: phone calls dropped, patients advised to return/call at another time?
Balance reactive and planned capacity	What is the demand from patients who attend very frequently?
If possible, look at re-attendance rates – how many patients are seen again within 14-28 days	

Unmet need is challenging to measure but here are some suggestions:

- Count 'Just say no' for 1-2 weeks – patients wanting an appointment who are asked to call back later or another day or use another care setting.
- Patients' use of other services, some of which may represent care that could be better offered in general practice. For example, for Extended Primary Care Access (EPCS) Hub, use Accident and Emergency Department (A&E) presentations that have no investigations or treatment (coded as VB11Z).

See Suggested improvement projects: 1. Matching capacity and demand – Appendix 2.

2.3.2 Provide stable capacity

Stable capacity is important to prevent backlogs. If a GP session doesn't happen, it will have a bigger impact on access than the usual variation in patient demand. Practices should agree on a minimum, stable appointment number per day or week with variation based on historical demand over the year (ensuring clinicians' workload does not exceed safe levels).[16]

The many demands that take clinicians away from patient-facing care need to be factored in, but not at the expense of agreed appointment commitments. Plan for the impact of meetings and other professional commitments with appointments later in the day or week to cover those missed.

See Suggested improvement projects: 1. Matching capacity and demand – Appendix 2.

[15] Primary Care Foundation. Potentially Avoidable Appointment Audit. [16] BMA. Safe working in general practice.

Plan for stable capacity If capacity is not used, it is lost, whereas some demand will carry over to the next day
Leave policies and cover arrangement to provide stable weekly capacity
Clinicians to agree on an individual weekly appointment commitment or number of patient contacts
Ensure enough capacity for non-patient-facing work
Contingency plans in place for unpredictable events, such as clinician illness
Collaborating with neighbouring practices and sharing the workforce to prevent capacity fluctuations
Have a clear policy for using locums for planned and unplanned leave

2.3.3 Working off any backlog

In ideal circumstances, before introducing any new appointment system, it is best practice to work off any backlog – to give the new system every chance of success. This means offering additional capacity for a short period to clear those patients waiting, so you no longer have a wait when the new system starts.

Suggestions for working off your backlog
Employ a locum to do extra sessions
Add additional appointments to each session
Agree a time without leave to maximise capacity
Align changes to the appointment system, such as introducing telephone appointments with initial excess capacity

2.3.4 Reduce failure demand

Not all activity (and some work in the backlog) is necessary, such as rework, duplication and failure demand, which are wasteful.[14]

Examples of failure demand:

- Escalating expressed needs because of delays in treatment pathway or increasing anxiety.
- Patients with complex needs who require continuity being seen by a locum clinician.

See Suggested improvement projects: 4. Identify bottlenecks – Appendix 2.

Reduce failure demand
Communicate to patients about their points of access so they use the most appropriate contact method for their needs
Actively promote and enable digital solutions, ensure your website is up to date with prominent links to self-service, self-care and self-referral (see Working with patients section)
Practice team have a consistent approach to, e.g. prescribing, signposting, referrals
Support remote triage with online consultation tools and telephone
Use of the multidisciplinary team (MDT) in your practice and PCN
Introduce a system for tailoring management of patients who frequently present
Review recall rates
Put systems in place for relationship-based care and continuity
Create effective back-office functions – for referrals, repeat prescriptions, letters into notes
Work with colleagues from other services to reduce failure demand resulting from other providers. For example, secondary care not communicating to the practice or patient, or not arranging follow up for investigations, leading to additional contacts in general practice

Table 6: Myths about demand and capacity (EQUIP)

Myth	Myth buster	Notes
Demand is infinite	**Demand may be high but it is not infinite**	Demand will feel infinite if it is routinely not met. If demand were infinite, then waits for appointments would get exponentially longer. Most GP practices operate a relatively stable system in that the wait for an appointment is relatively constant. This is usually achieved by mopping up on-the-day excess demand with a 'duty doctor' or 'on-call' system
Demand is unpredictable	**Demand is predictable and often less variable than capacity**	Variation in demand over the week and year is predictable with Monday being the busiest day There is variation in demand between patient groups, but this is relatively stable for a practice population
Capacity is stable	**Capacity needs to closely mirror demand – if average capacity meets average demand but there are peaks and troughs in the capacity, bottle necks will arise**	Use contingency planning to mitigate the impact of: Predictable variation in capacity, e.g. annual leave, non-patient-facing work Unpredictable variation in capacity, e.g. sickness, can be mitigated by contingency planning Loss of capacity, e.g. a GP session not happening, will have a bigger impact on access than the usual fluctuations in patient demand

2.3.5. Contingency planning

As well as meeting the requirements of business continuity planning[17], which focuses on emergencies and major incidents, teams need plans in place for the more mundane and frequent issues that arise and affect access. Planning for staff illness in advance reduces staff stress, patient inconvenience, and the risk of presenteeism[18] when colleagues feel they have to come to work when unwell.

Table 7: Examples of what to include in contingency plans

Agree on plans with the team and document them as policy, empowering staff to act when issues arise	
Clinician short-term illness	Cancel appointments – recognising this will impact on stable capacity
	Work within your PCN for a shared response with patients being seen in another setting for risk-sharing approach
	Share workload among other clinicians, recognising this can only be a short-term solution as it can be stressful for the remaining team
	Employ a locum but recognise this is expensive and may not be possible. Have a list of regular locums who may be able to do sessions at short notice
Clinician longer-term illness	Consider insurance policy to cover locum costs
Receptionist sickness	Create a flexible team to cover various roles

2.4 Points of access: how patients contact their practice

How patients contact their practice is going through rapid change with the increase in digital solutions – accelerated by the need for reduced face-to-face contacts during the coronavirus pandemic.

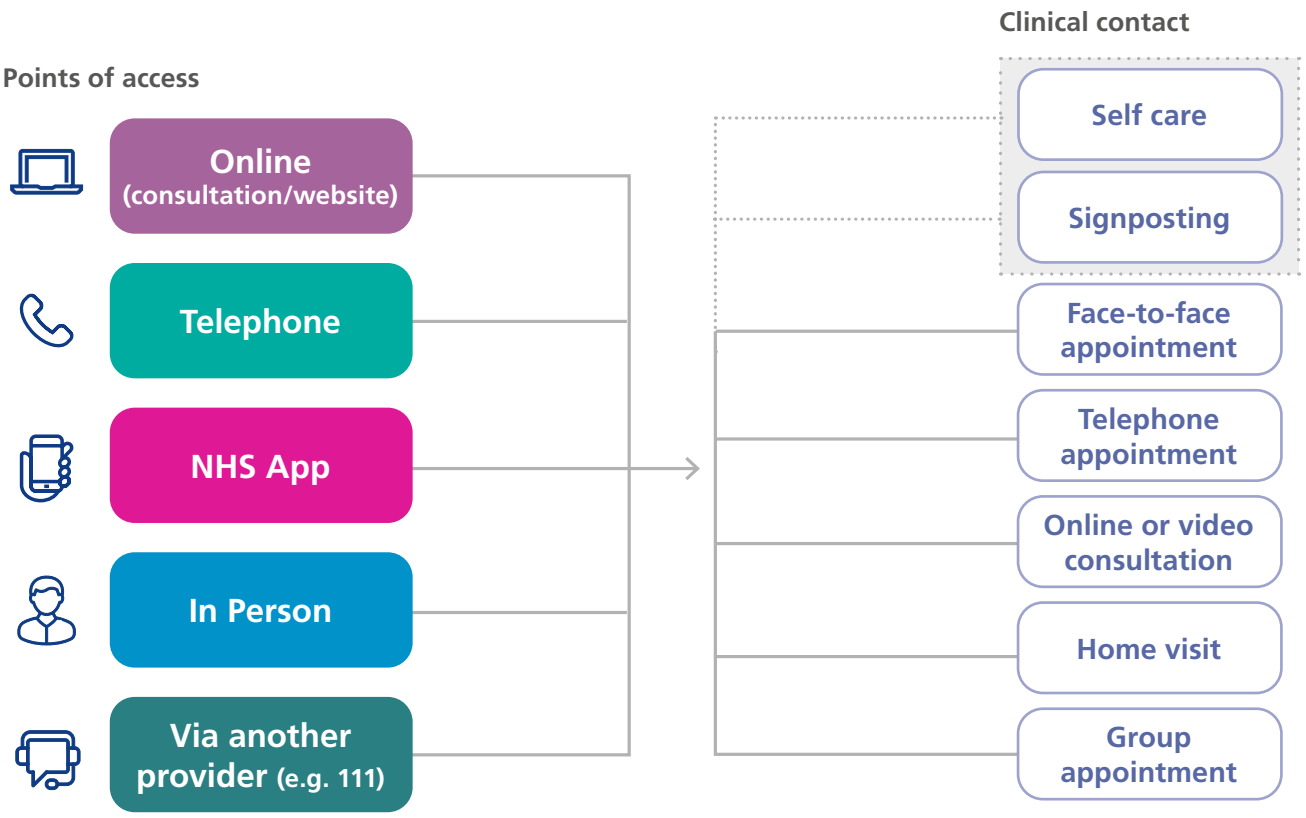
Practices must inform patients what appointments are available to them and the various ways they can access care.

Patients need a steer and support to understand how self-care, online triage, and telephone consultation can meet their needs rather than default to requesting face-to-face contact.

[17] CQC. Nigel's surgery 69.

[18] BMJ (2015) Why doctors need to resist 'presenteeism'.

Figure 5: Points of access and clinical contacts



Each point of access needs a clear pathway, inclusive of all patients and flexible in response to feedback and underpinned by practice policies. Fixed contact times and rigid systems, e.g. only phone between 8am and 10am, can cause bottleneck, long waits, patient frustrations, and staff stress, making it particularly difficult for patients with the greatest need to access care. Patients value having a clear contact time, for example, within a two-hour timeframe, for telephone and online contacts, reducing the risk of missed calls. Staff training can minimise the risk of antagonistic patient encounters and both patient and staff dissatisfaction. How to communicate your points of access is a topic well suited to work with patients to ensure your system best meets their needs.

Practice teams may agree on a preferred mode of access which is then given greater prominence and then promoted, communicated and resourced ahead of other points of access. For example, if a practice's preferred mode of access is online consultations, these contact details should be placed with greater prominence on the practice website, with a prominent banner. Staff should be trained and deployed to meet the demand through this method of contact.

The role of front desk teams in signposting patients to self-care can free up valuable clinical time, allowing clinicians to focus on the most vulnerable patients. Your points of access need to align closely to your capacity and demand work as the best-designed system can only work if there is available capacity to meet demand or need.

Consider a project to involve Social Prescribing Link Workers (SPLW) or volunteers to work with digitally disadvantaged patients to ensure equity (see Equality and equity section) or to install a smart telephony system.[19]

[19] Building Better Healthcare (2017). How the telephone can help.

2.5 Appointment types

There is no perfect appointment system; they all include trade-offs between convenience, continuity, resource and equity.

Aim for a blend of appointment types that best meet the needs of your patients, the team and the wider system. Inform your choice by using activity data and patient and staff feedback, balancing:

- **reactive care and planned care**
- **episodic and continuity of care**
- **patient-facing and non-patient-facing work.**

A structured appointment book gives clarity but should also offer flexibility in response to the demands of the day, offering contact types to meet individual patient circumstances and needs. Carving out inflexible times for each appointment type risks wasting valuable capacity and contributes to clinician stress. Systems that capture information ahead can make appointments more effective, e.g. online triage or front desk teams asking pertinent questions. This helps prioritisation based on need and clinicians to be ready with the right results or information for patients. Front desk teams need clear guidance and training to avoid the risk that patients view their questions as intrusive. A careful balance is required between offering appointments on the day and protecting time for planned care. Whenever possible, aim to offer patients continuity.[20]

See Appendix 2: Suggested improvement projects 3. New modes of contact and 9. Continuity of care

Appointment length is a challenging issue, with many patients presenting with complex issues impossible to deal with in a 10-minute appointment. **Consider longer appointments for patients with complex needs and which member of the team is suited to the patients' presenting need, for example, a longer contact with an SPLW for patients with social needs.**

Ask patients to prioritise what is important to them, rather than imposing inflexible rules such as only one problem per appointment,[21] which can create more work and patient frustration.

Carving out and segmentation[22]

We have often dealt with healthcare problems by prioritising, ring-fencing or **carving out** the time of an expert, with the time spent using specialised equipment or keeping resources or facilities only for one group of patients. By carving out in this way, the process of care for one group of patients is prioritised over another irrespective of their needs.

For example, if a GP practice gives priority to all pregnant women with diabetes and offers them urgent appointments, it means another patient group, for example patients without diabetes, may have to wait. Prioritising in this way, or carving out capacity for one group of patients, interrupts the flow for other patients who inevitably end up waiting longer.

Accurate measuring of the backlog or waiting time for other groups of patients has shown that carving out capacity significantly increases waiting times overall and creates a difficult system to manage effectively.

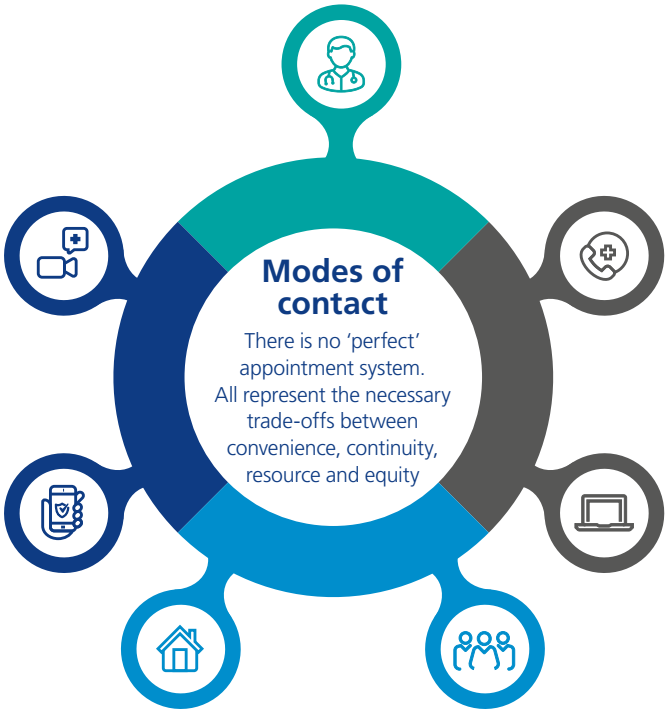
Segmentation is about separating the whole process of care for one group of patients but not at the expense of other patients.

Capturing your activity data (see 2.1 Measuring your activity) will allow your team to reflect and adapt or refine your appointment offer. Appointment systems need the flexibility to respond to external factors, such as the rapid shift to remote consultations during the coronavirus pandemic, with clinicians re-evaluating what was safe to manage remotely in dramatically changed circumstances.[23]

There is no 'best' appointment type. Clinicians need to be trained, confident and supported to deliver a range of modes.

[20] RCGP (2020). Remote vs face-to-face.
[21] Mona Kular (2018) Consultation skills.
[22] The NHS Institute for Innovation and Improvement. Matching Capacity and Demand.
[23] NHSE. Third Phase response to COVID-19.

Figure 6: Modes of contact



Face to face
Valued by patients and clinicians, face to face consultations are important for building trust and rapport, complex cases, breaking bad news and when a physical examination is needed. Ensure your system has capacity to meet patient needs for face to face contacts.

Video consultation
can replace face-to-face appointments or when a clinician is carrying out a telephone consultation they may switch to a video to help their assessment. Some patients may prefer the convenience of video over coming into the practice for planned or reactive care. Practices should use an NHS-assured system.

Telephone triage and appointments
mean different things in different teams depending on ways of working. A reactive care telephone contact is often termed 'triage' and a planned telephone contact 'telephone appointment' – but once a clinician speaks to a 'triage' patient they may manage the consultation in that contact – and not triage to another service or appointment.

Practices should be clear about their terminology and coding, aim to align as closely to the emerging national appointment classification, for shared learning across practices.

Text and secure online messaging
are useful tools for simple messages to patients and to send resources and documents. The use of secure online messaging as part of your access system can free up capacity for patients who need more personal contacts. Some tools allow two-way conversations and for patients to complete a questionnaire ahead of an LTC review. Use secure, approved systems only.

Online consultation
can be used to ask questions, report symptoms, submit an administrative request and discuss other information, including the review of a known problem or condition, and upload photos where appropriate. The practice usually triages the request and responds within a stated timeframe. SPLW, volunteers and front desk staff can support patients to enter details for an online consultation to reduce the risk of digital inequality.

Home visits
are an important part of general practice and invaluable for some vulnerable patients for both reactive and planned care. New members of the clinical team, such as pharmacists and paramedics, are well suited to undertaking home visits (see members of The general practice team section 4). Use of mobile IT systems, e.g. EMIS remote, can make home visiting more effective.

Group: face-to-face or virtual
involves two or more patients being seen at the same time by one or more health professionals. Practices are increasingly using group consultation for patients with long-term conditions, and report improved outcomes, patient experience and value.

Those practices providing remote contacts pre-COVID-19 were best able to respond flexibly to the pandemic.[24] The pandemic has accelerated the move to more remote contacts.

The NHS has produced helpful training material for practice staff to support a remote triage model.[25] Also, see the Resources section 2.7 for further practice support.

[24] Health Foundation (2020). How has COVID-19 affected service delivery.

[25] HEE. Remote total triage.

Figure 7: Advice for using new appointment types.[26]

For patients

- Ask for a timeslot for when your remote consultation will take place
- Let your healthcare provider know if you prefer to talk by phone, video or in person
- Find somewhere quiet and confidential and, if this isn't possible or is tricky, make this clear when you are making your appointment
- Start with a phone call if you're not confident using video technology
- Ask for help if you need it and, if possible, do a practice run with a friend
- Take some time to prepare in advance, consider what you want to say and key questions you would like to ask
- Ask your healthcare provider to summarise the next steps at the end of the appointment
- Remote consultations can be useful for routine appointments or ongoing care with a healthcare practitioner
- Not all appointments are suitable for remote consultations – if you would like to see someone in person, please say so

For health and care professionals

- Provide a precise time for appointments
- Check that the person is in a confidential and safe place to have the phone or video call
- Understand the person's level of confidence using technology and give people a choice of how to communicate
- Proactively check what the patient needs, clarify what is happening next and who is responsible for the next stages of care
- Slow down the pace of the consultation, demonstrate active listening
- Don't ask people to provide information you already have access to
- Give guidance about how the appointment will work
- Seek feedback about people's experiences and use this to improve the service

Mitigating digital inequalities with the move to more remote appointments[27]

- Clear messaging on access options across website, phone service and practice door
- Identification of patient access needs during triage
- Work closely with patient advocates and provide translation services
- Flexibility to change appointment length
- Maintaining an outreach primary care service

[26] Healthwatch (2020). The Doctor Will Zoom You Now.

[27] Verity and others (2020). Does total triage.

2.6 Management of Did Not Attends (DNAs)

"Every system is perfectly designed to get the results it gets."

Institute for Healthcare Improvement [28]

"To reduce non-attendance, it appears that the appointment system needs to change, not the patient."

Tom Margham, GP, EQUIP[29]

Did Not Attends (DNAs) result in wasted appointments, reduced clinical capacity and inequality of access to healthcare.

Efforts to reduce DNAs often consider them in isolation and focus on patient behaviour by using reminders, flagging the cost of missed appointments and implementing practice policies to warn and de-register 'repeat offenders'. Many vulnerable patients, especially those with mental health problems, struggle to manage existing general practice appointments systems and repeated DNAs is a marker for poor health outcomes.[30] A change in how your appointment system is managed to suit patient needs better will have a greater impact than focusing on patient behaviour.

74% of DNAs occur when the time between booking and attending an appointment is more than one day[29]

- **An appointment book that provides a flexible offer of appointment types and times suited to different patient groups and responding to patient feedback is likely to have fewer DNAs, such as remote consultation for long-term conditions (LTC) reviews for working people.**
- **Many practices have seen a reduction in DNAs since moving to clinical triage (online and telephone) models of access in the post-COVID-19 era. This may have a positive impact on overall capacity.**
- **Patients and carers are more likely to be available if practices give them a clear timeframe in which to expect a call, reducing repeat calls and 'failed encounters'.**
- **Patients should be clear on what the practice can offer them, and what is reasonable for the practice to expect of them, such as attending booked appointments or cancelling in a reasonable time. Have a clear system for patients who repeatedly miss appointments and, ideally, communicate this in a practice welcome pack or practice charter** (see section 3.2)**.**

2.6.1 Vulnerable patients who DNA

Consider safeguarding concerns for vulnerable patients who miss appointments, for example, children who regularly miss immunisation or vulnerable adults missing booked reviews.

When an acutely unwell patient doesn't attend, including mental health presentations, demonstrate and document that you took all reasonable and timely steps to investigate the circumstances and need for care.

Agree a practice system to follow up:

- patients who repeatedly miss hospital appointments when this may indicate a safeguarding issue
- when an acutely unwell patient misses a planned appointment, including mental health presentations
- any DNA from a two week wait referral.[31]

[28] Institute for Healthcare Improvement. Like Magic?
[29] T Margham and others. Reducing missed appointments.
[30] McQueenie and others. (2019). Morbidity, mortality and missed appointments.
[31] MDU. Who takes responsibility for missed appointments.

