Healthy London Partnership

London General Practice Access Guide

Supported by the London General Practice Access Manual

June 2021

This guide aims to:

Highlight a whole-system approach to achieving best possible general practice patient access within available resources

Signpost solutions that address access inequalities

Share good practice and effective access innovations.

NHS Digital

RCGP Royal College of General Practitioners

EQUIP ENABLING QUALITY IMPROVEMENT IN PRACTICE

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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How to use this guide

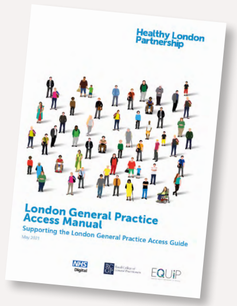
The London General Practice Access Manual supports this guide. Use the guide for an overview of a whole system approach to access and delve into the manual for more detail, resources, case studies and improvement projects.

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

When further resources are available

Signpost you to the manual

Using a paper copy of the guide?
Go to the online version to access underlined links



Whole-system approach to access

Why a London Access Guide?

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. This will complement the National Access Improvement Programme[1] by supporting all London practices with a whole system approach to access.

For the purposes of this guide, the term '**general practice access**' includes:

- 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.

Overview

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.[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 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."

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."

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."

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."

A diverse population, wide health inequalities and a high turnover of patients are challenges faced by many London general practices.

Good general practice access encourages Londoners to use the right service for their healthcare needs and is a good value NHS resource.

Core hours general practice[3]

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 Network (PPG)
- meet the reasonable needs of the patients and address areas of concern.

See pages 7-10 of the manual

General practice activity

"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 position statement[4]

Mapping your activity

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

Appointment mapping

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.

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.[5]

The Improving GP Appointment Data[5] rollout 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.

NHS England definition of a general practice appointment[6]

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

NHSE Appointment description[6]

All healthcare professionals
Includes an interaction with any health or care professional

All modes of contact
Includes all modes – face to face, telephone and remote interactions

All settings
Includes an interaction at any primary medical care setting

Mapping your appointments to national categories will help capture reliable data to help make access improvements.

Practice benefits of mapping appointments to national categories include:

- Better understanding of our daily activity
- Share data and learning with other practices and PCNs to support improvement
- Help develop services at practice and PCN level that best meet patient needs and deliver best value

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 need to categorise and consistently record their appointment activity.

Case study: Reducing DNAs

Practice X, with a registered population of 9,000 patients, faced a shortfall of appointments due to GP changes. They had a 9.5% Did Not Attend (DNA) rate for GP appointments, equivalent to over six hours of GP time each week. Using the Edenbridge Apex workload tool, the team identified that >70% of DNAs occurred when the gap between booking and appointment date was over two days. They decided to test reducing the booking time from 28 days to one working day.

The team discussed which groups of patients might be disadvantaged by this approach and exempted them from the policy. Within two weeks of the intervention, DNAs fell rapidly to 3-4%. This level was maintained to the end of the study period.

Before purchasing a workload tool consider

	Yes	No
1. Are you using current data resources to maximum benefit to understand your practice activity?	☐	☐
2. Do you have the right skill mix in the team with the ability to undertake, understand and act on searches to help drive improvements?	☐	☐
3. Are you clear on what added value you will receive from using a workload tool?	☐	☐
4. Are you clear on what areas in the practice you hope a workload tool will help with?	☐	☐
5. Have you considered if improvements can be made as easily without a workload tool?	☐	☐
6. Are you recording your activity consistently, e.g. appointment types? If not, are you prepared to move to consistent recording of activity?	☐	☐

Mostly no

Practices replying no to most of these questions may benefit from using existing data and developing capacity in the team before purchasing a tool

Mostly yes

Practices answering yes to most of these questions will be in a good position to make the best use of a workload tool

Tips for appointment mapping

- By following a standard process, appointment mapping should take 1-2 hours
- Using a tool like Edenbridge Apex 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

Resources

The General Practice Data Hub

More accurate general practice appointment data NHSE, NHSI, BMA

NHS Digital guidance Improving GP appointment data, NHS Digital

Clinical system providers will have their own guidance. This is an evolving landscape so keep an eye out for updates.