2.7 Resources: General practice activity

R

Improving access: General

How to access your GP practice: Short NHS film on how to access your GP practice, viewed January 2021

Treating Access: a toolkit for GP practices to improve their patients' access to primary care, Royal College of General Practitioners

NHS Practice Management Network: Improving access, responding to patients – A 'how-to' guide for GP practices, 2009

NHSE/I: Improving access to general practice, viewed December 2020

Appointment mapping

Improving GP appointment data, NHS Digital, viewed February 2021

Understanding capacity and demand and releasing time for care

Capacity and demand

NHS Institute for Innovation and Improvement: Matching Capacity and Demand guide 2005

Demand and Capacity guidance, West of England Academic Health Science Network, viewed December 2020

Meeting need or fuelling demand? Improved access to primary care and supply-induced demand, Nuffield Trust briefing, June 2014

NHSE: Fundamental concepts in demand and capacity, viewed December 2020

Reducing Did Not Attends

British Journal of General Practice: Reducing missed appointments in general practice: evaluation of a quality improvement programme in East London

Rethinking DNAs

Releasing time for care

NHSE: Releasing Time for Care programme, viewed December 2020

NHSE: 10 High impact actions to release time for care, viewed December 2020

The Health Foundation blog on GP waiting times: learning from the past, 2019, viewed December 2020

Business Continuity Planning

CQC: Nigel's surgery 69: Business continuity – arrangements for emergencies and major incidents, viewed December 20

Remote triage

Advice on how to establish a remote 'total triage' model in general practice using online consultations. NHS September 2020

Top tips: phone triage and remote consultations, Guidelines in practice, viewed December 2020

R

Remote triage
Remote vs face-to-face: which to use and when? RCGP, November 2020
eLearning for Health: Remote Total Triage Model in General Practice, viewed December 2020
e-learning for Health: Remote total triage for general practice administrative staff, viewed December 2020
Case study: Using telephone technology to support GP mergers and improve the patient experience. Building Better Healthcare, Feb 2018
Setting up a Total Triage System, EQUIP east London
NHS Futures: Digital triage demand calculator, March 2020

NHS App
NHS guidance on the NHS App, viewed December 2020
NHS Digital resources for NHS App use
eGP learning short film: How to Register with the NHS App, viewed December 2020
Promoting the NHS App, EQUIP, east London

Remote consultations in primary care
Digital First Primary Care
NHS: Using Online Consultations in Primary Care Implementation Toolkit, January 2020
Increasing Online Consultations, EQUIP, east London
Video consultation information for GPs, NHS England and the University of Oxford guidance, March 2020
Comparing the content and quality of video, telephone, and face-to-face consultations: a non-randomised, quasi-experimental, exploratory study in UK primary care, British Journal of General Practice, 2019
Alternatives to face-to-face consultations in primary care – University of Bristol, Centre for Primary Care, viewed December 2020
eGP learning: Dr Gandalf's resources for technology enhanced primary care, viewed December 2020
The potential of alternatives to face-to-face consultation in general practice, and the impact on different patient groups: a mixed-methods case study, NIHR, 2018
ViCo toolkit – A guide for GP practices wishing to set up video consultations through the internet Usher Institute, University of Edinburgh, viewed December 2020
The Doctor Will Zoom You Now: getting the most out of the virtual health and care experience. Insight report, June-July 2020
ARC Remote consultation Education hub: Free educational resources to give you practical advice on remote consultations, viewed December 2020
RCGP/NHSE Principles for supporting high quality consultations by video in general practice during COVID-19 August 2020
Acceptability, benefits, and challenges of video consulting: a qualitative study in primary care, BJGP, 2019
Remote vs face-to-face: which to use and when? RCGP November 2020, viewed January 2021

R

Group consultations

Primary care children and young people's toolkit: Resources to support group consultations for children and young people Healthy London Partnership, viewed December 2020

Introducing group consultations for adults with Type 2 diabetes. Case study: The Atlas of Shared Learning – NHSE, viewed December 2020

A systems approach to embedding group consultations in the NHS, RCP, Future Healthcare Journal, 2019

City and Hackney Group Consultations pilot, viewed December 2020

Home visits

Technology to ease your workload on home visits RCGP bright ideas, viewed December 2020

Home visits are a core part of general practice – and invaluable for some vulnerable patients, November 2019 – RCGP news, viewed December 2020

Contingency planning

CQC: Business Continuity Planning – Nigel's surgery 69, viewed December 2020

3. Working with patients to improve access

3.1 Patient experience

Patients place importance on different aspects of care, some value speed of access, others value continuity or convenient appointment times.[32] Some aspects of a patient's experience of general practice access are beyond the practice team's control. But small, practice-led improvement projects can reap real benefits for your patients, reflected in an improved experience.[33] See Patient experience measures in the Making change section.

Suggestions to improve patient experience with general practice access[34, 35]
Actively seek and act on patients' and carers' feedback (see table 14: Patient experience measures 6.2.5)
Talk to your community to find out what is important to local people
Share best practice within your PCN
Increase information and links to reliable external sources on your websites to enable patients to self-manage with greater confidence
Use the opportunity of people waiting, such as in waiting rooms and on the phone, to provide information on common symptoms and appropriate patient action
Flexibility in your access to meet the needs of different patients – working patients, the seriously unwell and vulnerable – not a one-size-fits-all approach
Promote services offered by your local pharmacist. See the Access beyond the practice section
Providing training for front desk teams in signposting to reduce the need for multiple contacts
Health champions and Social Prescribing Link Workers (SPLW) work with patients to help them access digital resources and points of access

3.2 Patient expectations

You can often trace negative feedback back to parts of a process that don't work for patients or staff. Asking for and acting on patient and staff feedback is a great way to identify themes for practice improvement work.

Patients with a clear expectation of your service and how best to use what you can offer should reduce the risk of failure demand (see 2.3.4 Reduce failure demand), DNAs, complaints and challenging encounters for patients and staff.

Consider a welcome pack for new patients or a practice charter developed with your Patient Participation Group (PPG) explaining how best to use your services, what patients should expect from the practice and what the practice expects in return.

[32] S Boyle and others (2010). A rapid view of access.
[33] The Health Foundation (2014). Improving quality.
[34] NHS Practice Management Network (2009). Improving access.
[35] Healthwatch. GP access challenge.

This could include:

What you can expect from us:

- Courtesy and kindness
- Opening hours and points of access (including online)
- A website that explains what the practice offer and signposts to resources and support
- Use of the NHS App for booking appointments, ordering medicines and health information
- If you are a patient who is new to the UK, an explanation of how the NHS works and where the GP fits in
- We may signpost you to another service if we think this will better meet your needs
- How to give feedback and get involved in the Patient Participation Group (PPG)
- We will deal promptly with any abusive or discriminatory behaviour

What we expect from you:

- Courtesy and kindness
- Check the practice website for details of self-care, self-referral and self-service and whether the practice is the right place for your current healthcare needs
- Keep the practice informed if you change contact details
- Cancel appointments with plenty of time for other patients to use them
- Give feedback on our services to help us improve
- Plan ahead when possible. For example, order repeat prescriptions in plenty of time and please only ask for emergency or urgent care when really needed

3.3 Self-care

Figure 8: Relationship between self-care, self-service, personalised care and self-referral

Patients with greater control over their health have healthier behaviours leading to a reduced risk of long-term health problems and are better able to self-manage minor ailments.

Self-care has an important role in both supporting patients and reducing demand on services and should be a dominant element of your practice access system.

The self-care continuum (see figures 10 and 11) describes the range from 100% self-care for daily life to 100% medical care for life-threatening illness. It encompasses a wide range of interventions from giving passive information to personal motivational support.

"Self-Care is the actions that individuals take for themselves, on behalf of and with others in order to develop, protect, maintain and improve their health, wellbeing or wellness."

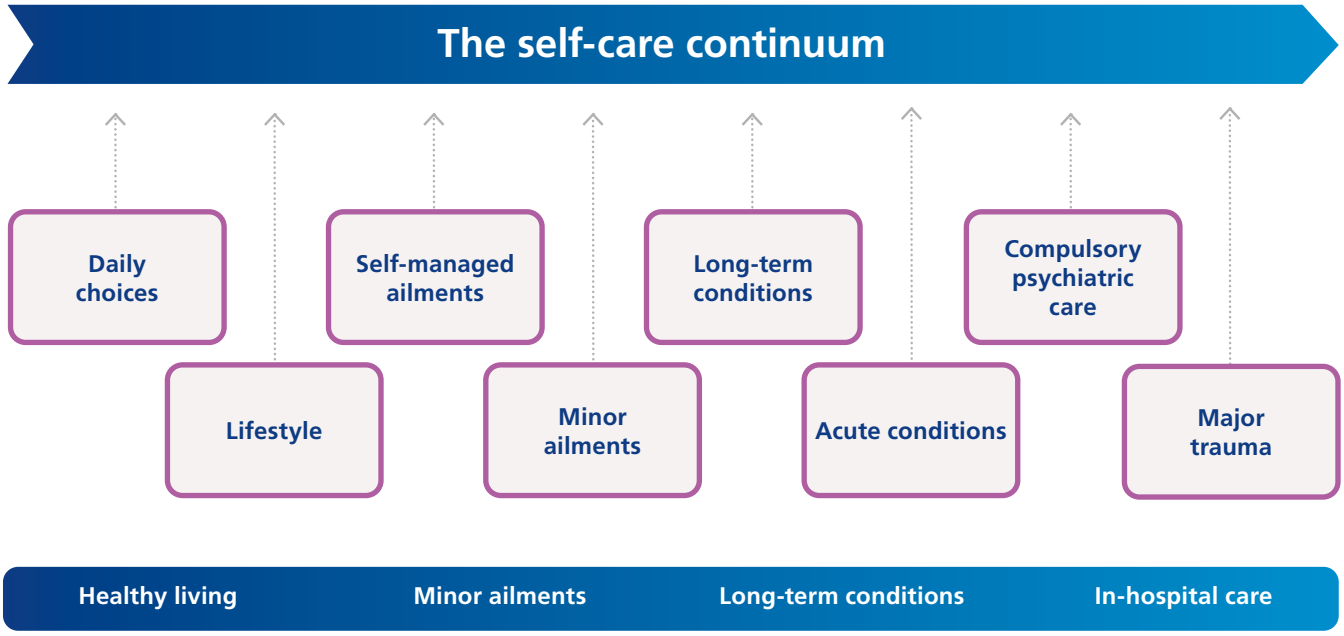
Self Care Forum[36]

Figure 9: NHS Self-care

Figure 10: Self-care continuum[37]

Pure self-care
Individual responsibility

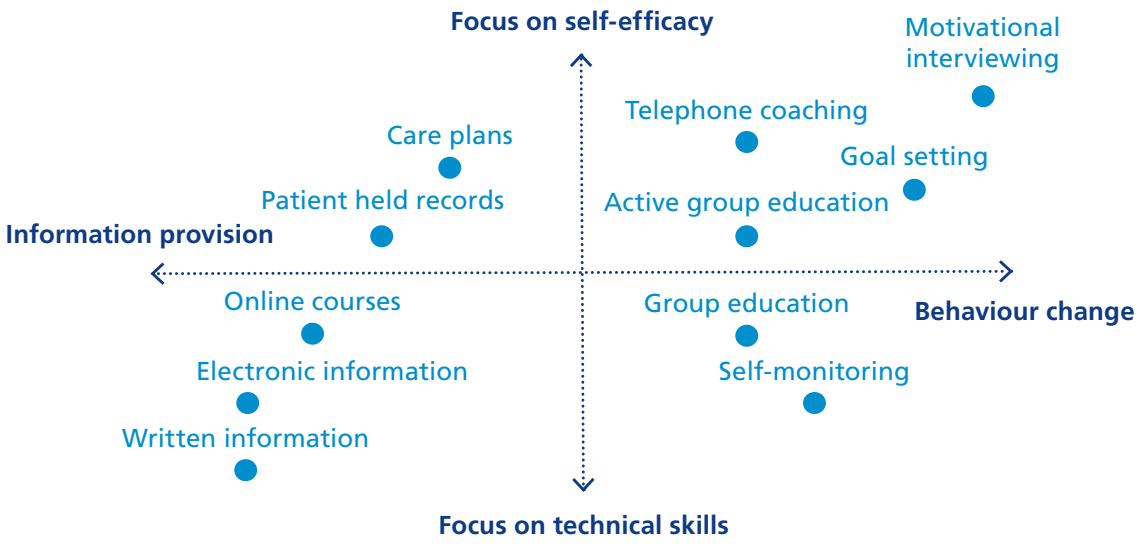
Pure medical care
Professional responsibility



[36] Self Care Forum. What do we mean by self care.

[37] Health Foundation (2011). Helping people help themselves.

Figure 11: Continuum of self-care strategies[37]



Tips for practices in supporting self-care[38]
All clinicians, healthcare assistants and receptionists should agree on the advice they give patients for common self-limiting illnesses and work with local pharmacists and community nursing teams for wider system consistency of advice
Involve all clinicians in prescribing approaches and policies to ensure consistency, evidence-based practice and fairness, particularly for antibiotics and opiates
Embed self-care advice and resources into all long-term condition reviews and health promotion contacts, for example, new patient checks and health checks
Involve your Patient Participation Group and other service users to design, plan and get feedback on your initiatives in self-care
Promote high-quality self-care information on the practice website Signpost to digital support such as: Local Authority directories NHS website NHS Apps library NHS video library Good Thinking – digital mental wellbeing service for Londoners' wellbeing
Promote self-management courses such as Expert Patient Programmes (EPP) and other local and national courses
Encourage all clinicians to learn how to assess a patient's self-care status and to identify when they are most receptive to self-care information and advice
Patient activation explains why some patients are better able to self-care than others.[39] Patient Activation Measures (PAM) are a useful tool to tailor interventions and approaches to suit an individual's needs. Goal setting, health coaching and expert disease programmes help raise low levels of patient motivation
Make the best use of the team to support self-care, including social prescribing link workers with tailored signposting to local support
Have a self-care champion in the team and encourage team members to use Self Care Forum resources and look out for self-care training
Tailor your self-care offer to individual patients, give clear guidance when to ask for further support from the team or arrange a follow-up to ensure the self-care approach meets their needs

[38] The Self Care Forum. Tops Tips.

[39] J Hibbard and H Gilburt (2014). Supporting people to manage.

3.3.1 Self-referral

Self-referral is an important part of self-care and can be promoted through regularly updated website information at a practice, PCN or borough level.

Typical services available for self-referral include:

- Antenatal care
- Counselling and talking therapies
- Drug and alcohol addiction services
- Stop smoking services
- Sexual health services

Figure 12: Example of practice self-referral page

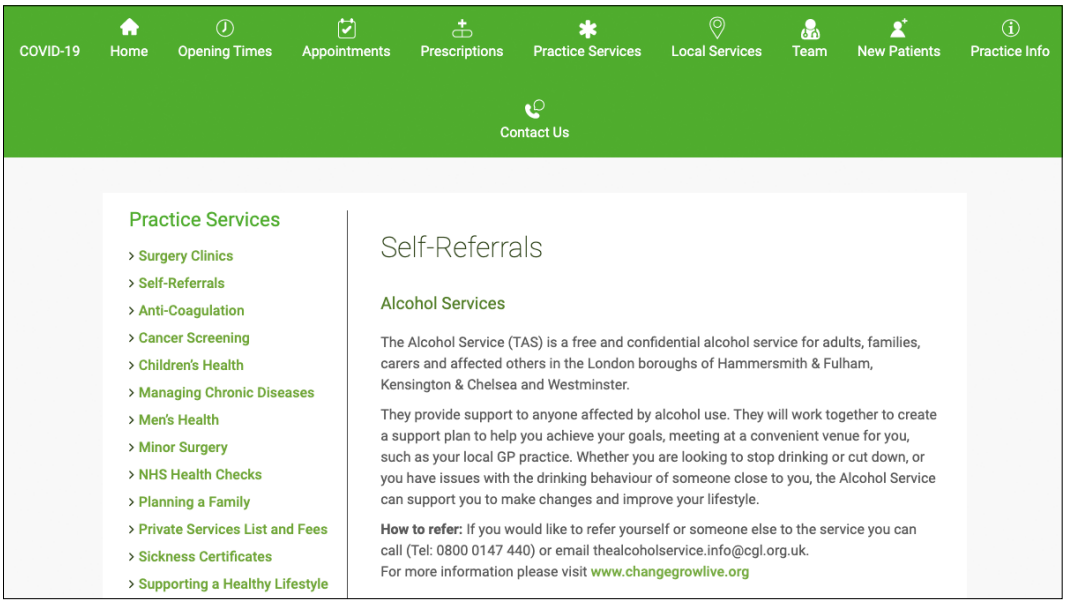
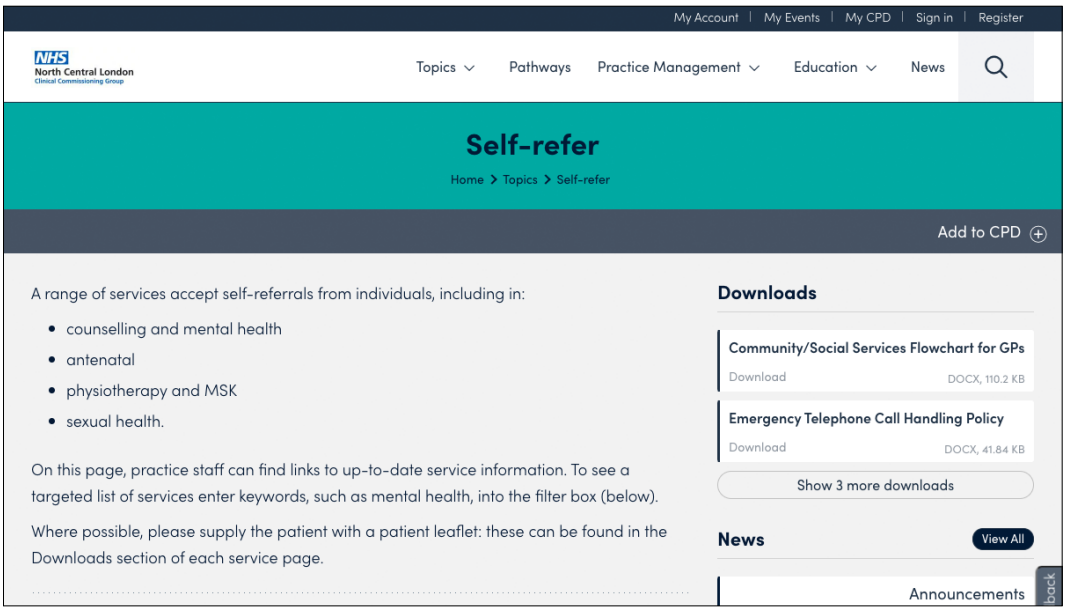


Figure 13: Example of CCG self-referral page



3.3.2 Self-service: Access to health information

Patients able to access their health records can act on their results, check their medication and even see recent consultations, referrals and hospital correspondence. By enabling this through the NHS App[40] or online provider, practices can support patients in self-service for their health needs, reduce the need for clinician contacts and help access. Practices that have promoted this have found it has improved patient satisfaction, access safety and effectiveness.[41]

Since 2019, patients should be offered full online access to their digital record, starting from when they registered for online services.[42]

Include details of how patients can access their records on your website, the Patient Association has a useful guide – Seeing your medical records.[43]

3.3.3 Personalised care[44]

> "Personalised care is a partnership approach that helps people make informed decisions and choices about their health and wellbeing, working alongside clinical information. A one-size-fits-all health and care system simply cannot meet the increasing complexity of people's needs and expectations, and personalised care gives people the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life."
>
> Personalised Care Institute[45]

The RCGP has set up the virtual Personalised Care Institute (PCI) with programmes focused on:

- shared decision-making
- personalised care and support planning
- social prescribing and community-based support
- supported self-management.

The NHS Long Term Plan makes a commitment to providing more personalised care, arguing that it will improve patients' wellbeing and health outcomes, so reducing emergencies and unplanned use of health services, and positively impacting patient access.[46]

[40] Support for accessing your information via the NHS App.
[41] Neves and others (2019). Impact of providing patients access.
[42] NHSE. Patient access to records.
[43] Patients Associations. Seeing your medical records.
[44] NHS. Personalised care resources.
[45] Personalised Care Institute website.
[46] NHS: Making the case for a more personalised care approach.

3.4 Equity in general practice access

"There are substantial variations in health and wellbeing outcomes in London compared to England."

Public Health England[47,48]

"There can be no more important task for those concerned with the health of the population than to reduce health inequalities."

Michael Marmot[49]

"Looking at how equitably services are delivered, and whether they meet local needs, has to be a proactive process that draws in people who, traditionally, have not had good access. Working with local third sector groups may be a way of assessing those groups."

Department for Health[50]

Figure 14: Equality and equity

3.4.1 Equity in registering with a GP practice

Socially excluded patients are less likely to register with a GP, contributing to poorer health outcomes in the most vulnerable patient groups, and ineffective use of other NHS services less able to meet their needs, for example, Accident and Emergency (A&E).

Practice access policies should work to mitigate the combination of barriers to GP registration and provide staff training in equity of registration.

[47] Filton and others (2014). The impact of patient record access.
[48] PHE (2015). Health inequalities in London.
[49] The Health Foundation. The Marmot Review.
[50] NHS England. Improving GP registration.

Figure 15: Factors that impact on equity in patient registration[50]

Patients have a legal right to choose a practice that best suits their needs and registration can only be refused if there are reasonable grounds for doing so, such as:

- the patient lives outside the practice area or within the outer boundary area
- the practice has an agreed closed list.

Reasons for any refusal must be communicated to patients in writing within 14 days.[51]

In the rare occurrence that a practice is considering removing a patient from their list, we suggest they refer to the BMA guidance.[52]

Patients do not need to provide proof of ID or address to register with a GP

Work with partner organisations such as Healthwatch to develop local systems that support socially disadvantaged patients to register with a GP.

Doctors of the World is an independent humanitarian movement committed to empowering excluded people to access healthcare. It provides resources and training through its Safe Surgeries initiative. These include:

- Safe Surgeries Toolkit for general practices
- Safe Surgeries Toolkit for COVID-19 Response for primary care staff
- Toolkit for commissioners

A Safe Surgery ensures patients can register with a GP even if they do not have proof of ID or address. It also ensures that immigration status or language are not barriers to registration. Doctors of the World provides free training to clinical and non-clinical staff in primary and secondary care settings and has a range of practical resources such as posters, leaflets and a toolkit on the website in a wide range of community languages.