See pages 11-15 of the manual

Need, demand and capacity

Need	The capacity to benefit from healthcare
Demand	What patients ask for
Supply	The healthcare provided
Capacity	What we could be doing
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
Failure demand	Duplication, waste and inappropriate use of time

Steps to matching need, demand and capacity
Matching capacity and need/demand requires regular attention, the best appointments systems are flexible and constantly refined in response to data and staff and patient feedback. A good place to start is by mapping your current processes.

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.[7]

Myth ?	Myth buster ✓
Demand is infinite	Demand may be high but it is not infinite
Demand is unpredictable	Demand is predictable and often less variable than capacity
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

Source: Myth Busters (EQUIP)

1 Understand your demand and capacity

Capacity
- Use appointment naming described above
- Count appointments offered by type and clinician
- Review appointment distribution over the week and year
- Include all patient contacts and consider using a tool to help
- Review capacity in both your clinical and non-clinical teams
- Understand your DNA rate
- Balance reactive and planned capacity
- If possible, look at re-attendance rates – how many patients are seen again within 14-28 days

Demand
- Demand audit over a minimum of two weeks at different points of the year
- Set standard patient appointments/week and see if this meets demand
- Use historical demand to inform standard
- Undertake a Primary Care Foundation 'Potentially Avoidable Appointment Audit'[13]
- Align to continuity: what percentage of contacts would benefit from continuity with a clinician?
- What is unmet demand: phone calls dropped, patients advised to return/call at another time?
- What is the demand from patients who attend very frequently?

2 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

3 Work off any backlog

Before introducing any new appointment system, it is important to 'work off' your backlog – to give the new system every chance of success.

- 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

4 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 to improve access)
- 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 (see page 18)
- 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

5 Contingency plan

Having a plan for what to do when staff are unwell reduces staff stress, patient inconvenience, and the risk of presenteesim, when colleagues feel they have to come to work when unwell.

Resources
Case study: Contingency planning, South Cheshire & Vale Royal GP Access Fund (GPAF)

See pages 15-20 of the manual

Points of access: how patients contact their practice

Patients need an understanding of what appointment types are available and the various ways they can access them, including support to understand how self care, on-line triage and telephone consultation may meet their needs rather than default to requesting a face-to-face contact.

- Online (consultation/website)
- Telephone
- NHS App
- In Person
- Via another provider (e.g. 111)

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.

Appointment types

Practice should provide a blend of appointment types taking into account:

What works best for patients

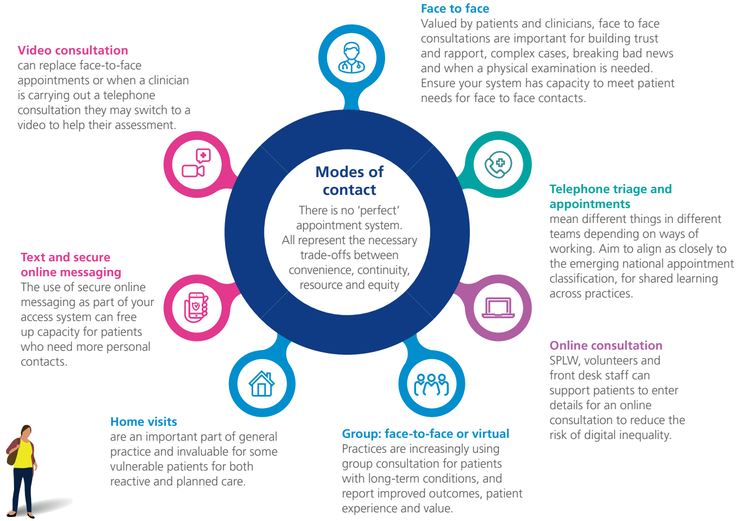
What works best for the team

What works best for the system

Informed by activity data and patient and staff feedback.

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,[8] which can create more work and patient frustration.



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.

Telephone triage and appointments
mean different things in different teams depending on ways of working. Aim to align as closely to the emerging national appointment classification, for shared learning across practices.

Text and secure online messaging
The use of secure online messaging as part of your access system can free up capacity for patients who need more personal contacts.

Online consultation
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.

Group: face-to-face or virtual
Practices are increasingly using group consultation for patients with long-term conditions, and report improved outcomes, patient experience and value.

Management of Did Not Attends (DNAs)

74% of DNAs occur when the time between booking and attending an appointment is more than one day[9]

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 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 page 12).

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.

An improvement project to reduce Did Not Attends (DNAs) can lead to fewer wasted appointments, increased clinical capacity, and improved equality of access to healthcare.

See the case study on page 7 for how using a workload tool and systematic approach helped a practice reduce its DNAs

"Every system is perfectly designed to get the results it gets." Institute for Healthcare Improvement [10]

"To reduce non-attendance, it appears that the appointment system needs to change, not the patient." Tom Margham, GP, EQUIP[11]

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.[12] A change in how your appointment system is managed to suit patient needs better will have a greater impact than focusing on patient behaviour.

Resources
Case studies:
West Wakefield reception care navigation

10 High Impact Actions: Docklands Medical Centre

Clinical 'buddies', AT Medics practices, London

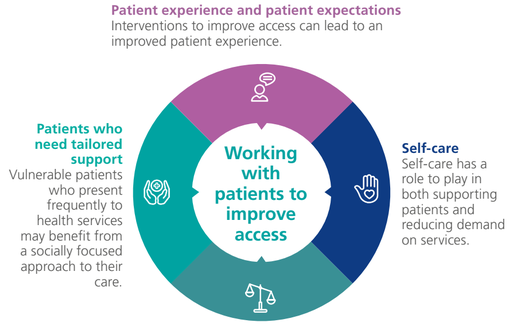
Reducing missed appointments in general practice: evaluation of a quality improvement programme in east London, British Journal of General Practice 2020

Rethinking 'Did Not Attend' – YouTube

See pages 20-28 of the manual

Working with patients to improve access

Patients place importance on different aspects of care, some value speed of access, others continuity or convenient appointment types.[13] Small, practice-led projects can reap real benefits for your patients, reflected in an improved experience.[14]



Patient experience and patient expectations

Though it is difficult to compartmentalise patient experience with access from other aspects of general practice care, interventions to improve access can lead to an improved patient experience.

Agree a new patient welcome pack/practice charter

Agree this with your Patient Participation Group (PPG) explaining how best to use your services and what patients can expect. It could include:

- How to give feedback and get involved in the PPG
- We will deal promptly with any abusive or discriminatory behaviour

What you can expect from us:

- Courtesy and kindness
- Opening hours and points of access, including online
- A website that explains what the practice offers 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

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

Suggestions to improve patient experience with general practice access[15, 16]

- Actively seek and act on patients' and carers' feedback
- 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.
- 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

Self-care

"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[17]

Tips for practices in supporting self-care[18]

All clinicians, healthcare assistants and receptionists should agree on the advice they give patients for common self-limiting illnesses

Involve all clinicians in prescribing approaches and policies to ensure consistency

Promote high-quality self-care information on the practice website such as:
Local Authority directories
NHS website
NHS Apps library
NHS video library
Good Thinking website– digital mental wellbeing service for Londoners' wellbeing

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

Resources
Case study: Practice Health Champions, Robin Lane Medical Centre, Leeds

See pages 29-34 of the manual

Equity in general practice access

Socially excluded patients are less likely to register with a GP, contributing to poorer health outcomes and use of other NHS services less able to meet their needs e.g. 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.

Factors that impact on equity in patient registration

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

Public Health England[19]

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

Michael Marmot[20]