[51] NHS (GMS Contracts) Regulations 2015.

[52] BMA (2020). Removing patients from your list.

3.4.2 Equity of access to care for registered patients

Practice factors impacting on equity of access
By engaging with vulnerable patients, your practice will improve individual and population health outcomes, improve staff satisfaction and morale, and help achieve clinical targets.

Figure 16: Practice factors impacting equity of access[53]

Patient factors affecting equity of access

It is challenging to have a system that meets the needs of all patients and all groups. Practices should develop a broadly inclusive approach and a focus on particular groups in their population, such as sex workers and homeless patients, while also meeting the 'reasonable' adjustments described in the Equality Act. Good practice is for all team members to complete Equality and Diversity training.[54]

Many vulnerable patients are unaware or not focused on their health needs as other factors take dominance, for example, homelessness, strained finances, drug and alcohol use.

Patients new to the UK will likely find NHS systems difficult to navigate, and we should not make assumptions about digital and health literacy and understanding of how the NHS works.

Patients should be able to access primary care services in a way that ensures their language and communication requirements do not prevent them from receiving the same quality of healthcare as others. The NHS has clear guidance for commissioners and GP practices on providing translation services for patients, including British Sign Language.[55]

Patients may have multiple factors contributing to complex vulnerability. We need to offer tailored support from straightforward signposting to intensive hand-holding to best suit a patient's needs and circumstances. Many patients find seeking healthcare a difficult experience. A kind welcome and a smile go a long way to making patients feel welcome and at ease.

Consider arranging necessary investigations and treatment for temporary patients while they wait to be settled. Deferring risks a deterioration in their health, for example, a delayed cancer diagnosis.

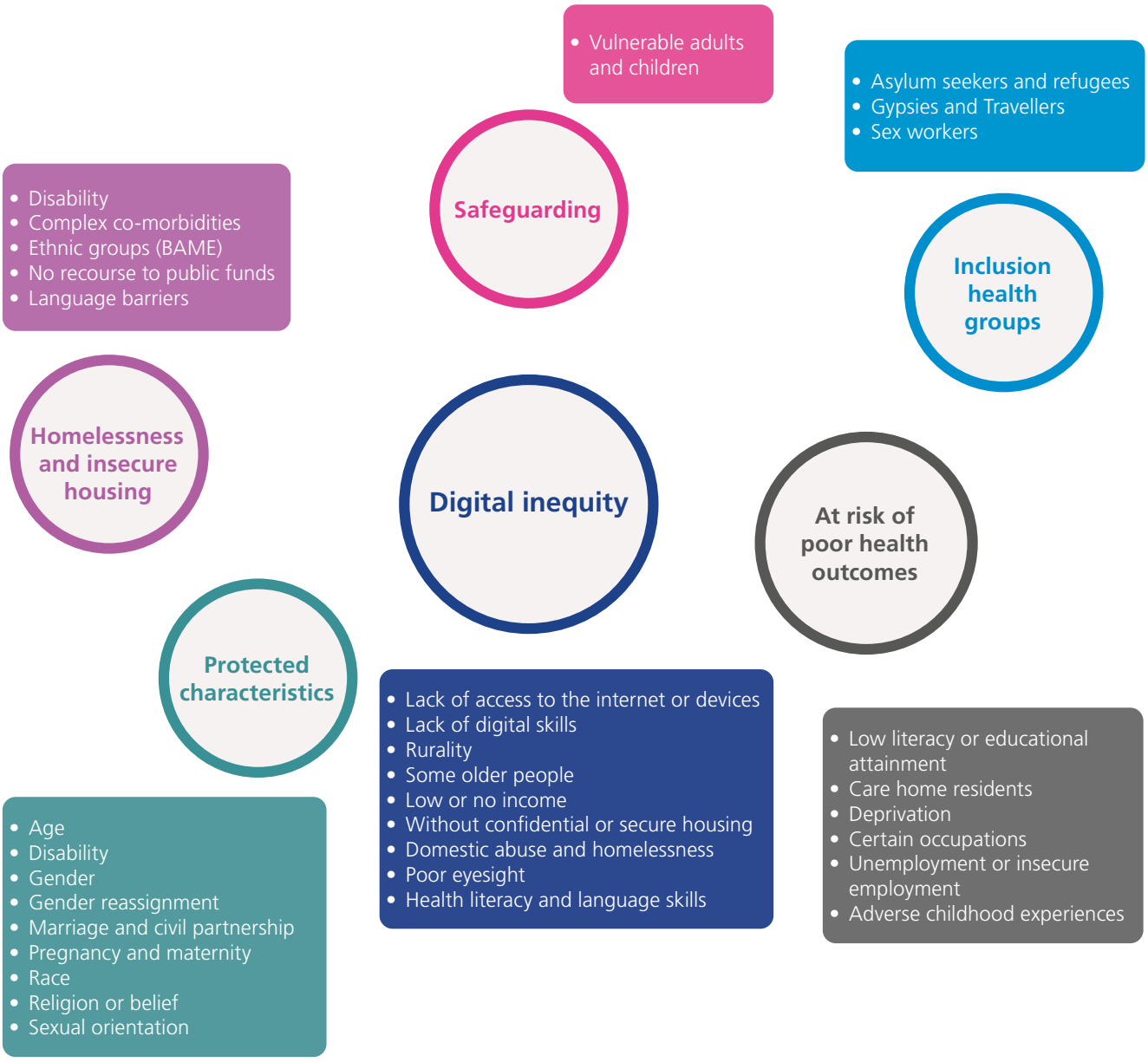
Care Quality Commission (CQC) inspection includes how practices care for vulnerable patients, including older people and people whose circumstances make them vulnerable – depending on individual practice populations. The CQC inspection may include the processes for registration, ability to book appointments and receive care.[56]

[53] NHS England (2018). Improving access for all.
[54] e-Learning for Health. Equality and Diversity training.
[55] NHS (2018). Guidance for commissioners.
[56] CQC. What we will inspect.

For a long time, practices have coded and searched for patients by disease condition and multimorbidity. There is a strong argument for a similar approach to the social determinants of health[57], enabling us to reach out to those patients at greatest need. Some groups may be more amenable to coding and searches than others; feedback from adverse events and case finding can identify gaps. A code may be perceived negatively as a 'label', so consider: is this something your patient would agree to and see the benefits of including in their medical records? Patients should be confident when accessing their medical records that this helpfully records their health issues and not perceive it as adding to stigma now or in the future.

Resources section 3.6 includes several helpful guides for different vulnerable groups.

Figure 17: Patient groups likely to experience inequity in access



Though the increasing use of technology in healthcare risks widening digital inequalities (see figure 17), it has been argued that technology can help reduce health inequalities and that digitally enabled pathways may increase inclusion. Staff training, connecting to local community organisations and charities, and social prescribing support are some of the ways of supporting digitally excluded groups.[58] The Resources section 3.6 of this manual, Technology to address health inequalities, includes more suggestions and examples.

[57] Moscrop and others (2020). If social determinants. Page 371.

[58] NHS. Digital Inclusion guidance.

Equality Act 2010[59]
By law, practices must make reasonable adjustments to ensure that service users and staff with a disability are not disadvantaged compared to non-disabled people.

These reasonable adjustments could include physical changes to make a building wheelchair friendly, clear lighting and signage, adjustments for people who have a sensory impairment and providing interpreters.

3.5 Patients who need additional, tailored support

Vulnerable patients may present frequently to both general practice and other health services,[60] often with unmet needs that have been poorly addressed by a medical model and would be better managed by a more socially focused approach. This leads to improved patient satisfaction and care while also reducing demands on general practice and other health providers.

Research across several London practices has highlighted that a small number of patients use a large proportion of general practice appointments, and rigid appointment systems can contribute to a large amount of resource being used by the highest demanding patients. This can be mitigated by moving away from a demand-led to a needs-based approach.[61]

[59] Gov.uk Equality Act 2010 government guidance.
[60] Health Foundation (2017). Characteristics of frequent attenders.
[61] London South Bank University (2019). The Asset Based Health Inquiry.

Figure 18: Meeting complex needs – acuity[62]

Community volunteers

Struggling with life (poor housing, poverty, isolated)

- Community collaboration – an asset-based approach to connecting people
- Volunteers/champions introduce themselves to local groups: find out what they can offer in an asset-based approach

Social prescribing link workers

People who need support to manage their health and context

- They need, e.g. care navigation, managing their ability to cope (mental health)
- Service includes accessing help, providing lifestyle coaching

Continuity with general practice team

People with multiple conditions who are at risk of becoming unstable

- May need Complex Care Nurse supervision
- Proactive management with pre-determined appointments of initially one hour

Complex care nurse and MDT

People with complex needs who are unstable/becoming unstable and require multiple-agency support

- Complex care lead assessment
- MDT including GP/social worker/ mental health worker/community
- Provided at PCN level

High intensity MDT across primary and secondary care

People who are high users of primary and secondary care – already unstable

- Collaborative care plan across all used services
- High intensity team intervention

[62] PCN Academy. Frequent Attenders.

Practical steps for people attending frequently

- **Identify patients who are attending more than average and flag them for continuity with their 'usual doctor' or care team**
- **Find out their needs: SPLW or health advocate spend time finding out 'What matters to you?'**
- **Have a shared care plan, so they know who to contact when unwell – perhaps a nominated member of the front desk team**
- **Signpost to community and social care support**
- **Be proactive, have systems in place, recognise there is something you and your team can do to better meet the needs of these patients, and reduce the perceived burden on your team**
- **Use everybody in the team, consider group appointments and longer appointments**

Case study – Personalising care for patient sub-groups in general practice: segmenting within general practice to improve health and increase efficiency.

3.6 Resources: Working with patients to improve access

R

Engaging with patients to improve access
National Association for Patient Participation – Welcome to the National Association for Patient Participation
The Patients Association, viewed December 2020
Healthwatch, viewed December 2020
National Voices, viewed December 2020
Patient Participation Groups, Best Practice Guide, Healthwatch, Central West London, 2017
Self-care patient resources
NHS symptoms checker, viewed December 2020
NHS Apps library, viewed December 2020
NHS Supported self-management, resources viewed December 2020
Good Thinking, wellbeing website for Londoners, viewed December 2020
Health and Care Video Library, viewed December 2020
BMA Self care guide, 2019
The Self Care Toolkit – from The Pain Toolkit, viewed December 2020
Self-help guides for a range of conditions, NHS inform, viewed December 2020
MIND Self care advice for patients with mental health problems, viewed December 2020
NHS advice: How to access your health records
Personalised Care Institute (PCI), viewed December 2020
Helping people help themselves, The Health Foundation evidence review of self-management, 2011
Supporting people to manage their health: An introduction to patient activation, The King's Fund, 2014
Supporting self-care in general practice, British Journal of General Practice, 2007
Londonwide LMCs: Patient Online Services: an overview of the most challenging areas for practices and how to overcome them

Website development

Build Your Practice Website the Smarter Way, Practice 365

Improving patient registration

How to register with a GP practice, NHS England, viewed December 2020

Improving GP registration among socially excluded groups, NHS England guidance and resources, viewed December 2020

'My right to access healthcare' cards, Healthy London Partnership printable cards sharing patients' rights to register, viewed December 2020

Doctors of the World
Safe Surgeries initiative

Safe Surgeries Toolkit

Safe Surgeries Toolkit for COVID-19 Response

Toolkit for commissioners

Technology to address health inequalities

Digital First Primary Care funding is available to support practices and PCNs co-design inclusive digitally enabled pathways

Digital Inclusion guidance in Health and Care, NHS, viewed December 2020

The Doctor Will Zoom You Now. Insight report from Healthwatch, National Voices and Traverse 2020

Good Things Foundation: NHS widening digital participation resources, viewed December 2020

Learn my way: Good Things Foundation courses for people to develop their digital skills:

A How To Guide for digital inclusion in health, Good Things Foundation, viewed December 2020

Digital inclusion for health and social care NHS Digital

Patient access and inequalities

Data sources and background reading

Shape Atlas: staffing and deprivation by practice, PCN etc, free for use by NHS staff, viewed December 2020

Consumer Data Research Centre maps of deprivation, viewed December 2020

Patients finding it harder to access general practice, but those in poorer areas report greater problems: Health Foundation response to British Social Attitudes Survey on emergency care, 2019

The London Health Inequalities Strategy, September 2018

Addressing equality and health inequalities, NHS England Analytics on health inequalities in UK

Practice resources: General

Accessibility checklist for GP surgeries Information on how to make your practice meet accessibility requirements Healthwatch, viewed December 2020

Improving access for all: reducing inequalities in access to general practice services – A resource for general practice providers and commissioners, September 2018

Inclusion Health: Improving primary care for socially excluded people, 2010

R

Website development
E-learning for heath includes training modules include a wide range of learning including Equality and Diversity and Human Rights, Disability matters

Vulnerable groups
Refugee and asylum seeker patient health toolkit Information on refugees' and asylum seekers' entitlement to NHS care BMA, viewed December 2020
Learning Disabilities resources RCGP, viewed December 2020
Information on the Accessible Information Standard, 2016 and how practices can make information accessible for blind and partially sighted patients
BSL Health Access for the UK's Deaf community Information on how to access British Sign Language (BSL) interpreters, viewed December 2020
Deafness and Hearing Loss Toolkit RCGP, viewed December 2020
Pride in practice, resource to support access to primary care services for LGBT communities, viewed December 2020
Homeless Health resources Healthy London Partnership Resources to support healthcare access for the homeless, viewed December 2020
Services for Sex Workers in London, BMJ Blog on information on services across London, viewed December 2020
Guidance for General Practice Teams: Responding to domestic abuse during telephone and video consultations, IRIS, viewed December 2020
Support for primary care in identification, risk stratification and interventions for patients at an increased risk of COVID NHS London, viewed December 2020
Mental health and access in primary care
Mental health in primary care: Policy for patients with mental health problems presenting to general practice, viewed December 2020
Advice for patients with metal health problems presenting to their GP MIND, viewed December 2020
A guide to making general practice dementia friendly – Alzheimer's Society, viewed December 2020
Children & Young People's Access in primary care
GP Champions for Youth Health Project: Toolkit for General Practice, viewed December 2020
Primary care children and young people's toolkit: Resources to support group consultations for children and young people Healthy London Partnership
Child Safeguarding Toolkit RCGP, viewed December 2020
The Association for Young People's Health, viewed December 2020

Equality Act
CQC guidance on reasonable adjustments for disabled people, viewed December 2020
NHS guidance on making reasonable adjustments, viewed December 2020
Equality and Human Rights Commission – examples of reasonable adjustments, viewed December 2020
Patients who need additional, tailored support
E-learning for healthcare: Managing frequent attenders
The Asset Based Health Inquiry, How to best develop social prescribing? London South Bank University 2019

4. The general practice team

A happy and effective team is the vital ingredient to deliver the inclusive model of access we describe in this guide.

During the coronavirus pandemic we have rapidly increased virtual working, connecting remotely with our patients and each other. This bring the benefits of convenience and efficiency but risks connectedness, equity of access and has challenged and changed our models of clinical supervision.[63]

The development of PCNs brings a range of new roles and ways of working, an opportunity for much-needed increased capacity and strengthened multidisciplinary teams. The benefits are likely to take time to realise and risk destabilising existing teams in the short term.

Recruitment and retention struggles, particularly in London, can thwart well-planned strategies to employ and engage staff members.

This section of the manual aims to bring evidence and case studies to demonstrate that time invested in the practice team pays off, with teams better able to deliver improved patient access.

To those new to general practice, this section will clarify the range of people who make up the general practice team. For more established team members, it will help them to reflect on team development and how best to lead, support and deploy new members of their teams.

4.1 Recruitment and retention

Many practices in London struggle to recruit and retain the workforce needed to deliver good patient access.

The Nuffield Trust briefing Delivering general practice with too few GPs[64] has some practical suggestions:

- **Keep it local** – avoid the imposition of national 'blueprints'.
- **Invest in change** – technology, clinical support for new roles, premises and organisational development.
- **Be realistic** about the pace of change.
- **Use data** to inform change.

The NHS People's Plan[65] recognises that a compassionate and inclusive culture helps staff retention and looks at local and national steps to help achieve this.

Recruitment initiatives can help, but only sign up to those that will help in your local context and do not come with cumbersome assurance processes.[66]

[63] Lisa Miller (2020). Remote Supervision.
[64] Rosen (2019). Delivering general practice.
[65] NHS People's Plan 2020/2021.
[66] I Staveley and J Sampson (2020). Will the GP workforce. Pages 509-510

Recruitment to improve patient access
What are the health needs of your population and are these likely to change?
What are the tasks that need doing, for example, website design, social media and communication skills, basic data analytics, front desk training, clinician contact time, QI expertise?
What skills are missing in your team, which roles would fit these gaps?
Who would best fit into your team and the teams outside your practice?
What are PCN recruitment plans and how can your practice recruitment align?
If you are recruiting into a new role, do you have any local champions who can advise on recruitment and offer support to appointees?
What or who would offer best value?
Which roles could you successfully recruit locally?

Consider the role of the new person on the team. Doing so will help you get recruitment right, plan for the best induction and encourage retention because new team members will know their purpose and feel a sense of belonging. Planning will support retention of existing staff because they will not feel displaced and will understand the benefits the new person will bring. Work with practices within your PCN to consider recruitment that will best meet your practice needs to deliver effective services, of which access is an important part.

4.2 The general practice team

There is no one-size-fits-all approach for the general practice team that will offer the best access, this will vary over time, in response to patient need, availability, costs and resources.

Figure 19: The general practice team

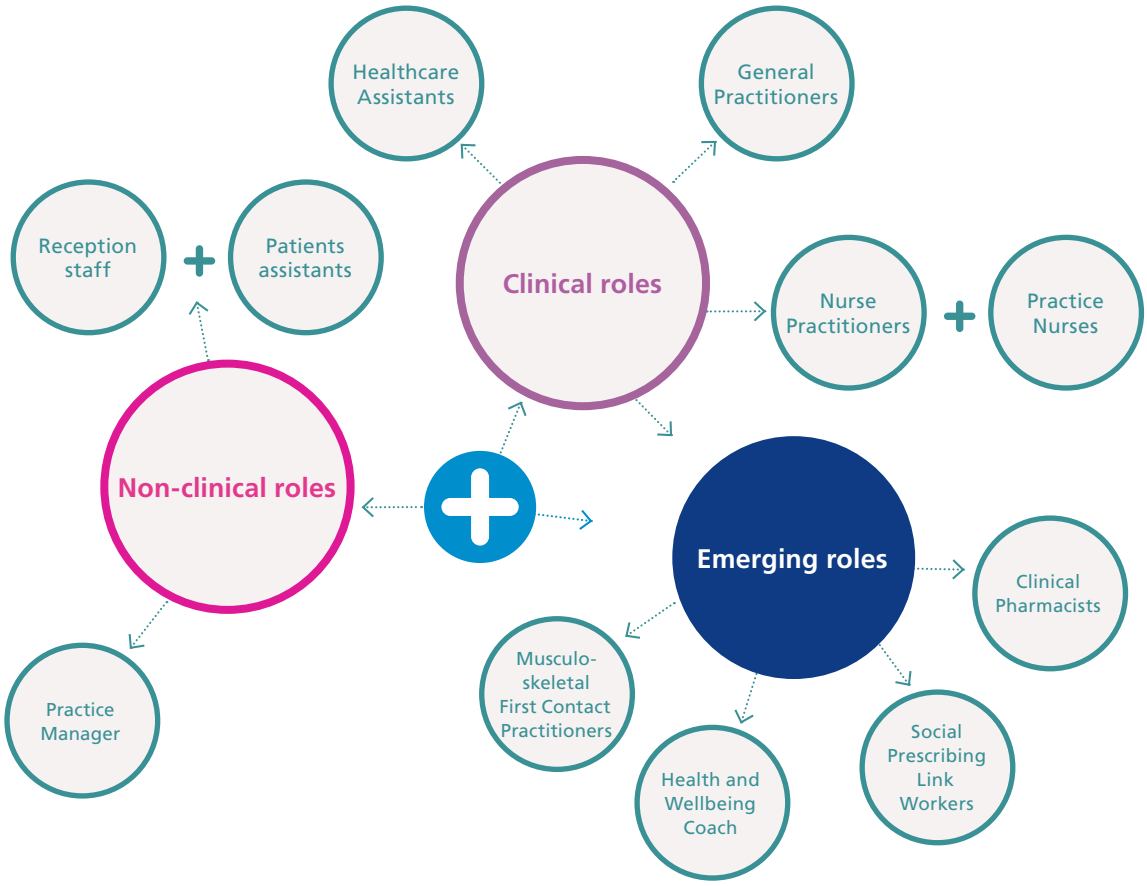


Table 8: The general practice team

Clinical team members	
GPs	The Royal College of General Practitioners (RCGP) describes the skills of the future GP to include not only the generalist clinical skills we are familiar with but also a 'stretch' to include leadership, educational skills, business management and IT skills to support the leadership of multidisciplinary teams.[67] These skills are important but potentially take GPs away from patient-facing care, impacting on access and reminding us of the importance of the wider team in delivering patient care. GPs should be clear on their patient-facing commitment every day or week to ensure a stable capacity (See 2.3.2: Provide stable capacity). Some GPs will be more interested in management and IT, and others in seeing patients regularly for ongoing health issues than dealing with on-the-day demand. Regular team meetings allow review of workloads and ensure all team members are deployed fairly and continue to develop and stretch their skills
Nurse practitioners and practice nurses	General practice nurses provide significant capacity for patient-facing care, contributing to good access. But they also need time for administrative work, meetings and for personal development to ensure they feel valued and are supported to learn, develop and progress in their career
Healthcare Assistants (HCAs)	HCAs or Healthcare Practitioners (HCP) can contribute to good access when trained to take on tasks that might otherwise use up a nurse or GP's time, particularly information gathering ahead of an LTC review. Examples include blood tests, weight and height – or supporting patients in home monitoring of their health. As with all roles, HCAs need regular training, supportive supervision and appraisal, working best with clear, agreed pathways and accessible senior support when seeing patients and dealing with any questions that arise
Non-clinical team members	
Practice Manager (PM)	"Put simply, without an effective management structure within primary care, the hopes of the Five Year Forward View risk never being realised."[68] Clare Allcock, Health Foundation Practice managers have a pivotal role in piecing together the parts of the jigsaw needed to deliver good patient access It can be helpful to consider all the functions of practice management and decide which are best placed to be delivered by the PM and which could be delegated. For example: • Functions such as human resources, estates and people development may be best delivered at scale across a network or borough • Payroll and bookkeeping may be outsourced or assisted by technology • Daily management of processes within practices could be distributed to the team closest to the process Partners should check in regularly with their PMs to make sure they have time and space to learn and develop themselves and the wider team
Reception staff and patients assistants	"Receptionists have a central influence on patient outcome, safety, and satisfaction."[69] The most accessible members of the team, receptionists work under intense pressure and scrutiny The GP Forward View[70] describes the importance of reception and clerical staff in signposting patients, handling paperwork, contributing to good patient access. Front desk teams need training and support, and a voice to feedback on access issues. Without this, patients may default to GP contacts, not using the wider team and best service to meet their needs, leading to access burdens on the practice

[67] Royal College of General Practitioners (2019). Fit for the future.
[68] Clare Allcock (2016). Making management work.
[69] Litchfield and others (2017). Future role of receptionists.
[70] NHSE (2016). GP Forward View.