Equality achieves fairness through treating everyone the same regardless of need

Equity achieves fairness through treating people differently dependent on need

Equity of access to care for registered patients

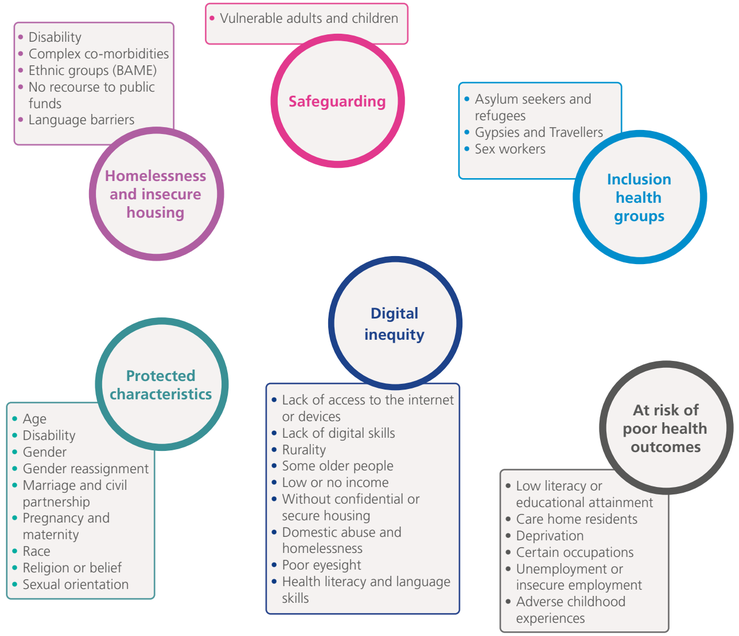
- Availability of appointments
- Availability of clear information
- Access to a professional interpreter
- The ease of the booking system
- Convenience of appointment times
- Staff training
- Responsiveness of practice to diverse needs

PATIENTS DO NOT NEED TO PROVIDE PROOF OF ID OR ADDRESS TO REGISTER WITH A GP

"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[21]

Patient groups likely to experience inequity in access



It is challenging to have an access system that meets the needs of all patients and all groups. Practices should develop both a broadly inclusive approach and focus on particular groups in their population, such as sex workers or 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.[22]

CQC
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.[23]

Equality Act 2010[24]
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.

Resources
Digitally excluded patients may benefit from support of community volunteers, front desk teams and SPLW to access digital resources

Digital Inclusion in Health and Care, NHS
National Voices getting the most out of the virtual health care experience
Good Things Foundation Digital health lab

See pages 35-39 of the manual

Patients who need additional, tailored support

Vulnerable patients may present frequently to both general practice and other health services,[25] 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.[26]

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

Resources

PCN Academy Blog. Frequent Attenders

E learning for health: Managing frequent attenders

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

See pages 39-43 of the manual

Meeting patient needs[27]

General Practices

Primary Care Networks

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
- Provided at PCN level
- MDT including GP/social worker/ mental health worker/ community

High intensity MDT across primary and secondary care

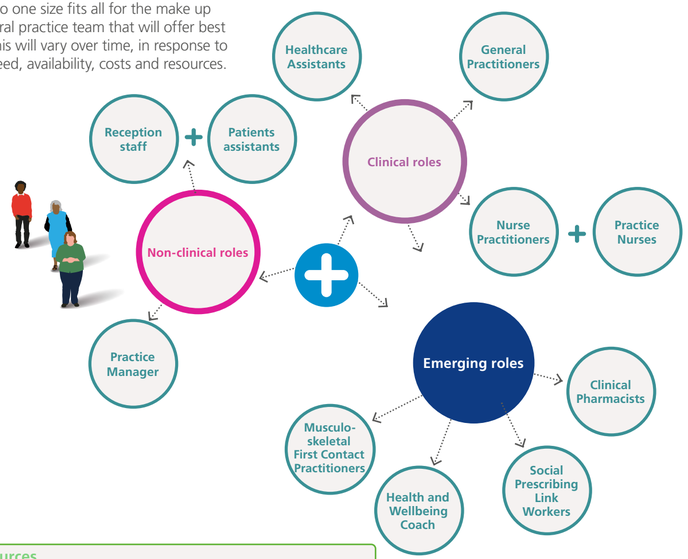
People who are high users of primary and secondary care – already unstable

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

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.

There is no one size fits all for the make up of a general practice team that will offer best access. This will vary over time, in response to patient need, availability, costs and resources.



Resources

Delivering general practice with too few GPs, Nuffield Trust Report 2019

NHS People's Plan 2020/2021

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 Additional Roles Reimbursement Scheme (ARRS) roles.

See pages 44-48 of the manual

PCN roles

Non-ARRS roles

The roles and bandings may flex over time. Non-ARRS roles include nurse prescriber, general practice assistant and medical assistants. Please see contract detail.