Examples of ARRS roles supporting access improvements	
Clinical Pharmacist	"Having a clinical pharmacist on the team can ease workload, reduce waiting times and improve effectiveness."[71] Repeat prescriptions, medication reviews, LTC reviews and checking discharge medications are just some of the tasks a practice pharmacist can undertake to improve patents access and safety
Social Prescribing link Workers (SPLW) Health and Wellbeing Coach	The SPLW can spend time with patients with complex and social care needs, addressing some of the wider determinants of health and signposting to support and care, improving patient satisfaction and reducing the need for clinical contacts. SPLWs are well placed to support patients who attend health services very frequently.[72] (See 3.5 Patients who need additional tailored support.)
Musculoskeletal First Contact Practitioners (FCP)	"More than 1 in 5 GP presentations are for musculoskeletal conditions."[73] With the high number of musculoskeletal contacts in general practice, first-contact physiotherapists can give improved patient care and open GP capacity for other patients

4.2.1 Additional Roles Reimbursement Scheme (ARRS)

A step-change in the general practice team underpins PCNs, with an expanded and 'shared' workforce recruited from varied disciplines, many of whom are new to general practice.

The intention of ARRS is to increase capacity and improve patient access, and strengthen multidisciplinary working, providing resilience and sustainability in general practice. The RCGP describes these new roles as complementing the more traditional general practice roles with "task substitution not role substitution".[74]

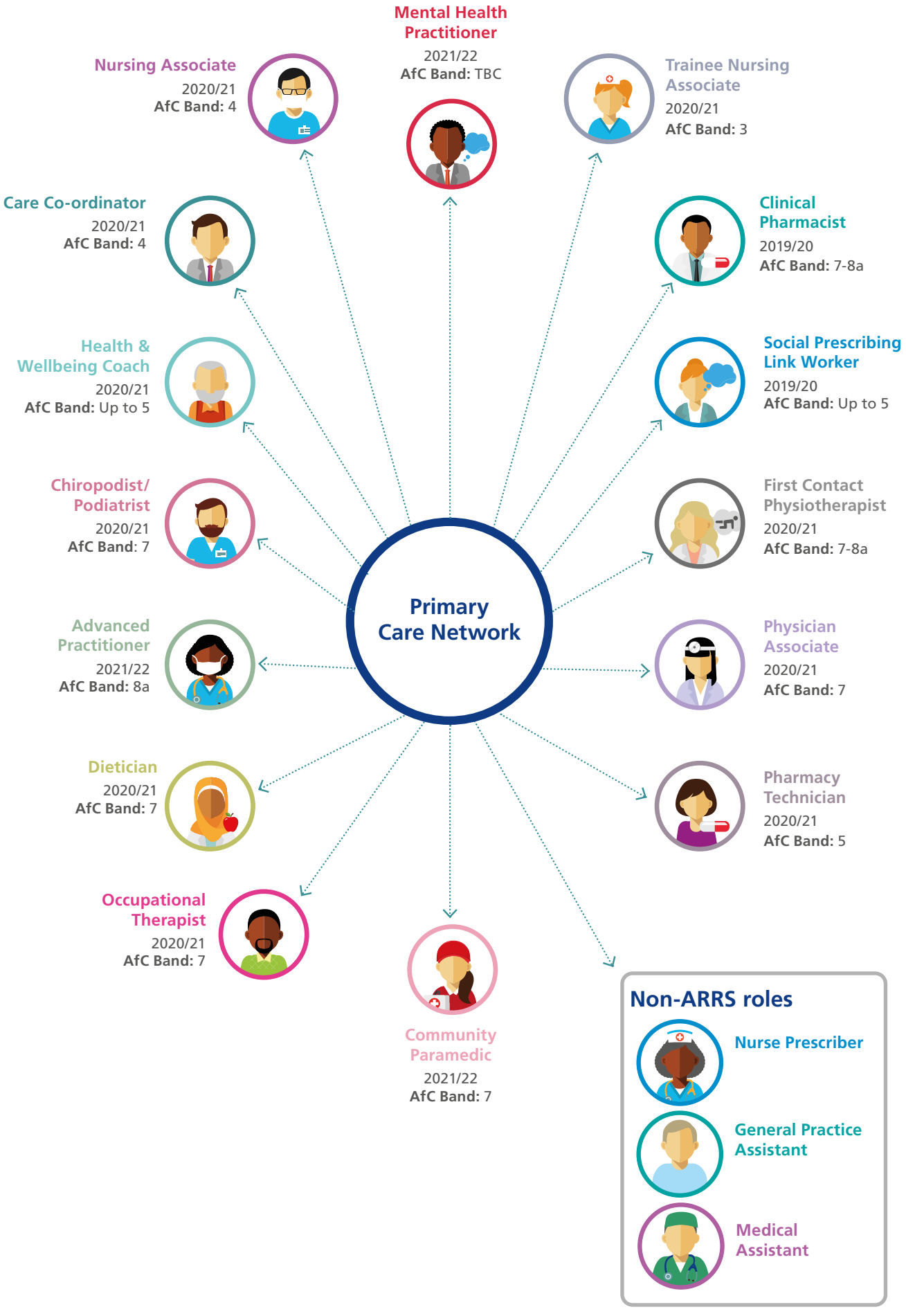
These new roles bring a valuable resource to help practices and PCNs improve their access, but this will take time, flexibility from existing teams and realism in our expectation of the pace of change.[75]

New team members with little general practice experience will have significant training needs and will require experienced support and supervision. Supervision needs planning to mitigate the impact on patient-facing activity. A survey by the National Association of Link Workers highlighted how much SPLWs value regular, structured supervision, and how important this was to retention in SPLW roles.[76]

PCN leaders need to agree how best to deploy this shared resource fairly across the PCN, while also meeting individual patient and population health needs. Practices need to work flexibly with newer members while also supporting their existing teams in this transition period, and work with their PCNs to think through how PCN recruitment will really help them deliver best access and care. To increase continuity and reduce the risk of work duplication, practices and PCNs should be clear about the functions and scope of new roles, actively plan for skill-mix change as tasks move from one professional to another, and ensure plans match patient needs.

[71] BMA (2020). Employing clinical pharmacists.
[72] BMA (2019). Social Prescribing.
[73] NHS England. Musculoskeletal First Contact.
[74] RCGP (2019). Fit for the future.
[75] Rose R (2019). Delivering general practice.
[76] NALW (2020). Care for the Carer.

Figure 20: PCN roles including those outlined within ARRS
The roles and bandings may flex over time. Non-ARRS roles include nurse prescriber, general practice assistant and medical assistants. Please see contract detail.



4.2.2 Deploying the team

Care related encounter involves the patient and can be any contact type, e.g. face-to-face, home visit.

Administrative and practice staff activity required for managing practice and staff, e.g. meetings, appraisals, training.

Care related activities do not involve the patient but are about the patient, e.g. a prescription request, referral, results handling.

Each of these groups can be subdivided into more specific activities

An important but challenging task is deploying the limited team capacity between different general practice activities.[77] Activity data and feedback from patients and staff will identify bottlenecks and gaps to direct attention to where team members' skills can be used for maximum impact and improvement. This balance needs constant attention, for example, how much clinical capacity is needed for on-the-day demand and how much for planned care and continuity.

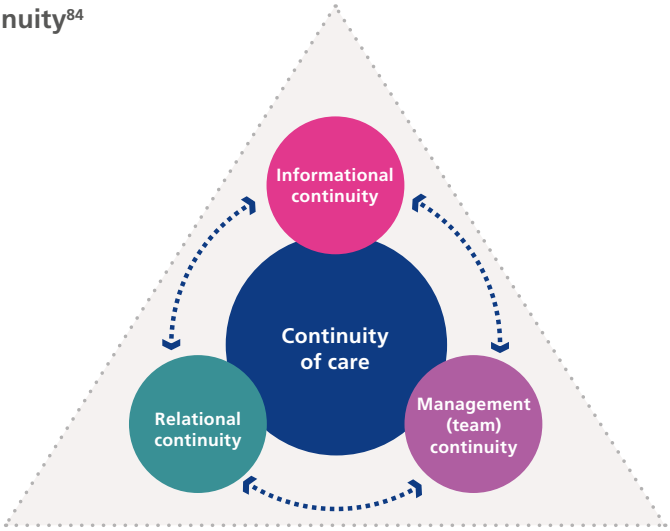
4.3 Continuity of care

> "Patients who receive continuity of care in general practice have better health outcomes, higher satisfaction rates and the healthcare they receive is more cost effective."[78]
>
> Holly Jeffers and Maureen Baker

Continuity of care is associated with higher patient satisfaction, better adherence to medical advice and prescribed medications, better take-up of personal preventive medicine, fewer emergency department visits and fewer admissions to hospital, especially for older people.[79, 80] But patients report it is getting harder to see the same GP for their problems,[81] and we know that patients with the greatest to gain from continuity may struggle the most to achieve it, widening health inequalities.[82]

Continuity of care is defined as the interaction of a patient and healthcare team over time and is described as a building block of high-quality primary care.[83]

Figure 21: Types of continuity[84]



[77] P Nelson (2018). Skill-mix change.
[78] H Jeffers (2016). Continuity of care.
[79] Van Walraven and others (2010). The association between continuity of care.
[80] D Pereira Gray and others (2016). Improving continuity.
[81] National Audit Office (2015). Stocktake of access.
[82] The Nuffield Trust (2018). Improving access.
[83] T Bodenheimer (2014). The 10 Building Blocks.
[84] Palmer and others (2018). Types of continuity.

Continuity can be measured as:[85]

- continuity with the 'usual clinician'[86] over time
- episodic continuity – the continuity between a patient and different members of the interprofessional team, including the GP, over a period of ill-health or need.

Both for patient-facing and non-patient-facing activity, such as continuity in receiving and acting on correspondence, results and medication requests.

Continuity can be difficult to achieve – clinicians often work part-time and pressures to provide prompt access can be at the expense of continuity. Practices should set up their systems and appointment book to support continuity when possible and desirable. Practice teams should consider where to prioritise continuity, such as complex mental health issues and palliative care, and where it can be sacrificed, for example, for minor self-limiting conditions. Continuity can be clinician, condition and team specific.

There is no quick fix to providing continuity. Suggested next steps:

- Access the RCGP Continuity of Care resources webpage[87] for the latest resources, including the RCGP Continuity of Care toolkit.
- The micro-teams model[88] moves from an individual burden to a team approach to continuity.

See suggested improvement projects: 9. Continuity of Care – Appendix 2

Table 9: Approach to improve continuity of care

Adapted from 6 step tracker: One Care & Morecombe Bay practices with Health Foundation and RCGP

PDSA cycle

1. Start out	2. Define and scope	3. Measure and understand	4. Design and plan	5. Implement	6. Handover and sustain
AIM Increase your appetite for continuity of care	**AIM** Define your continuity of care ambition	**AIM** Identify areas for improvement	**AIM** Decide on the changes to make	**AIM** Make the changes	**AIM** Evaluate, share and embed
1a. We understand what continuity of care is and how this sits in our practice	**2a.** We understand what patients and staff believe is important in continuity of care	**3a.** We understand our level of continuity of care and have a way of measuring it again	**4a.** We have identified ideas that will achieve our aim	**5a.** We have made a change and recorded the results **PDSA**	**6a.** We know the difference our changes have made and what we have learned
1b. We understand the practice's current state and enthusiasm for continuity of care	**2b.** We understand what is happening within the practice that helps/hinders continuity of care	**3b.** We understand our practice data and we have identified focus areas to achieve our aim	**4b.** We know which change/s we are starting with	**5b.** We know if the change was an improvement **PDSA**	**6b.** We have built continuity into business as usual
1c. We understand where the practice may improve continuity of care	**2c.** We have an aim and agreement to work towards improving continuity of care	**3c.** We understand what data we will measure now, during and later	**4c.** We have a plan of action for our change/s **PDSA**	**5c.** We have made a decision on how to respond to the PDSA outcome **PDSA**	**6c.** We have shared our achievements and are connected into the continuity of care community

Statements within the Plan Do Study Act (PDSA) cycle will need to be repeated for each change.
Adapted from the 6-step tracker: One Care and Morecambe Bay practices with the support of The Health Foundation, hosted by the RCGP.

[85] Bice and Boxerman (1977). A Quantitative Measure.
[86] Sidaway-Lee and others (2019). A method for measuring.
[87] RCGP. Continuity of Care.
[88] Liliana Risi and others (2015). Micro-teams for better continuity.

There are some potential drawbacks of continuity which need to be understood and mitigated against:[89]

- High-attending patients can increase workload and the risk of individual clinician burnout.
- When an illness has progressed slowly, a doctor who has seen the patient regularly may miss a diagnosis that is obvious to a newcomer meeting that person with 'fresh eyes'.
- Continuity can make doctors less objective, affecting their decisions to investigate. They might be reluctant to avoid confrontation.
- A doctor can start to feel paternalistic/maternalistic especially towards vulnerable patients and lose their objectivity.
- A patient may be assigned a doctor in whom he or she lacks confidence, and adherence to medical advice suffers as a result.

4.4 Developing the team

The King's Fund guide: How to build effective teams in general practice[90] captures evidence to create and sustain well-functioning teams.

Teams are happier and more effective if three key principles are present:

- **A small number of meaningful objectives**
- **Clear roles and responsibilities among team members**
- **Taking time out as a team to reflect on what is working and how the team can improve**

Professor Michael West's short film[91] describes a compassionate leadership approach to team development.

[89] Denis Pereira Gray and others (2003). Towards a theory.
[90] Baird and others (2020). How to build effective teams.
[91] M West (2019). Compassionate leadership.

"Change need not be cajoled or coerced. Instead, it can be unleashed."[92]

Dr Steven Kelman, Harvard University

Attributes of effective teams[93]

Purpose
People may become disengaged and demotivated at work if they don't understand, or can't invest in, the 'bigger picture'. Leaders should aim to involve the whole team in developing the vision and aims of the practice

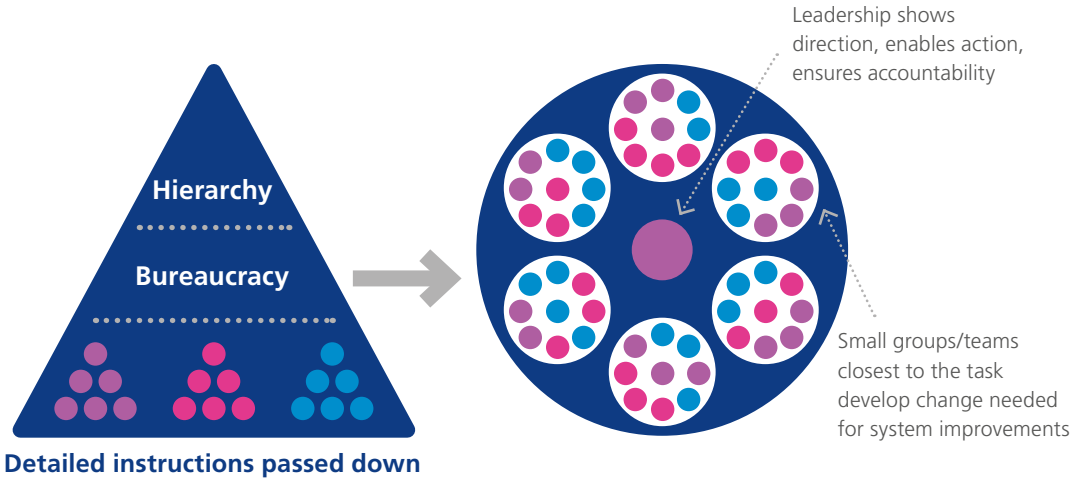
Autonomy
All team members should be able to suggest and act upon ideas that affect their working day – to have the autonomy to act. Leaders articulate clear goals and direction, then 'develop the team to do the task', within clear lines of accountability and safe practice

Safety
The highest-performing teams are those where members can speak up when mistakes are made without fear of the consequences, enabling learning and resilience

Relationships and belonging
Listen, hear and value everybody's contributions. Consider how your meetings work and if everybody's voice is heard

We all want to be good at what we do
Protected space and time to learn and improve

Figure 22: Autonomy in the team[94]



In general practice teams, goals and decisions may flow from a small leadership team. This provides stability but sometimes at the cost of rigidity, leaders can feel overwhelmed, team members disempowered, and this can create bottlenecks where things don't progress.

With a more independent approach, leaders could choose a direction and create a way in which people could be accountable. Within that framework, those closest to the work would be given the resources and decision-making power to make things happen.

A framework of accountability involves leading by example, celebrating success, identifying and addressing problem attitudes and behaviours, dealing promptly with any form of discrimination both from patients to staff and staff to patients.

[92] S Kelman (2005). Unleashing change.
[93] M West and D Coia (2019). Caring for doctors, caring for patients.
[94] Anghina and others (2018). The five trademarks.

4.5 Teams across organisations

Cross-organisational relationships differ from the stable relationships we develop within our practice teams, with different challenges in terms of leadership and accountability. Examples of this could be multidisciplinary meetings with community pharmacy colleagues and agreeing local urgent care pathways with multiple providers.

Working effectively in more fluid teams has been described as 'teaming' with a collaborative mindset – quickly sharing and valuing the experience of others. Amy Edmondson describes it in her TED Talk: How to turn a group of strangers into a team.[95]

Section 5 of the manual – Access beyond the practice – describes some of the teams with which general practice overlaps in providing access and patient care.

4.6 Virtual meetings

We thought it may be useful to include some pointers for effective virtual meetings to support your team.

Tips for leading virtual meetings[96, 97]	
Ground rules: for example, come on time, be prepared, no multitasking, but be forgiving for interruptions by children, pets and doorbells	**Actively listen** to the facts, feeling and intention
Virtual handshakes: create space to briefly hear something from everybody at the beginning and end of the meeting	**Incorporate the informal:** a little chat or personal news can help teams connect
Sub-groups: breaking out into smaller groups reduces formality and allows connection	**Mixing face-to-face and virtual participants:** avoid this as it can have a negative effect on group trust

4.7 Resources: The team

R

General team resources
The primary care network handbook, BMA
Health Education England training – e-Learning for Healthcare guide for primary care: details on job descriptions, skills and competencies, funding and training opportunities for all ARRS roles
Londonwide LMC learning: LMC training packages for the general practice team, accredited by RCGP, Middlesex University and the CPD Certification Service
General Practice Development Programme, NHSE, viewed December 2020
London Leadership Academy
Health and Care Video Library
NHS Health Careers
NHS People's Plan 2020/2021, viewed December 2020
NHS information on expanding the primary care workforce, August 2020
Time for Care Team, viewed December 2020

GPs
New to practice fellowships 2020/2021: for nurses and GPs, viewed December 2020
New to Partnership Payment Scheme, viewed December 2020
Supporting Mentors Scheme: A national scheme offering highly experienced GPs the opportunity to mentor newly qualified GPs entering the workforce through the fellowship programme

[95] A Edmondson (2017). How to turn a group (12min video).
[96] K Ferazzi (2015). How to run a great virtual meeting.
[97] S Hulks (2020). Leading Teams Virtually.

Practice nurse and Nurse Practitioner

New to practice fellowships: for nurses and GPs, viewed December 2020

New to Partnership Payment Scheme, viewed December 2020

The Power of Practice Nurses in London: podcasts and recruitment resources, viewed December 2020

Retaining General Practice Nurses: A guide for GPs and Practice Managers – a report by Capital Nurse, June 2020

General Practice Nursing in the 21st Century, The Queen's Nursing Institute survey, 2016

RCGP GPN Competency Framework, viewed December 2020

HEE District Nursing and General Practice Nursing Service, Education and Career Framework 2015, viewed December 2020

General Practice Nurse Education Network, viewed December 2020

Queens Nursing Institute: charity supporting community nurses, including practice nurses

Healthcare Assistants

Nigel's surgery 57: Health Care Assistants in General Practice

Practice Managers

Practice Managers Association, viewed December 2020

NHS Careers information for Practice managers, viewed December 2020

First Practice Management, viewed December 2020

AMSPAR diploma in Practice Management, viewed December 2020

Front desk teams

NHSE Training for reception and clerical staff, viewed December 2020

Medeconomics' Tips for helping your receptionists perform at their best 2017

NHS Health careers – administrators and receptionists

Practice Pharmacists

NHSE Clinical Pharmacists in general practice programme, viewed December 2020

Why having a mentor is so important to pharmacists working in general practice – The Pharmaceutical Journal

A Guide for GPs considering employing a practice pharmacist, RCGP and Primary Care Pharmacist Association, viewed December 2020

Pharmacists in Primary Care Networks. Royal College of General Practitioners and Royal Pharmaceutical Society's co-badged statements on the use of community and clinical pharmacists, viewed December 2020

Social Prescribing Link Worker (SPLW)

NHSE resources and case studies on social prescribing, viewed December 2020

NHSE SPLW Welcome pack, viewed December 2020

BMA Social Prescribing: Making it work for GPs and patients, viewed December 2020

RCGP Person-Centred Care Toolkit, viewed December 2020

National Association of Link Workers, viewed December 2020

The Asset Based Health Inquiry, How to best develop social prescribing? London South Bank University, 2019

First contact physiotherapists

HEE Musculoskeletal First Contact Practitioner Services guide

5. Access beyond the practice

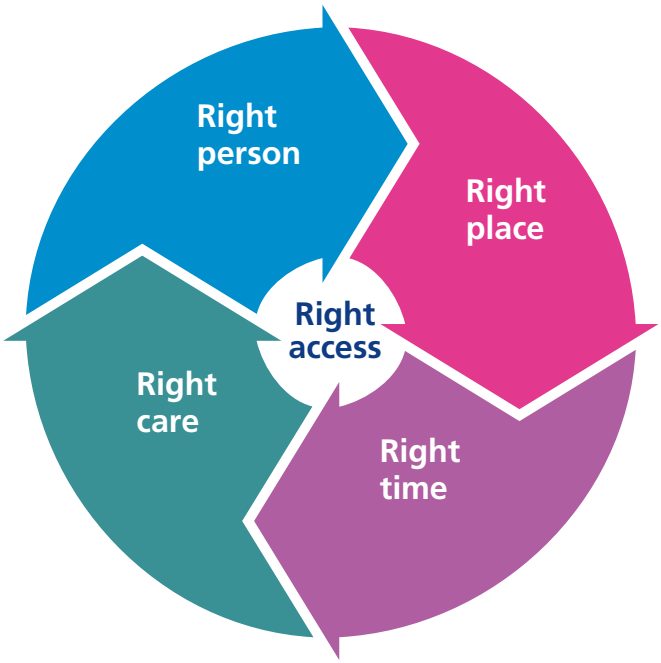
Patients' ability to access one part of the health and care system impacts on other parts. These relationships are complex, non-linear and in constant flux. Patients find it particularly challenging to navigate the Out of Hours (OOH) space as there are different services designed around patient need and convenience.

When developing your practice access system, it is important to consider:

- **how to make local services work best for your patients**
- **when to signpost**
- **how to respond when you patient has been seen elsewhere**
- **how information flows work.**

Consistent messaging will reduce the risk of multiple contacts and fragmented patient care.

Figure 23: Right access[53]



How patients use one service over another can have a ripple effect through the system. Patients choose other services when their problems could be better dealt with in general practice for multiple reasons. Many of those reasons are beyond an individual practice's control. Use data on how your patients use other services to help inform your own practice systems. You will have greatest impact by working with services where joint pathways and working are likely to benefit the most patients – such as community pharmacy or community nursing teams, with whom practices have multiple daily contacts.

It can be hard to keep up to date on other services – work with your PCN and Clinical Commissioning Group (CCG) to help shape and understand changes to your local system.

Helping patients receive the right service for their needs first time reduces unnecessary contacts and fragmented care.

5.1 Information flows

A well-informed team	Individual team members need to be aware of local services and where to look for ever-changing details. A lead person in the team can be responsible for recording and communicating changes to the wider team, and updating websites and other information sources to patients Commissioners are responsible for ensuring that practices are kept updated of changes to local services
Well-informed patients	Staff signposting should be reinforced through consistent communications on telephone answer messaging, practice websites, posters and video information in the waiting room. This should include directing patients to other healthcare professionals when appropriate, for example, dental problems to dentists
Practice website	A well-designed and regularly updated website will keep staff and patients informed and help patients get to the right place for their care. Several companies offer practice website support. Work with patients to ensure your website meets patients' needs
Information transfer between services	From other services to general practice, providing a timely and useful communication of patient contacts
	From general practice to other services, for example, agreed local referral templates and pathways, Coordinate My Care (CMC) which have clearly visible care plans – especially useful for patients with complex needs
	Consider using recognised communication tools such as Situation, Background, Assessment, Recommendation (SBAR)[98] – a communication tool to support communication of patient care between services
Directory of Services (DOS)	Keep your local Directory of Services (DOS)[99] updated with your services and opening times

Signposting resources

Use borough-based, regional and national resources. Individual practices may struggle to keep on top of all changes themselves. Ideally, CCGs should have a communications capability that supports consistent social media and patient-facing communications

NHS.UK[100] directs patients to self-care, local services and online services. Front desk staff can use its up to date information, maps and opening times to find local health services like opticians, pharmacies and urgent care	**When to call 999**[101]: NHS advice on what is an emergency
Local online signposting, local authorities, acute and mental health trusts, community services and third sector may have useful websites with information for patients and practice teams on services. Consider adding links to your website	**NHS App**[102] enables patients to access general health information, their GP record, book appointments and order repeat prescriptions

[98] NHS SBAR Implementation and Training Guide.
[99] NHS. Digital Directory of Services.
[100] NHS webpage.
[101] NHS. When to call 999
[102] NHS. About the NHS App.

Figure 24: General practice access in the wider system

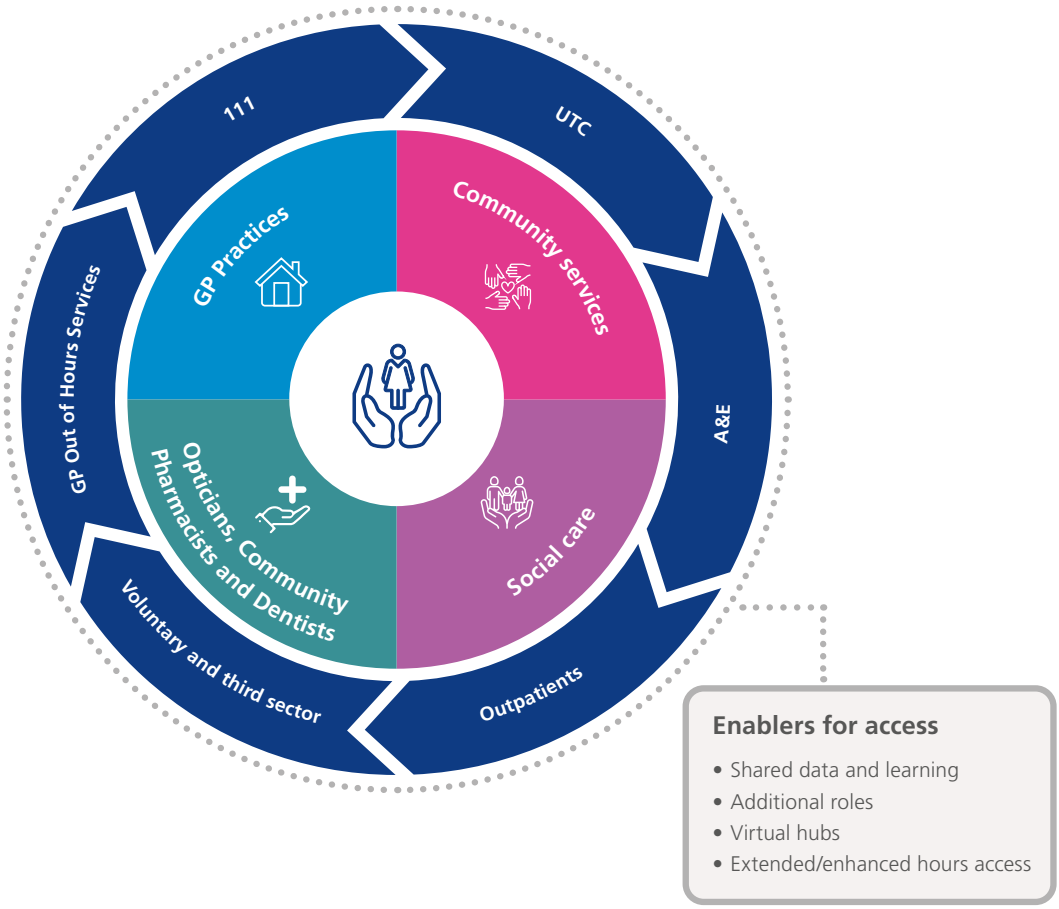


Table 10: Digital information flows between providers

GP Connect[103]	Allows authorised clinical staff to share and view GP practice clinical information and data between IT systems, quickly and efficiently
NHS Central Spine[104]	The digital central point for NHS online services and the exchange of information across local and national NHS systems
Co-ordinate My Care (CMC)[105]	Together with their clinicians, patients may record their preferences and wishes within an electronic personalised urgent care plan that also includes clinical information and relevant medical history. All the healthcare professional teams involved in the patient's care, including ambulance staff in emergencies, can view this care plan
Care Information Exchange[106]	An example of data sharing for patients and professionals in health and social care
Care Connect Open Application Programming Interface (APIs)[107]	Developed by NHS Digital and INTEROPen to support the delivery of care by opening up information and data held across different clinical care settings

[103] NHS Digital. GP Connect.
[104] NHS Digital. Spine
[105] NHS. Coordinate my care.
[106] Care Information Exchange North West London.
[107] NHS Digital and INTEROpen. Care Connect API.

5.2 Patient access: the relationship between general practice and other providers

5.2.1 Community pharmacy

Community pharmacy offers a range of services to promote self-care and reduce demand in general practice. Effective repeat prescribing systems, digital solutions such as electronic prescribing and encouraging use of the NHS App to order prescriptions can all make patients' lives easier and reduce the risk of unnecessary patient contacts. A practice pharmacist is well placed to lead on pathways with community pharmacy teams.

Table 11: Typical services offered by community pharmacy that can help GP access

Community Pharmacy Consultation Service (CPCS)[108]	Practices can signpost or triage patients with minor ailments to a community pharmacy contact. The pharmacist has access to the summary care record and can also return information to the GP using a secure connection
New Medicine Service[109]	Advice for patients starting new medicines for long-term conditions. Prompt your patients to ask for this additional support
Vaccination delivery	Ensure prompt information-sharing pathways in place
Other pharmacy services	Emergency contraception
	Smoking cessation advice
	Weight management
	Flu vaccinations

5.2.2 Dentists

Patients may need to be informed that dentists can prescribe antibiotics and pain killers for dental conditions and these requests should not come to the GP. Visit the NHS website[110] for information on how to find an NHS dentist.

5.2.3 Opticians

As well as eye tests, many areas run local NHS schemes with specially trained community opticians for minor eye conditions. Find out if these are available in your area. You can save the patient and practice time by sending a text to patients needing an eye exam as part of a medical report to get a documented optician's eye test.

[108] NHS (2020). Community Pharmacy Consultation Service.
[109] NHS (2020). New Medicine Service.
[110] NHS. How to find a dentist.

5.2.4 NHS 111

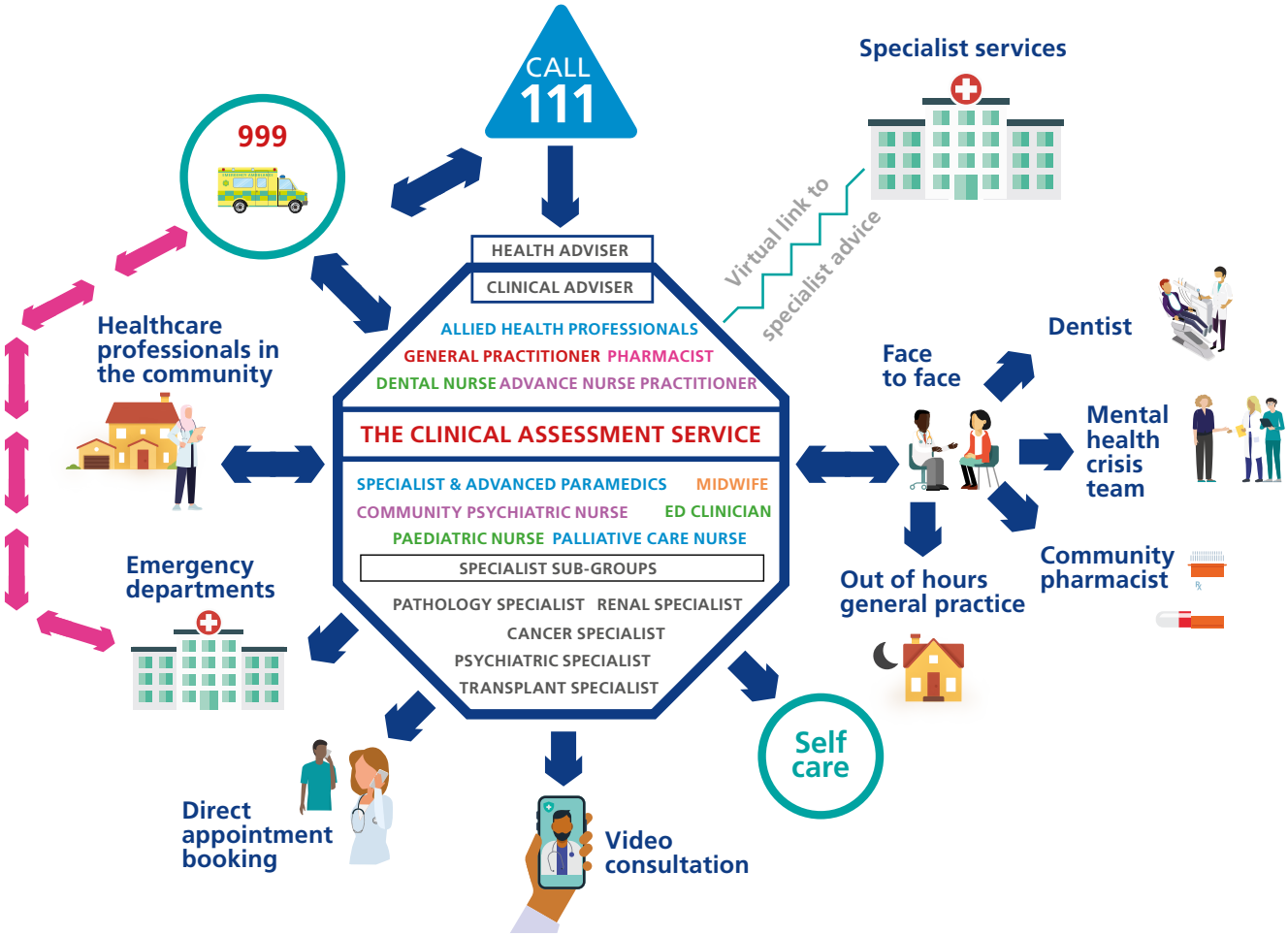
The 111 service can now book directly into GP appointments and many areas use it as the first point of contact when the practice is closed. Practices need a clear understanding of how 111 works to align with their own access systems. Recent 111 changes include increased clinical input into the advice and care for callers contacting 111. Health advisers using a clinical decision-making support system and clinician assessments result in a **disposition** which directs the management of each patient, for example, to self-care.

Using a **Directory of Services (DoS)**[111], the 111 team can book patients directly into urgent treatment centres (UTCs), pharmacy, Extended Primary Care Services (EPCS), dentists and general practice in and out of hours. Surgeries must keep an agreed number of appointments per day for 111 bookings. It is CCGs' responsibility to collect information from on-the-ground teams to update the DOS with changes to, for example, opening hours and waiting times. If the DOS is not up to date, there is a risk that patients are directed to a service that does not suit their needs and NHS resources do not deliver best value.

The 111 Clinical Assessment Service includes connections to hospital experts, for example, cancer and renal specialists, community services such as care homes and the London Ambulance Service (LAS) can use the 111 service to seek expert clinical advice to help manage patients. This cross-organisational integration is enabled by GP Connect.[112]

111 First[113] enables Direct Booking from NHS 111 into local Accident and Emergency departments (A&E), intending to shift patient behaviour to call 111 before attending A&E. Patients then receive a dedicated appointment time if their 111 disposition directs to an A&E attendance, aiming to protect A&Es from overcrowding.

Figure 25: NHS 111 pathways[114]



[111] NHS. Digital Directory of Services (DoS)
[112] NHS Digital. GP Connect.
[113] Healthwatch Islington (2020). NHS 111 First.
[114] NHS (2019). Next Steps for 111.

5.2.5 GP Out of Hours Services (OOH)[115]

OOH services provide general practice care for problems that can't wait until the surgery is next open. The GP survey has highlighted that patient awareness of the GP OOH service is often poor, particularly among younger patients and patients from Black, Asian and Minority Ethnic (BAME) groups.[116] Patients and carers need information from the practice team, website and telephone message saying local general practice OOH care is available when their practice is closed, when to use the service and how to access it.

There is a range of OOH providers across London, including private providers, not-for-profit and social enterprises – usually staffed and led by a team of local clinicians. OOH services typically offer telephone, video and face-to-face contacts at a local base or via a home visit and are integrated to accept referrals from A&E, 111 and UTCs. There must be clear and prompt pathways in place for practices to be updated for any care given to their patients in the OOH service.

5.2.6 Primary Care Networks (PCNs)

PCNs bring general practices together to work at scale and with other community providers. They are an integral part of the NHS Long Term Plan.[117, 118, 119]

An important ambition for PCNs is improved patient access, through a number of routes:

- ARRS – (described in section 4.2.1), increasing capacity and releasing GP time for more complex care
- Responsibility for provision of extended/enhanced hours
- More integrated care as services come together, reducing the risk of duplication
- Shared learning and collaboration between practices
- Improved population health and reduced health inequalities, reducing the need for unplanned care

PCNs are emerging and will need to balance the potential efficiencies of at-scale collaboration with continuity of care and personalised care provided in smaller, practice-based teams.

5.2.7 Urgent Treatment Centres (UTC)[120]

Typically encompassing **Walk-in Centres, Minor Injury Units and Urgent Care Centres.**

UTCs are intended to be a primary or community-delivered service, often co-located with other urgent care services such as EPCS or A&E. They include walk-in appointments and bookable slots through 111. GPs should be updated when their patients attend a UTC and UTCs should be commissioned against an agreed set of standards, including opening hours, routes of access and integration with other local services.

[115] NHS. NHS out-of-hours service.
[116] Comptroller and Auditor General (2014). Out-of-hours GP Services.
[117] NHS (2019). The NHS Long Term Plan.
[118] B Baird and J Beech (2020). Primary Care Networks.
[119] BMA (2020). Primary care network handbook.
[120] NHS. Urgent Treatment Centres.

Typical presentations suitable for a UTC	
Strains and sprains	Skin infections and rashes
Suspected broken limbs	Coughs and colds
Minor head injuries	Feverish illness
Cuts and grazes	Eye problems
Bites and stings	Vomiting and diarrhoea
Minor scalds and burns	Abdominal pain
Ear and throat infections	Emergency contraception

There is a clear overlap with typical UTC and GP presentations, and presentations that a community pharmacy could manage. Practices should agree as a team when to signpost a patient to a UTC, and which patient's needs would be better dealt with by the patient's general practice team or another provider. This is an area ripe for pathway development across providers. UTC provision varies widely across London. Find out what is on offer close to you; for example, does your local UTC have x-ray?

NHS England has published principles and standards[121] as well as FAQs[122] for commissioners establishing UTCs.

5.2.8 Accident and Emergency (A&E) – also known as Emergency Department (ED)

There are multiple reasons why a patient chooses A&E instead of GP services, many outside a practice's control.[123] Patients who frequently attend A&E are likely to frequently attend their registered practice and A&E attendance are highest among older patients, those with multiple conditions and those with lower levels of educational qualifications.[124, 125, 126] Patients may attend A&E because they perceive difficulty accessing their GPs, negative press or as directed by another health professional.[127] Reduce the risk of A&E attendance when the practice could better meet a patient's needs using a range of communication methods to ensure your patients (and the practice team) know what to expect from their practice. For example, on your website, answer machine message and even on your front door, include:

- when you are open
- that you will respond to emergencies in hours
- where to seek help when you are closed
- signposting to online consultations for non-urgent queries OOH
- what other services are available locally, like UTC.

Have a clear system in place for patients who may need additional, tailored support to reduce frequent attendances in A&E and other settings (see 3.5 Patients who need additional tailored support).

111 First: see 5.2.4. NHS 111

[121] NHS (2017). UTC principles and standards.
[122] Acute Care Team, NHSE/I: UTC FAQs.
[123] R. Rosen (2017). Why extending GP hours.
[124] NIHR (2019). GP or A&E?
[125] Hull and others (2018). Population and patient factors.
[126] Hull and others (1998). Use and overlap of AED and general practice.
[127] Royal College of Emergency Medicine (2015). Time to Act.

5.2.9 Acute outpatient services

An effective interface between primary and secondary care is crucial for safe patient care and best health service value. Access in one sector impacts on the other. Timely and comprehensive information flows are needed to reduce the risk of failure demand leading to unnecessary patient contacts and work for the practice.

Suggested practice initiatives to ensure patients receive the best access include:

- Patients waiting for long periods for specialist appointments and treatment are likely to re-present to primary care. Simple steps like signposting to local acute Patient Advice and Liaison Service (PALS)[128] when making referrals allows patients to chase up their appointments themselves
- Advice and guidance function on Electronic Referral Service (e-RS)[129] for queries
- Consultant Connect,[130] if available in your area, for immediate senior clinician advice
- Encouraging patients to use self-referral when available
- A range of well-promoted self-referral services

Work with PCN, CCG and local trusts to develop pathways and templates to ensure the best value from secondary care services.