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."

Holly Jeffers and Maureen Baker[28]

Patients differ in how much they value continuity over prompt access or convenience, depending on characteristics such as age and underlying health conditions.

An important but challenging task is deploying the limited team capacity between different general practice activities.[29]

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.

Approach to improve continuity of care

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** (see page 24)	**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.

Recruitment and Retention

Some questions to consider before recruiting

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, quality improvement (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?

Developing the team

Building effective teams

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

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

Tips for leading effective teams

Attributes of effective teams

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.

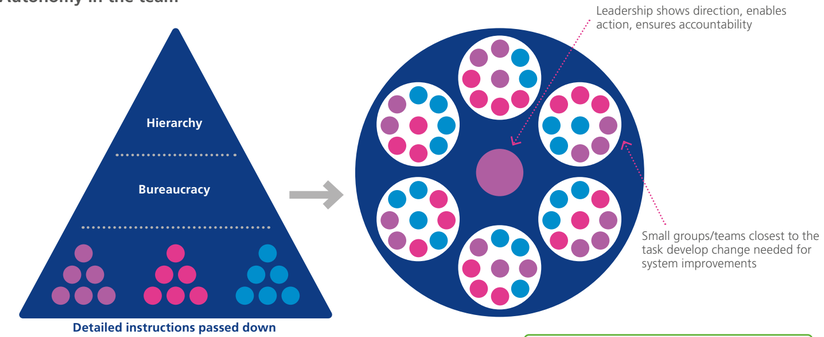
We all want to be good at what we do
Protected space and time to learn and improve.

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, the teams 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.

Autonomy in the team[30]



Resources

RCGP. Continuity of Care resources webpage

Caring for doctors, Caring for patients: How to transform UK healthcare environments to support doctors and medical students to care for patients

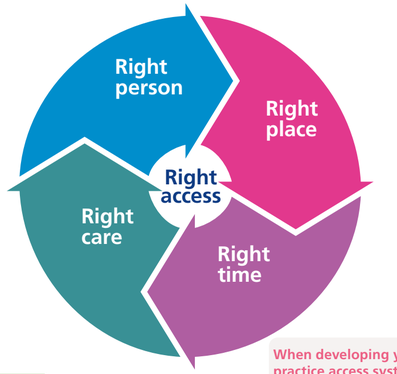
How to build effective teams in general practice, King's Fund 2020

Michael West's compassionate leadership – a short film, King's Fund 2019

See pages 49-54 of the manual

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.



Resources

NHS.UK directs patients to self-care, local services and online services. It can be useful for front desk staff for up-to-date information to find local health services with maps and opening times, e.g. opticians, pharmacies, and urgent care.

NHS App enables patients using the National Health Service in England to access information, such as their GP record, and perform a range of activities such as book appointments with their GP and order repeat prescriptions.

GP Connect allows authorised clinical staff to share and view GP practice clinical information and data between IT systems, quickly and efficiently.

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.

Information flows

A well-informed team: Individual team members need to be aware of local services and where to look for ever-changing details.

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.

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.

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.

Directory of Services (DOS): Keep your local Directory of Services (DOS)[31] updated with your services and opening times

Patient access: the relationship between general practice and other providers

Primary Care Networks

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

- With additional roles increasing capacity and releasing GP time for more complex care
- Taking on the 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

NHS 111[40]

There have been significant changes to 111 since it was first introduced. 111 has an increasing interface with general practice. It can now book directly into appointments and many areas use 111 as a first contact point when the practice is closed.

Urgent Treatment Centres (UTC)[32]

Practices should agree as a team when to signpost patient to a UTC, and which patients' needs would be better dealt with by the patient's own general practice team or other provider.

Accident and Emergency (A&E)

Patients who frequently attend A&E often attend their registered practice and A&E attendances are highest among older patients, those with multiple conditions and those with lower levels of educational qualifications.[33, 34, 35]

Reduce the risk of A&E attendance when the practice could better meet patients' needs using a range of communication methods to ensure your patients (and the practice team) know what to expect from their practice.