The BMA has produced guidance and letter templates for general practice to use if secondary care is making inappropriate requests.[131]

Clinical responsibility when referring between services

Consider where the responsibility lies:

- with the referring service for the correct assessment, advice for worsening symptoms and appropriate onward referral or advice
- with the patient (or guardian) to follow such recommendation
- with the receiving service
  - for timely management of the patient once they have presented to the service
  - or on the receipt of an agreed method of arranging a call back to a patient
  - for example using the Interoperability Toolkit (ITK).[132]

It should be noted that the receipt of any message to advise of the potential presentation of a patient to a non-bookable service, or the booking of an appointment alone, should not be considered as transfer of responsibility for further care.

Outlined within NHS England and NHS Improvement's guidance for Urgent Treatment Centres – FAQs to support implementation.[133]

Always consider possible safeguarding issues for children or vulnerable adults who miss appointments. Watch this short film: Rethinking DNAs.[134]

[128] NHS. What is PALS?
[129] NHS Digital. e-Referral Service.
[130] Consultant Connect.
[131] BMA (2020). Pushing back on workload.
[132] NHS (2020). Digital Interoperability Toolkit.
[133] Acute Care Team, NHSE and NHSI (2019): Urgent Treatment Centres – FAQs
[134] Safeguarding Nottingham (2017). Rethinking DNAs.

5.3 Resources: Access beyond the practice

R

Information flows

Technical:
GP Connect, NHS Digital, viewed January 2021
Spine, NHS Digital, viewed January 2021
Care Connect, viewed January 2021

Handover:
NHS SBAR Implementation and Training Guide
Coordinate my care, viewed January 2021

Directories, patient and front desk resources:
Directory of Service (DoS), NHS Digital, viewed January 2021
London Ambulance Choose Well, viewed January 2021
NHS App information, viewed January 2021

Community pharmacy

Community Pharmacy Consultation Service (CPCS), NHS, viewed January 2021
New Medicine Service, NHS, viewed January 2021

PCN

The Primary Care Networks Academy
Primary Care Network, NHS Confederation
Understanding primary care networks, The Health Foundation

111

NHS 111 Directory of Services: Frequently Asked Questions
GP Connect, NHS Digital, viewed January 2021
NHS 111 First, Healthwatch Islington, viewed January 2021

UTC

Urgent treatment centres, NHS, viewed January 2021

Secondary care

What is PALS (Patient Advice and Liaison Service)? NHS, viewed January 2021
NHS e-Referral Service, NHS Digital, viewed January 2021
Consultant Connect, viewed January 2021

6. Making change

Key messages:

- **Improvement involves investment of time and resources.**
- **Improvement is a team sport and most effective in cultures where those closest to the task inform and lead on change.**
- **Small improvements develop confidence and free capacity, leading to larger improvements and a learning team culture.**
- **Proportionate use of quality improvement (QI) methods and data can help your team become more effective, happier and improve patient outcomes.**

This section looks at making the changes needed to deliver improvement projects, exploring what are simple tasks that need doing – and what would benefit from more formal QI methods. Involving patients, carers and the team to achieve small changes can release capacity for larger changes. We hope this section helps 'improvement newcomers' take the first steps to make a change and acts as a helpful update for those with more improvement experience.

The approach and methods described are not unique to access improvements but can be used to implement any improvement you intend making in your practice or PCN.

"QI involves a **structured approach** to tackling **complex** problems. It offers practices the chance to free up capacity and time by tackling constraints, delays, duplication and other problems in their care processes and pathways. It allows them to take a step back and look with fresh eyes at the service they provide, and the tools they need to do things differently."[135]

Health Foundation December 2019

"While all changes do not lead to improvement, all improvement requires change. The ability to develop, test and implement changes is essential for any individual group, or organisation that wants to continuously improve."[136]

Institute for Healthcare Improvement

[135] The Health Foundation (2019). Quality improvement in general practice.

[136] Institute for Healthcare Improvement (2021). Changes for Improvement.

6.1 What does good quality improvement (QI) look like?

Improvement is everyone's business

All general practice team members are empowered to contribute to improvement and can relate this to their daily work

Teams have dedicated capacity for QI

We have the capacity to focus on continuous improvement in a meaningful way

Teams have QI skills and tools

Trained change leaders support teams to use best available methods and tools to continuously improve

The right incentives facilitate QI

Incentives are used thoughtfully, only where they will have helpful impact

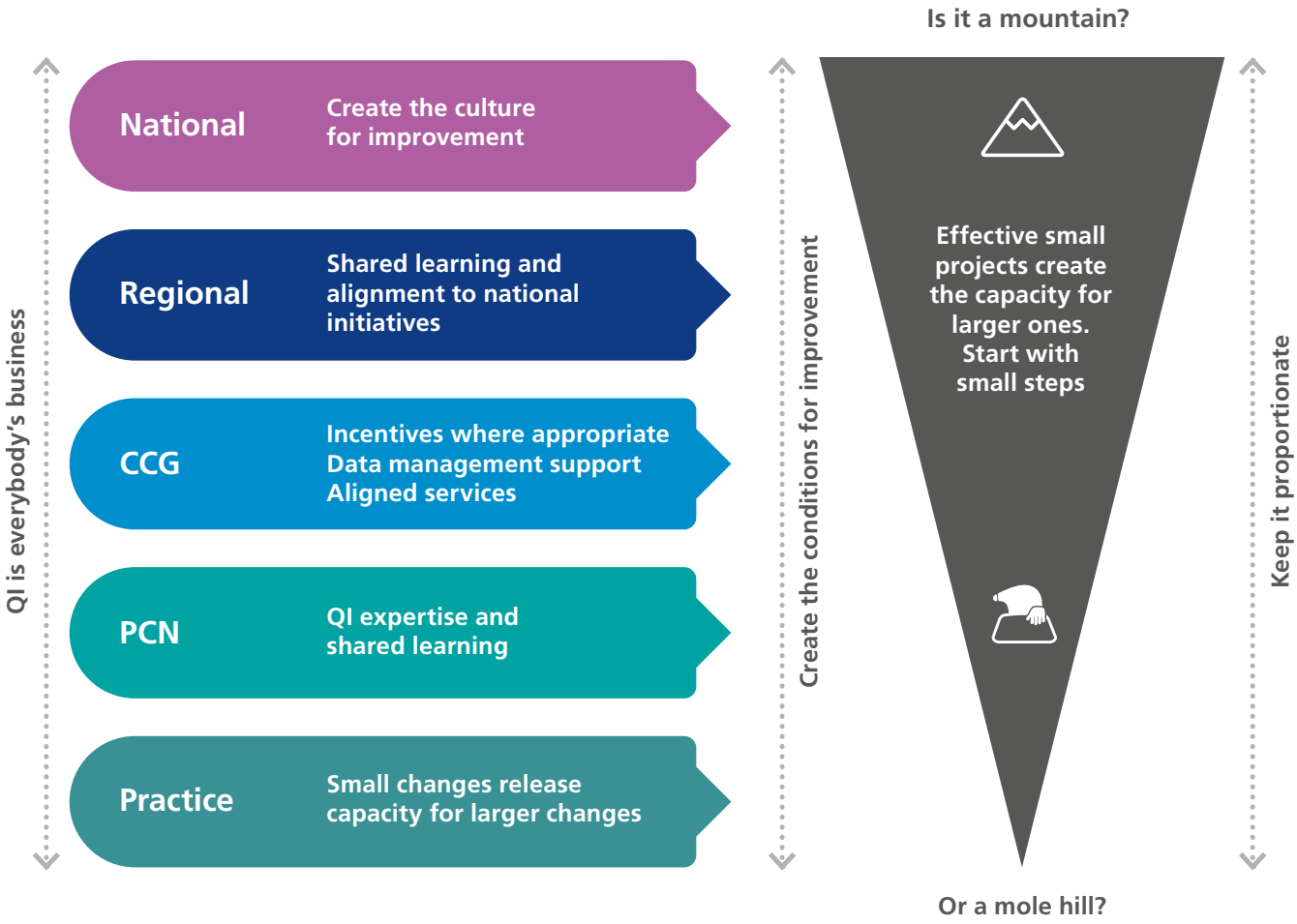
Useful data and information supports QI

We have trusted information to help us focus our effort, understand how we are doing and share our learning

Though nearly all practice teams are involved in improvement, many are not familiar with structured QI methods. Most GPs and PMs are interested in a better understanding of QI methodology but cite time, staff shortages and other NHS agencies' demands as barriers.[135] Other recognised barriers to improvement include fragmented and inconsistent data, a crowded and confusing improvement landscape, top-down initiatives and incentives that may not resonate with local priorities.

There needs to be commitment in every part of the NHS for successful improvement, not at the practice level alone. Working collaboratively in PCNs is an opportunity for practices to share QI resources, expertise and learning.

Figure 26: A commitment to change is needed at every level of the NHS



If you are new to QI methods, keep it simple with a small, realistic change project to develop your and your team's confidence and build on this over time. Larger changes may need more experienced help. Practices within a PCN or community of practices[137] may share a QI lead with training and experience to draw on.

Not every improvement needs formal QI methods; some tasks just need to be done (see table 12: Is it a task or a test?). Be proportionate when planning for change. QI methods don't always need to be used in their 'pure' form but can be mixed and adapted to suit the needs of your planned changes and team.

Build on what has been successful elsewhere, most problems are not new or unique to your practice (see Appendix 2 for Suggested access improvement projects).

"Having hundreds of organisations all trying to do their own thing also means much waste, and the absence of harmonisation across basic processes introduces inefficiencies and risks."[138]

Mary Dixon-Woods, Professor of Healthcare Improvement Studies, University of Cambridge

6.2 Key ingredients for improvement

6.2.1 People

"Healthcare improvements are 80% human and 20% technical."[139]

Whenever possible, work with your team, patients and carers on your improvement journey to ensure improvements remain patient-focused and empower and engage the team. This co-production may require a culture change and more collaborative ways of working for both professionals and patients. Patients' and carers' experience can be used to inform what to change and as a measure of improvement (see table 14: Patient experience measures.

Think about ways your team can actively encourage more feedback on your services – in the consultation room and via front desk teams. Purposefully engage with those patients most affected by a change – especially those from disadvantaged groups, for example, from digitally excluded groups (see figure 17: Patient groups likely to experience inequity in access) for digital innovations, and a broad patient representation from your local Healthwatch or your PPG. Welcome both positive and negative feedback to drive improvement.[140]

Demonstrate that you value and have acted on what you have heard:

- **'You said, we did' poster in waiting room, in practice newsletters and on website**
- **A standing item in team and PPG meetings to share improvement successes and discuss what further improvements are needed and consider social media channels for sharing improvements**

Section 4 of this manual looks at how to support and develop your team – engaging, empowering and devolving decision-making to those closest to the task.

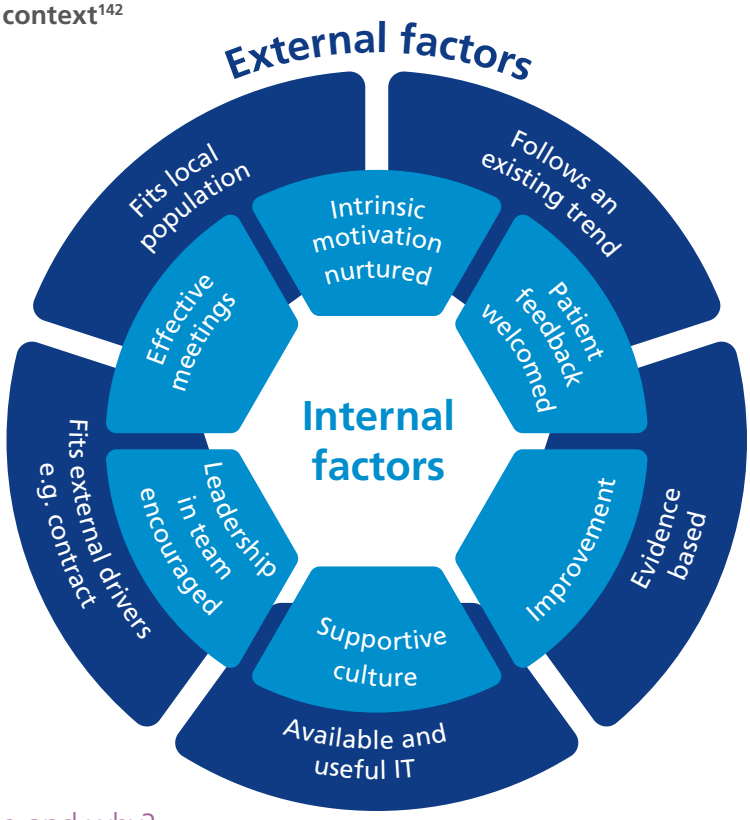
CQC inspections[141] may ask how people who use your service, the staff and patients, are engaged and involved.

[137] Health Innovation Network (2016). Communities of Practice.
[138] M Dixon-Woods (2019). How to improve healthcare.
[139] A Backhouse (2020). Quality improvement into practice.
[140] Parliamentary and Health Service Ombudsman. Good leadership.
[141] CQC (2018). Five key questions we ask.

6.2.2 Culture and context

The Royal College of General Practitioners (RCGP) describes the internal and external factors[142] impacting the culture and context in which you are making change and has a context checklist you may find helpful. This checklist recognises the external factors, out of individual practices' control, and the need for an improvement culture and resource at every NHS level (see figure 26: A commitment to change is needed at every level of the NHS). Depending on the change you want to make you will need to decide whether to address or work around any cultural or contextual challenges. Your team underpins the culture and context in your practice (see 4.4 Developing the team).

Figure 27: Culture and context[142]



6.2.3 What to change and why?

One of the biggest challenges of improvement is prioritisation of projects.

The Pareto Principle states that 20% of the sources cause 80% of any problem. It is a tool reminding you to focus on the 20% that matters, 'the vital few', which will have the greatest impact if solved, rather than the 'trivial many'.[143]

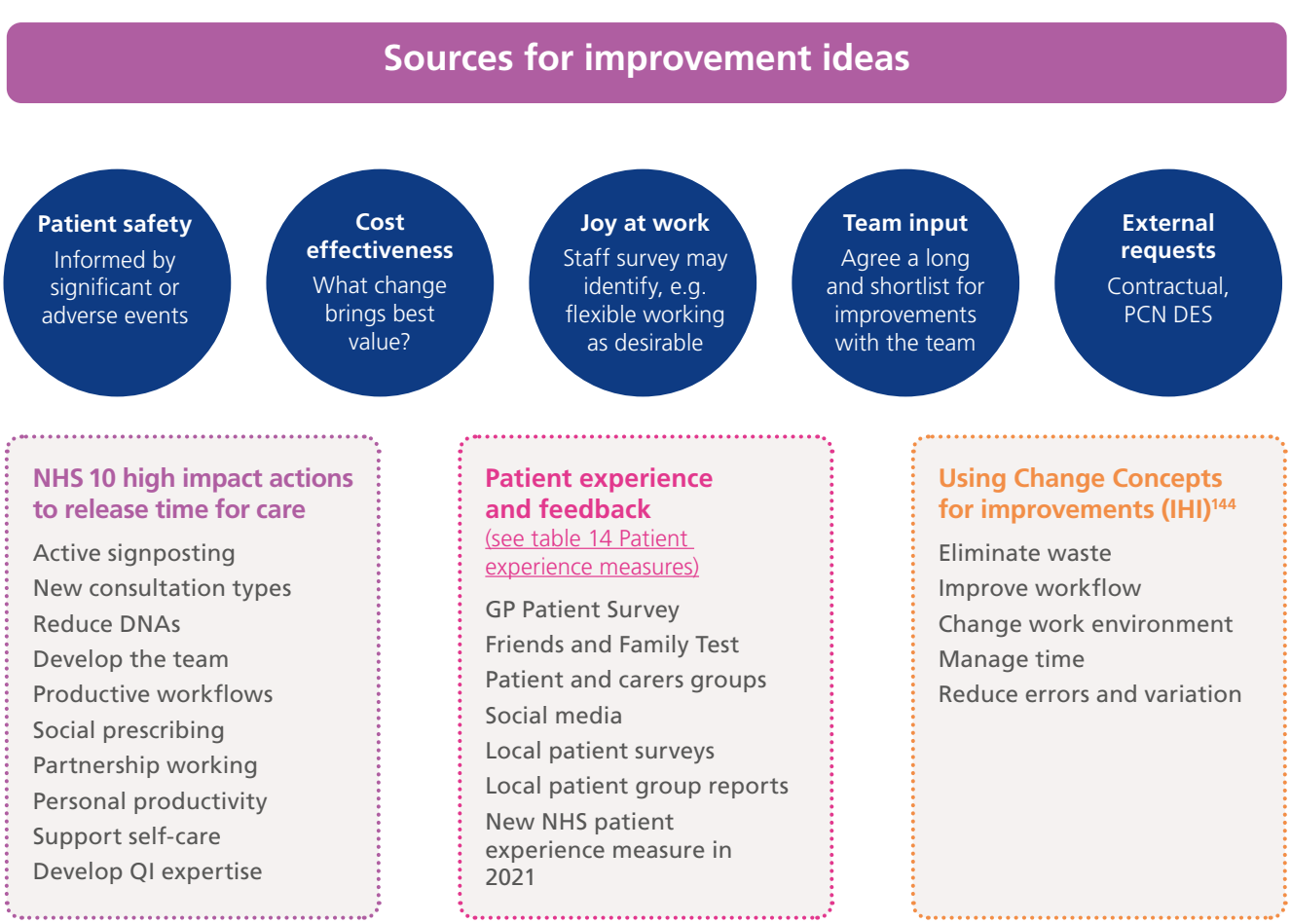
Useful questions to ask when choosing improvement projects

- What will bring the most benefit – and to whom?
- What will engage team members and service users in the improvement work?
- Is the problem right for a QI project or is this an implementation project?
- What is within our control to change?
- What not to focus on – recognising that we can't do everything
- What is achievable with the skills and capacity of the team?

[142] RCGP QI Ready. Learning Network.

[143] NHS East London Foundation Trust (2014). The Pareto Principle.

Figure 28: Sources for improvement ideas



Spending time on this step of the journey to agree on a clear focus for your improvement will pay dividends down the line. The sources for improvement ideas summarised in figure 28 may give ideas but most importantly work with your team, patients and carers to identify improvement projects most needed in your practice. Agree on small steps, each with a precise aim, and empower team members to own and make changes.

Tips for choosing access improvement ideas as a team:

- **Make a to-don't list – things we want to stop doing**
- **Find out about the 'pebbles in people's' shoes', capture frustrations a 'Grr wall' and fix them**
- **Don't innovate, exnovate – remove older technology and ways of doing things to make way for new developments**

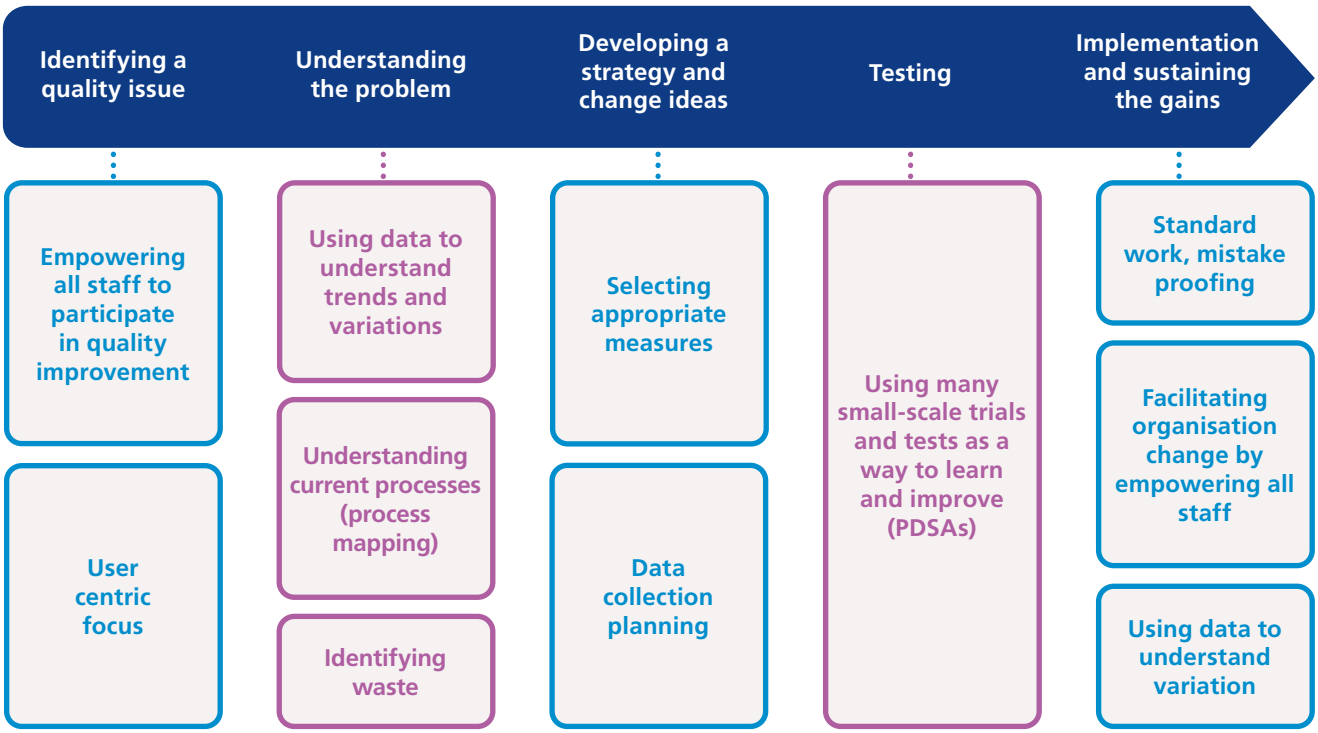
6.2.4 Have a plan: QI methods helpful in access improvements

Here, we summarise the most commonly used QI methods useful for access improvements. 6.3 Resource section shows more detailed information, other QI methods and resources.

QI methods should not over complicate what could be a simple task. For example, if clinical rooms are missing certain items – a quick conversation with the team to agree on a standard room-stocking list may be all that is needed to resolve the issue. Larger-scale changes such as introducing a mental health worker to the team or offering group consultations will benefit from a more structured QI approach using the tools described here. Figure 29 captures an approach to using QI methods.

[144] Using Change Concepts for Improvement (IHI)

Figure 29: A QI Approach, EQUIP[145]



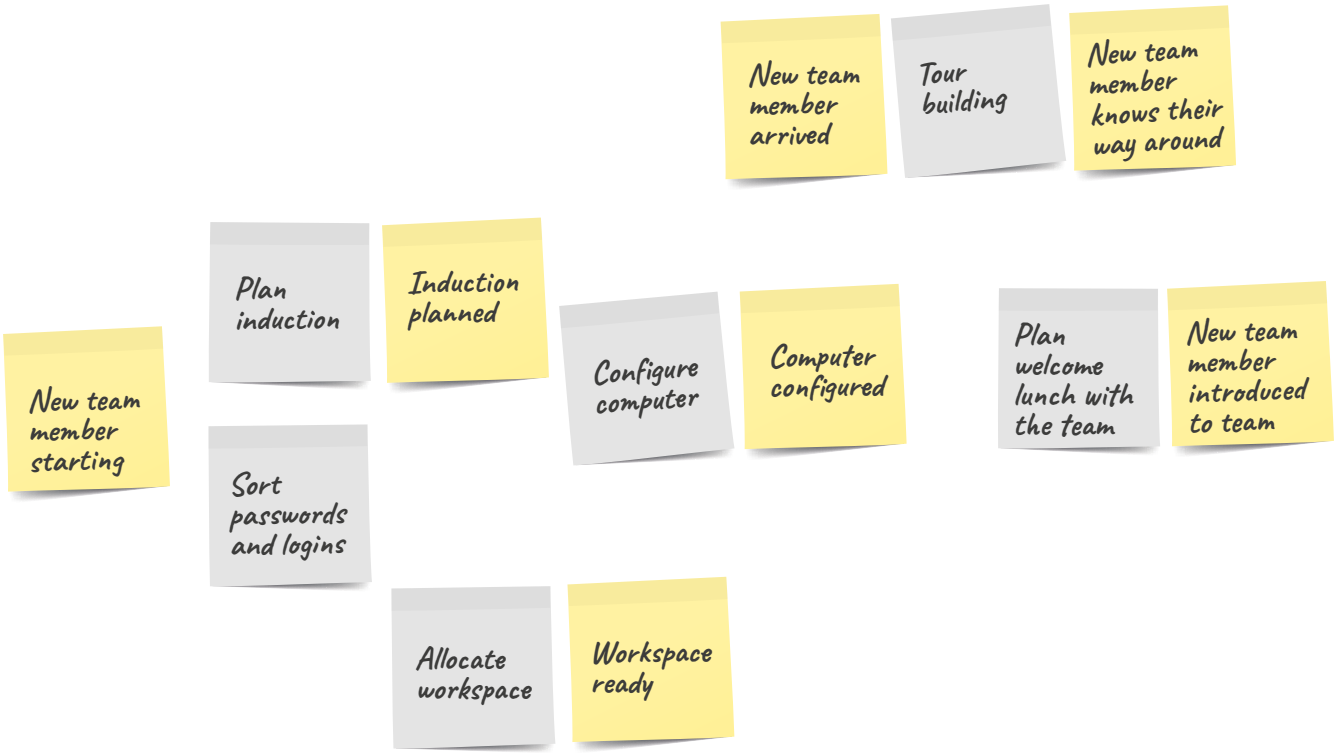
QI methods helpful in access improvements:

QI methods can overlap, be used separately or in combination depending on the task:

- Process mapping helps to identify trouble spots in your patient access pathway
- SMART objectives help to agree a clear aim
- A PDSA cycle can be used to test a change
- A clinical audit for a clinical issue impacting patient access, for example, high-risk drug monitoring.

[145] EQUIP (2020). Total Triage Manual.

Figure 30: Process mapping[146]



1. Process mapping

Process mapping is a visual and fun improvement tool, engaging the team and ideally patient representatives, looking at current processes and pathways and identifying areas that are causing problems or could be improved. Though it takes time and planning, process mapping can ultimately save time by focusing your efforts and engaging team members and patients in improvement. Do the following:

- Plan an area of focus (see figure 28: Sources for improvement ideas). For example, booking appointments.
- Have the right people in the room (or virtually!) – those who use and understand the pathway.
- Agree who is leading the session.

Process mapping leader tasks
Consider using online tools like Jamboards and Lucidcharts
Consider journey mapping.[147] Walk through the process you are mapping 'live', for example, trying to make an appointment, to experience the process 'warts and all' – mapping what really happens rather than what we think is happening
Use one colour sticky note to map out where the process starts and finishes, and then the steps in between. It can take some time but ensures you all understand exactly what happens as it really is, not how you would like it to be
Once you have agreed the current process, then use another colour of post-it note to highlight points along the pathways that are bottlenecks, troublesome or wasteful
Look critically at the process to identify value-adding steps for the team and patient/carer
Agree who is currently responsible for each step and if that is the person best suited to the task
Review each of the trouble points and agree on an area or areas that you want to work on to improve

[146] RCGP (2017). Process and Value Stream Mapping.

[147] Sarah Gibbons (2018). Journey Mapping.

2. SMART aims

Once you have agreed an area for improvement, agree your precise aims and use a SMART approach to help you structure realistic and effective plans.

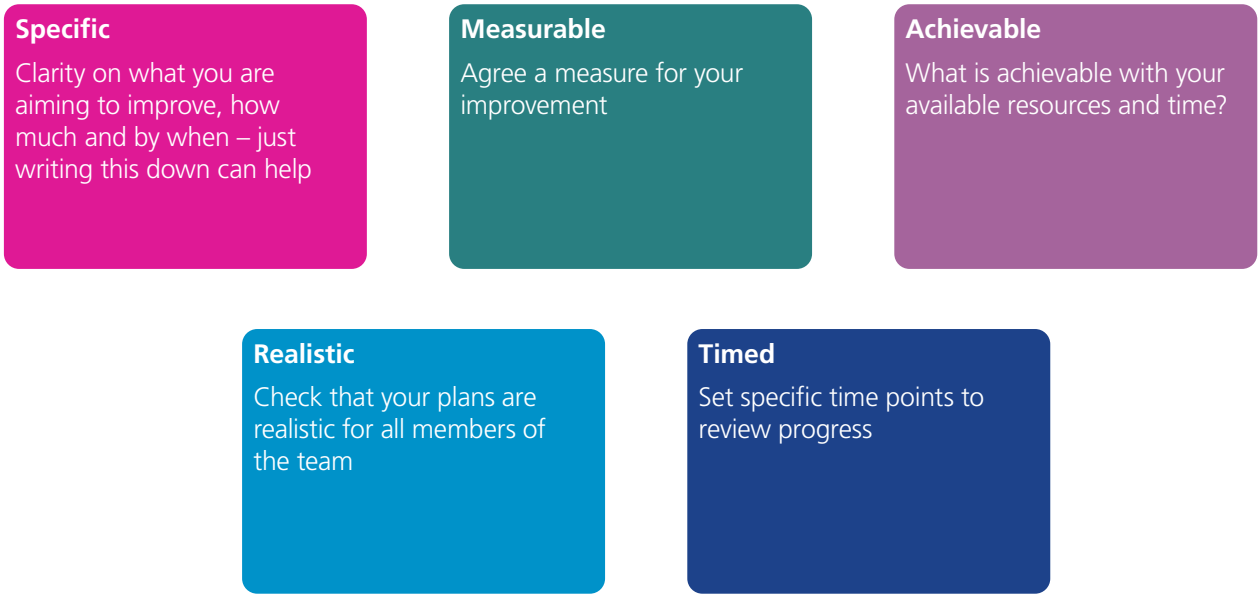


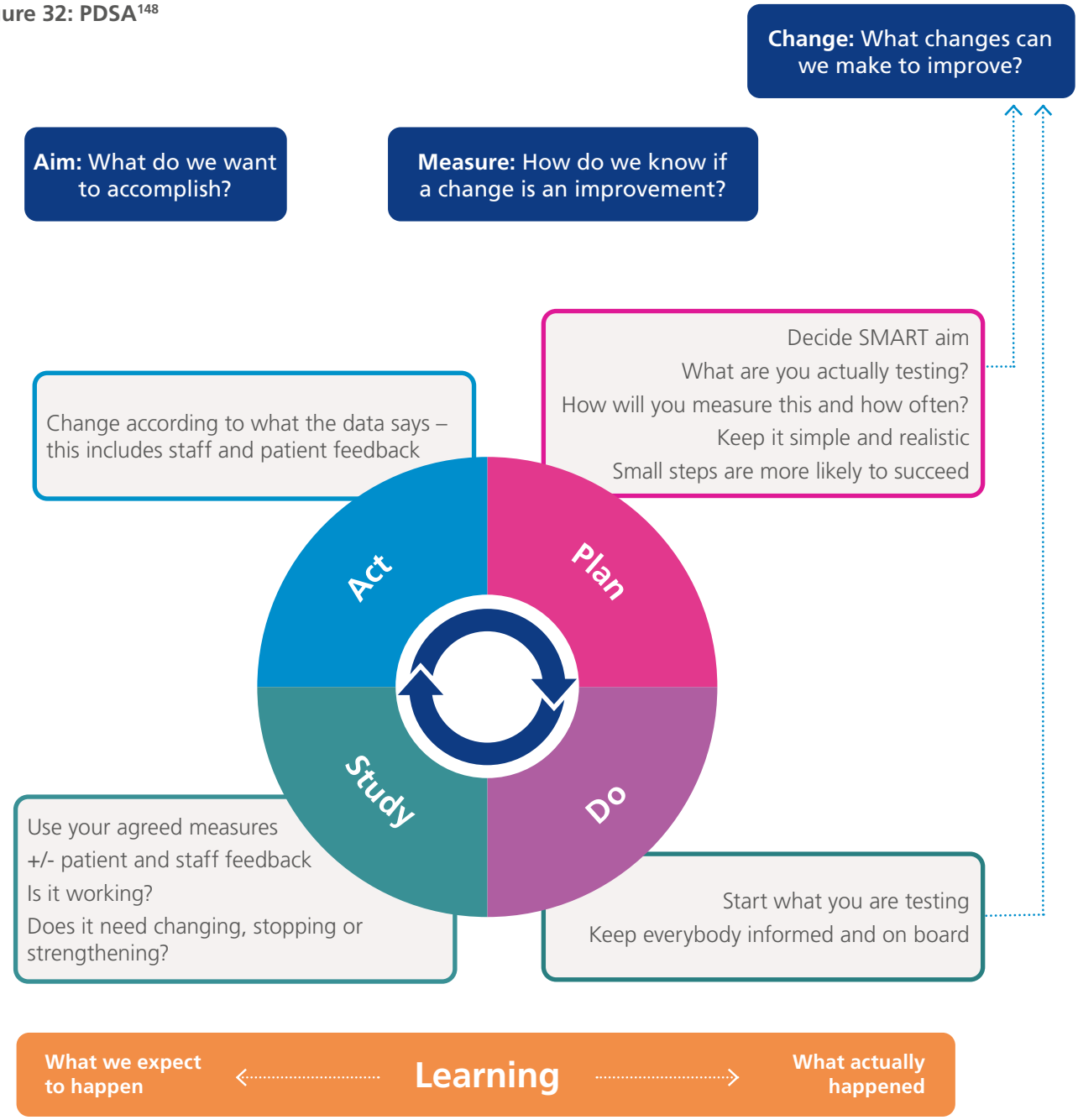
Figure 31: An example of a SMART plan – increasing online consultations

Specific
You want to increase the proportion of requests coming in via online consultation tool from 10% to 20% over three months
Measurable
Your measure will be the number of online consultations (numerator) as a proportion of all consultations (denominator) including telephone, face to face and visits – measured daily and expressed as a percentage
Achievable
This is achievable as you already have an online platform in place, you have plans and resources to update the practice website to encourage online consultation use, and will use existing meetings to train staff and the wider team, and the PPG to help plan a patient information approach
Realistic
You have discussed this at a patient and practice meeting and patients and staff agree it is achievable and desirable
Timed
You plan to achieve this over three months, with a monthly review of the data to adapt if needed

3. Plan Do Study Act (PDSA)

The most widely used QI method is the PDSA cycle. It can support the delivery of almost all changes you decide to prioritise and is a systematic way of testing and learning.

Figure 32: PDSA[148]



Using PDSA cycles enables you to test out changes on a small scale, building on the learning before implementing on a large scale, making the change safer and less disruptive for patients and staff.

Be clear on your aims and measures and use the PDSA cycle to test out if what you expect to happen does happen. This leads to learning and builds confidence in improvement.

[148] Institute for Health Improvement (2021). How to improve.

Tips for planning a PDSA:

- **What is the question you want to answer?**
- **What do you expect to change? For example, if we promote online consultation on the website, will we see more use of this?**
- **How will you know if a change has happened, i.e. what are your measures?**
- **Do a small change, see if it works and then build on this.**
- **Be clear on what is a task and what is a test (see table 12: Is it a test or is it a task?).**
- **Think of PDSA as rapid cycles of testing and learning. The main trick is to think about the smallest scale of test (think one patient, one hour, one clinic) required to learn the largest amount as quickly as possible with the least risk.**
- **Build your knowledge sequentially, with multiple PDSA cycles for each change idea.**
- **At the act stage in the cycle – the decision on what to do is usually 'adopt', 'adapt' or 'abandon'.**
- **Include a wide range of conditions in the sequence of tests – for example, patient groups, times of day, day of the week.**
- **Document the learning and testing in a standard template – this is the memory of your improvement work.**

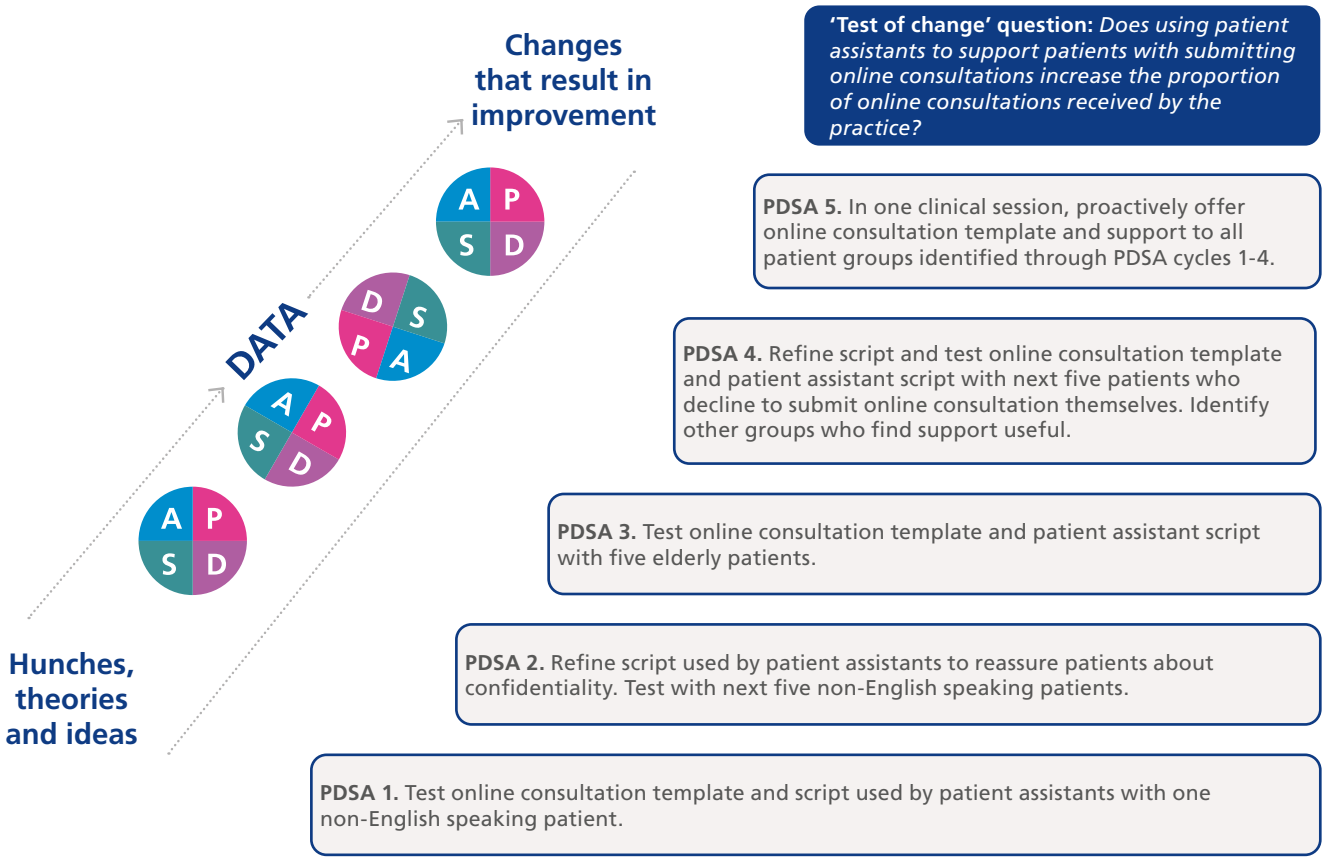
Table 12: Is it a task or a test?

A test can be for a single task, or several tasks in an improvement project, looking at the key change or changes to deliver your desired outcome.

Task	Test
Decide if a task 'just needs doing'	**Decide if something would benefit from a test with a QI plan and measures**
Develop a document management protocol	Test whether the document protocol reduces time taken to process documents or the number of errors
Set up an accuRx[149] reminder message for patients to have a blood pressure check	Test whether sending accuRx reminder increases uptake of blood pressure tests. Test out different wording and content with a small number of messages to see which works best, before sending to larger groups of patients
Upload Community Health Service referral form onto EMIS	Test whether staff find a template easy to complete and whether it reduces errors
Share ground rules for practice meetings at the beginning of all meetings	Test whether using ground rules in meetings helps to improve the meeting's dynamic and effectiveness

[149] accuRx

Figure 33. Example of a PDSA ramp demonstrating rapid-cycle testing to answer a specific question[150]



4. Audit

You're likely to be most familiar with the QI method of audit, including clinical audit. It takes a snapshot measure at two time points and provides a systematic approach to setting and achieving evidence-based standards. It can include some elements of process mapping, SMART objectives and PDSA elements around a pathway.

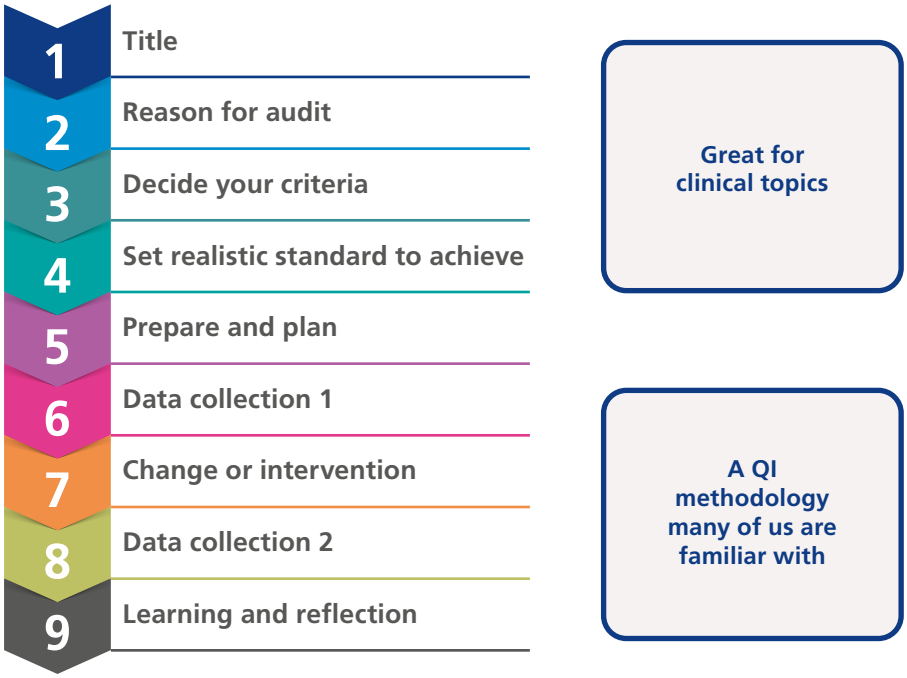
Auditing how we safely manage clinical presentations is key to achieving good access for our patients.

Suggested audits to improve patient access:

- An audit of case mix before and after moving to triage or online consultation model of access, used to establish if there has been an impact on access for excluded groups.
- An audit of cancer diagnoses may highlight that access issues contribute to delays in diagnosis.
- An audit of children presenting with self-limiting illness may highlight an opportunity to strengthen self-care advice for parents and signposting to other services.
- A diabetes audit may consider the role of group appointments.

[150] Langley and others (2009). The Improvement Guide. Page 130.

Figure 34: Practice audit[151]



6.2.5 What measures?

Table 13: Use these questions when considering an area for change[152]

Using the example of increasing online consultations above	
Celebrate and build on success	You have successfully introduced online consulting and are currently offering 10% of contacts online
Know the areas you could improve	A meeting in your PCN demonstrates other practices are offering up to 40% online consults and find this a good use of resource and that patients are happy with it
Do you know where your variation exits?	You find you have a higher proportion of online consults on a Monday as you receive those submitted over a weekend
Do you know how you are improving over time?	You develop a simple system to look at % online consultations monthly

Measures and data are crucial to quality improvement: understanding where to focus your efforts and when a change is working, if modification is needed and for quality control.

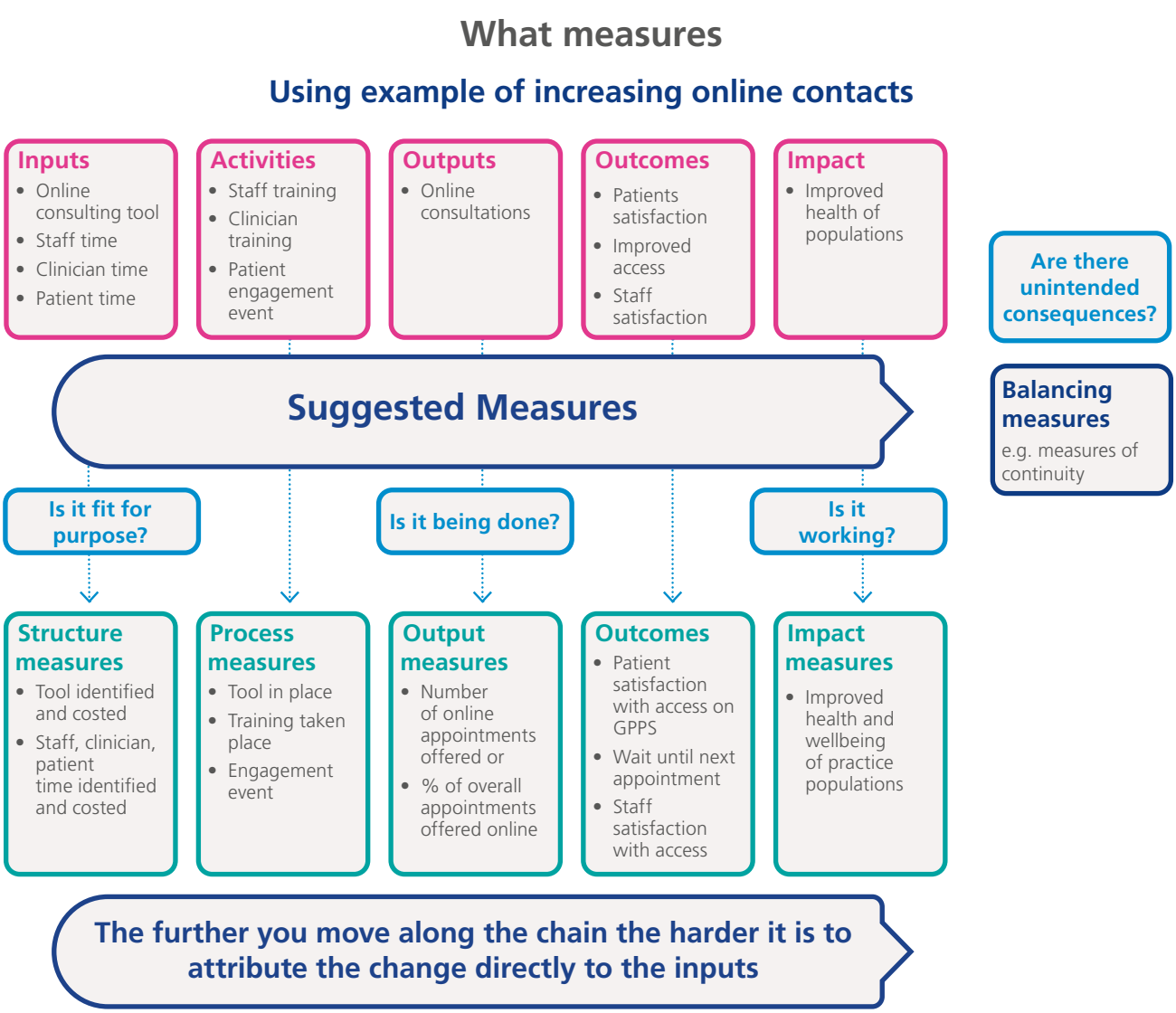
Measures can be quantitative, like the activity data described in Section 2, or qualitative, such as patient and staff feedback. Both bring value, often a combination of the two is most helpful. Decide if a measure is for a snapshot in time or a continuous measure.

Your practice may collect its own measures, for example, a measure of the proportion of requests via online consultations, or use measures from other local or national data such as patient satisfaction measures from the national GP Survey, allowing benchmarking with other teams.

The World Health Organization (WHO) Results Chain[153] helps people think about what measures they need for the process, outputs and outcomes of a project. It recognises that the further down the chain you are, the harder it is to attribute changes to the improvement you made. You can apply different measures to different parts of your change process. You might measure the number of staff who have received training for a change, the cost of clinician time to make a change, or its impact on, for example, patient satisfaction.

[151] RCGP (2017) Quick guide: Clinical audit
[152] M Bisognano (2018). 'Harvesting': a method.
[153] World Health Organization (2014). The Results Chain.

Figure 35: What measures? Adapted from WHO results chain[153]



The main measures you are likely to use in access improvement projects are the activity measures described in Section 2 of the manual, and patient experience measures captured below.

Patient experience measures
No one source can capture the totality of patient experience. Each source is a balance of measures that can be either:

- generalised to populations, such as GP survey measures
- or deeper descriptive measures particular to a smaller group of patients and carers. For example, feedback from your PPG.

Take care to understand the strengths and weaknesses of the measures described in table 14: Patient experience measures and not be overwhelmed by multiple data sources. Decide which measure is best suited to your improvement.[154]

A new nationwide patient experience measure 'as real time as possible', to be agreed by NHSE/I and the BMA, is due to be introduced in 2021.[155]

Like QI methods, be proportionate in your use of measures.

[154] G Robert (2018). Friends and family test.

[155] BMA. GP contract England 2020/21.

Table 14: Patient experience measures

Have clear systems to demonstrate to patients and carers how you have acted on their feedback. Don't ask unless you are able and prepared to act on what you hear.	
Information source	**Strengths and weaknesses**
A new national, 'as real-time as possible', general practice patient experience measure, with a focus on access, will be introduced in 2021.[155]	
GP Patient Survey **GPPS**	This national survey allows for comparison with national and local measures. It has a response rate of about 30% and is reported on once a year, limiting usefulness for recent improvements and local issues[156]
Friends and Family Test FFT (suspended during COVID-19 pandemic)	This quick feedback tool gives a high-level satisfaction score. FFT data can engage patients and staff in making improvements. There has been some unease about its mandatory use in primary care. It's criticised as lacking an evidence base and not reflecting local issues and enabling local QI[157]
Feedback on NHS.uk	Although patients may sometimes post discouragingly negative comments on nhs.uk, there is usually something that a practice can learn from to improve. Practices can respond to patient reviews, or remove them if unsuitable, and the moderator will then be informed
Patient and carers groups	Practices are required to establish and maintain a PPG.[158] These groups are a great place to hear, engage, test ideas for change and to feed back successes. Practices may also engage with carer groups and other local patient groups like Healthwatch. Purposefully seek the views of particular patient groups who will be affected by proposed changes, such as digitally excluded groups for digital innovations
Local patient surveys	CCG, PCN, practice specific
Local patient group reports	Patient groups like Healthwatch have produced some insightful reports on local access issues, identifying issues important to patients

6.2.6 Sustain and spread

Develop the improvement culture in your team and systems to maintain and build on effective changes. When planning any improvement, think at the beginning of your change how successes will be sustained and spread. Positive changes that fall by the wayside are wasteful and discourage further change.

Embed successful change into practice policies and procedures with a regular review date. A team member with an interest should 'own' the improvement, raising the issue if things stop improving or go backwards. Feed back your improvement to the team and patients, share your learning with colleagues in the PCN and document successes for CQC visits.

[156] NHS. GP patient survey.
[157] Friends and family test should no longer be mandatory BMJ 2018
[158] NAPP. What are PPGs?

6.3 Resources: Making change

R

Quality improvement
General
Releasing Time for Care programme, NHS
10 high impact actions to release time for care
QI Improvement Guide for General Practice, RCGP
Introduction to Quality Improvement in General Practice, NHSE
Quality improvement made simple, The Health Foundation
Measuring patient experience, The Health Foundation
How do we involve our service users and carers?, East London NHS Foundation Trust
Process mapping
Process and value stream mapping, RCGP quick guide
Conventional process mapping, Service Improvement and Redesign tools, NHSI
Process mapping, analysis and redesign, NHS Institute for Innovation and Improvement
Institute for Healthcare Improvement (IHI), process mapping article
Lucid charts
Experience Based Co-design, The Point of Care Foundation
SMART
Developing your aims statement, Service Improvement and Redesign tools, NHSI
PDSA
Model for improvement and PDSA (Plan, Do, Study, Act), RCGP
Plan, Do, Study, Act (PDSA) cycles and model for improvement, Service Improvement and Redesign tools, NHSI
How to Improve. Science of Improvement: Testing Changes, IHI
Clinical audit
Audit Toolkits, Self Assessment and Action Planning, RCGP
Clinical Audit, Short film, RCGP
Other QI tools
Cause and Effect (fishbone), Service Improvement and Redesign tools, NHSI
What is lean? Lean Enterprise Institute
Going lean in the NHS, NHS Institute for Innovation and Improvement
Patient experience measures resources
NHS guidance to managing nhs.uk feedback comments
National Association for Patient Participation
Using online patient feedback to improve NHS services: the INQUIRE multimethod study, NIHR
A London Healthwatch report on GP access
Patient Participation Group Information & Support Pack, The Patients Association
Case studies
Improving telephony services using GPPS data
GP example: Engaging people
Using FFT to drive improvement
Practice developed patient survey

Appendix 1: Example appointment types[7]

Single appointment	Consultation mode changes during a single interaction (e.g. a telephone consultation changes to video)
	Patient query or electronic consultation comes into the practice, is reviewed by a health or care professional, and is closed by a message exchange with the patient
	Health or care professional proactively contacts a patient to discuss an issue, e.g. after reviewing their results
Multiple appointment with the same patient	Where a patient query or electronic consultation comes into the practice and is reviewed by a health or care professional (such as the duty doctor) who then refers it to a health or care professional for action at a later time, for example, making a telephone call to the patient. Taken together, these will be counted as two appointments
Appointments with multiple patients	A list of appointments with multiple patients, for example, a care home list. Each patient counts as an appointment
	If practices are working off a block or a list of appointment activities with multiple patients, including for, example care home consultations as part of care home rounds, home visits or group appointments, each patient should be counted as a single appointment If a duty health or care professional is carrying out 'instant' assessments/triage when patients call, each patient who is transferred for an assessment should be given a dedicated slot in the appointment list; this can be in an untimed list if the practice is using one If a practice is using untimed lists for which more than one patient can be added, for example triage lists, then when each patient is provided with an untimed appointment, each patient should be provided with an individual appointment slot on the untimed list

Appendix 2: Suggested improvement projects

Suggested access improvement projects				
	Projects	**Smallish steps**	**Larger steps**	**Suggested measures**
1	**Matching capacity and demand** Section 2 General practice activity	Capture demand over the week: daily audit at reception of requests for contacts over a minimum of two weeks Adapt appointment book to match the demand over the week. For example, move practice meetings, teaching sessions and practice development time to lower demand days to free clinical capacity on high demand days Suggested QI method: PDSA	Comprehensive review of appointment system – aligned projects looking at: • capacity and demand • blend of appointments types and skill mix in appointment capacity • DNAs • contingency planning This may lead to training for new appointment types, for example, group appointments, HCA training for remote information gathering Suggested QI method: Audit, PDSA, external QI support +/- tool Case study: Redesigning care, The Robert Darbishire Practice, Manchester	See section 2.3.1 for capacity and demand measures See table 14: Patient satisfaction measures
2	**Stable capacity** Section 2 General practice activity	Aim for stable clinical capacity over the year: • Calculate leave requirements of clinical staff over a 12-month period • Calculate capacity needed to accommodate this over the year Agree a leave policy with clinicians: • How much notice for leave? • Who can be off at the same time each week and maintain minimum capacity? Suggested QI method: process mapping + PDSA	• Align practice leave for clinicians with leave for PCN employed clinicians. Include contingency planning for sick leave and emergencies • Consider an HR tool to help plan leave • Look at funding considerations for such as locum cover for leave • Identify gaps in capacity and practice needs and consider recruitment to fill gaps. Practice nurse, SPLW or mental health worker Suggested QI method: process mapping, PDSA, external QI support +/- tool	Variation in weekly capacity Staff satisfaction survey See section 2.3 for capacity and demand measures

3	**New modes of contact** Section 2 General practice activity	Test virtual group consultations for a single condition such as hypertension • Recruit a small number of patients via text to test if they would be interested in a remote review in a group • Agree clinician to lead session and how session will run Suggested QI method: PDSA	Move a range of conditions like COPD, asthma, diabetes and chronic pain to group consultations as the predominant contact type Suggested QI method: PDSA +/- external support	Clinical time 'saved' by move from single to group appointments Patient feedback from group session compared to individual sessions
4	**Identify bottlenecks** Section 2 General practice activity	A small group maps the appointment system to identify for troublesome points, work collaboratively to identify and test potential solutions Suggested QI method: brief process mapping	Larger group including team members and patients to review practice appointment pathway and how it aligns with 111, EPCS and other external provider systems Identify troublesome points, work collaboratively to identify and test potential solutions Planned and timed session/s Suggested QI method: process mapping +/- external support and tools	Time to next available appointment See table 14: Patient satisfaction measures Informal staff feedback
5	**Self-service** Section 3 Working with patients to improve access	Appoint a practice champion to promote self-service, e.g. online services, apps for ordering repeat medication, and patient accessing records online		No of patients accessing information from their records

6	**Patients who need additional, tailored approach** Section 3 Working with patients to improve access	Opportunistic referral of patients with complex social needs who have frequent contacts to SPLW Suggested QI method: use of measurement and data to identify target population	Comprehensive practice plan for patients who attend frequently to: • identify patients who contact more than, for example, 30 times a year • review individual notes • work with SPLW to consider tailored interventions • SPLW to work with individual patients to understand their needs and agree helpful interventions • flag high intensity users and have bespoke mode of contact like a dedicated front-desk member with training to signpost to appropriate care Suggested QI method: Process map and PDSA	Number of SPLW referrals For those identified as frequently contacting: • contacts over time • survey of patient satisfaction
7	**Best value from the team** Section 4 The general practice team	Move a single task from one clinician to another. For example, HCA trained to do diabetes foot checks to free practice nurse time As a team, identify a group of consultations, appointments or online consultations and look at the presenting problem. Discuss which staff group (clinical or administrative) could deal with it safely. From this, agree a list of problems or presentations for each staff group and use this for signposting Suggested QI method: measurement or PDSA	Introducing a new team member, for example, practice pharmacist. Identify tasks done by other clinicians that could be taken on by new team member, such as medication reviews, some LTC reviews. Plan for training, supervision and to assess competence – train front desk team on change and communication plan to patients. Agree regular review points As a team come up with a 'long list' of problems that can be dealt with by pharmacy/nurse/ANP/AHP/SPLW/first responder etc., and then run a search of consultation activity over a one-month period, looking at GP consults that have this problem code exclusively This gives a really good guide into how much work can be shifted to, and the capacity needed in, different skill-mix groups when all team members are working at the top of their licence Suggested QI methods: process planning, PDSA and clinical audit Case study: Practice-based paramedics, S Kent Coast	• Staff satisfaction survey • Staff feedback • Patient satisfaction • Waiting times • QOF outcomes • Staff costs • DNA rates • Attendance rates

8	**Reducing avoidable clinical workload** Section 4 The general practice team	Front-desk staff to check and manage any administrative tasks requested by patient, log queries and review in-team meeting for shared learning Suggested QI method: using measurement and data to prioritise or audit	Comprehensive change in document management, moving from a predominantly GP task to administrative and pharmacy members of the team, will need to: • review good practice in other practices • identify which administrative practices could be self-service for patients • consider external tools • agree a practice protocol • staff training • test and refine Suggested QI method: process mapping and PDSA +/- external support and tools Case study: Clerical staff processing letters, Wincanton Health Centre	• Clinical time freed • Additional administrative time needed • Safety audit
9	**Continuity of care** Section 4 The general practice team	Front-desk team to ask patients for their preferred clinician and code as usual doctor or named clinician All letters and prescriptions to go to usual doctor or named clinician Suggested QI methods: Process map and PDSA	See table 9: Approach to improve continuity of care Measure, by sampling, episodic continuity for patients attending above average for the practice over a 3-month period. Look at the total number of contacts and divide this by the number of other healthcare professionals seen in this period. This gives a view of episodic continuity (a lower number means lower episodic continuity) Case study: Proactive medication reviews, The Robert Darbishire Practice	• Patients on a clinician's list for whom they are the named clinician • % of letters or prescriptions going to named clinician • Patient satisfaction with continuity from GPPS • Reattendance rates
10	**Right person, right care, right person, right time** **Community pharmacy** Section 5 Access beyond the practice	Ensure up to date details on your telephone message and website for contacts when the practice is closed Suggested QI method: this is a simple task and does not need a QI approach	Work with community pharmacy colleagues to ensure seamless service for patients to: • understand community pharmacy offer and integrate into practice working (table 11: Typical services offered by community pharmacy, page 58), for example, medical reviews, minor illness management • ensure digital connection • staff training for signposting to pharmacy services • align with in-house clinical pharmacist care Process mapping, PDSA, clinical audit	No of CPCS uses. Feedback from patients, staff and community pharmacy Patient demand measures

11	**Right person, right care, right person, right time** **A&E** Section 3 Working with patients Section 5 Access beyond the practice	Promotion to patients of alternative services to A&E, including: • website • telephone message while waiting to get through and when closed • waiting area • through PPG	See 3.5 Patients who need additional, tailored approach Section 3: Working with patients	Identify cohort of patient who attend A&E frequently Review A&E and practice attendance rates pre and post intervention
12	**Identifying groups at risk of health inequality** Section 3 Working with patients	Train frontline staff to implement the Safe Surgeries Toolkit to ensure that everyone in their community can access the healthcare they're entitled to Clearly document and communicate with all frontline staff to ensure they know that patients do not need proof of ID or address to register with a GP Ensure your practice does not insist on proof of address for patients to register	Undertake searches to identify patients at risk of inequity of access to understand the size of different cohorts Identify interventions that can be tested for specific cohorts and individuals to improve equity of access See section 3.4.2 Equity of access to care for registered patients, for patient cohorts	Rates of attendance for groups at risk of inequity of access Patient satisfaction measures Participation of individuals from groups identified as at risk from inequity of access in PPG or other practice forums

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Appendix 4: Abbreviations

A&E	Accident & Emergency
AfC	Agenda for Change
AIP	Access Improvement Programme
AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner
ARRS	Additional Roles Reimbursement Scheme
BMA	British Medical Association
CCG	Clinical Commissioning Group
CPCS	Community Pharmacy Consultation Service
CQC	Care Quality Commission
DES	Directed Enhanced Service
DNA	Did Not Attend
DoS	Directory of Service
ED	Emergency Department
EPCS	Extended Primary Care Services
EPP	Expert Patient Programme
EQUIP	Enabling Quality Improvement in Practice
e-RS	Electronic Referral Service
FFT	Friends and Family Test
GP	General Practice/Practitioner
GPAD	General Practice Appointment Data
GPN	General Practice Nurse (also referred to as Practice Nurse – PN)
GPPS	GP Patient Survey
HCA	Healthcare Assistant
HCP	Healthcare Practitioner
ICS	Integrated Care System
LAS	London Ambulance Service
LMC	Local Medical Committee
LTC	Long Term Conditions
MDT	Multi-Disciplinary Team
NHS	National Health Service
NHSE	NHS England
OOH	Out of Hours
PALS	Patient Advice & Liaison Service
PAM	Patient Activation Measures
PCG	Primary Care Group
PCN	Primary Care Network
PDSA	Plan Do Study Act
PHE	Public Health England

PM	Practice Manager
PPG	Patient Participation Group
QI	Quality Improvement
RCGP	Royal College of General Practitioners
SBAR	Situation, Background, Assessment, Recommendation
SMART	Specific, Measurable, Achievable, Realistic, Timed
SPLW	Social Prescribing Link Worker
STP	Sustainability and Transformation Partnership
UC	Urgent Care
UTC	Urgent Treatment Centre
WHO	World Health Organization

Appendix 5: Figures and tables

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Appendix 6: London Access Guide Task and Finish Group

Region/STP	Name	Role	Organisation
London	Dr Siân Howell (Chair)	Clinical Lead for Access, Transforming Primary Care Team	Healthy London Partnership
London	Giash Ahmed	Project Manager	NHS Digital
London	Dr Minal Bakhai	GP and National Clinical Director for Digital First Primary Care	NHS England and Improvement
London	Dr Stephanie Coughlin	Clinical Lead for Innovation	Royal College of General Practitioners
North West London	Richard Ellis	Associate Director, Primary Care Transformation	NHS North West London Collaboration of Clinical Commissioning Groups
London	Dr Lisa Harrod-Rothwell	Deputy Chief Executive and Lead Medical Director	Londonwide LMCs
East London	Dr Tom Margham	Clinical Lead	Enabling Quality Improvement In Practice (EQUIP), Tower Hamlets CCG
North East London	Jenny Mazarelo	Director of Primary Care (Interim)	Waltham Forest, Newham and Tower Hamlets (WEL) CCGs
London	David McKinlay	Programme Manager	Healthy London Partnership
London	Matthew Nye	Regional Lead for Digital First Programme	Healthy London Partnership
London	Atiyah Patel	Project Officer	Healthy London Partnership
London	Maria Rodrigues	Senior Programme Manager – PCNs and Access	Healthy London Partnership
London	Dr Elliott Singer	Medical Director	Londonwide LMCs