GP Out of Hours Services (OOH)[39]

OOH services provide general practice care for problems that can't wait until the surgery is next open.

Enablers for access

- Shared data and learning
- Additional roles
- Virtual hubs
- Extended/enhanced hours access

Community Pharmacy

Typical services offered that can help GP access
Community Pharmacy Consultation Service (CPCS)[36]
New medicine service[37]

Opticians

Many areas run local NHS schemes for minor eye conditions with specially trained community opticians for minor eye conditions.

Dentists

Visit the NHS website[38] for information on how to find an NHS dentist.

Acute outpatient services

Effective communication between primary and secondary care is crucial for safe patient care and value and access in one sector impacts on the other.

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

- Advice and guidance function on Electronic Referral Service (e-RS) for queries
- Consultant Connect, if available in your area, for immediate senior clinician advice
- Encouraging patients to use self-referral when available

The Out of Hours (OOH) space can be particularly challenging for patients to navigate, with different services designed around both urgent need and patient convenience.

Resources

The primary care network handbook, BMA
The Primary Care Networks Academy
Primary Care Network, NHS Confederation
Understanding Primary Care Networks, The Health Foundation

See pages 55-63 of the manual

Making change

"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."

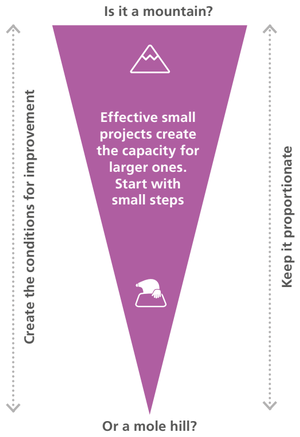
Institute for Healthcare Improvement[41]

What does good quality improvement (QI) look like?

Improvement is everyone's business	Teams have dedicated capacity for QI	Teams have QI skills and tools	The right incentives facilitate QI	Useful data and information supports QI
All general practice team members are empowered to contribute to improvement and can relate this to their daily work	We have the capacity to focus on continuous improvement in a meaningful way	Trained change leaders support teams to use best available methods and tools to continuously improve	Incentives are used thoughtfully, only where they will have helpful impact	We have trusted information to help us focus our effort, understand how we are doing and share our learning

Developed from: NHS London Clinical Senate forum: Applied QI in Primary Care, October 2019

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



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

Build on what has been successful elsewhere, most problems are not new or unique to your practice, for suggested access improvement projects see page 26 (and page 80 in the manual for a more comprehensive list).

"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."

Mary Dixon-Woods, Professor of Healthcare Improvement Studies, University of Cambridge[42]

"Quality improvement (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."

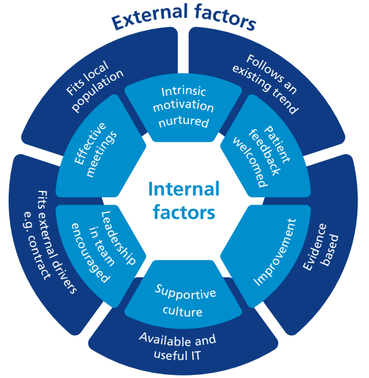
Health Foundation December 2019[43]

Key ingredients for improvement

"Healthcare improvements are 80% human and 20% technical."

A Backhouse (2020). Quality improvement[44]

Culture and context[45]



People

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.

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.

What to change and why?

The Pareto Principle[46] 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'.

Useful questions to ask:

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

Have a plan

QI methods helpful in access improvements

Process mapping	SMART	PDSA	Audit

What measures?

Practices that want to continually improve should be able to:

- celebrate and build on their successes
- know the areas where they could further improve
- know the variation within their own practice and where they vary from other similar practices
- know how they are improving over time.

Adapted from 'Harvesting': a method to open your organization to alternative solutions, Institute for Healthcare Improvement[47]

Sustain and spread

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.

See pages 64-78 of the manual

Quality Improvement methods

Using a QI methodology will help you structure your improvement project. Use the method or methods best suited to the project.

Process mapping

Use one colour sticky note to map out where the process starts and finishes, and then the steps in between.

Once you have agreed the current process, use another colour of post-it note to highlight points along the pathways that are bottlenecks, troublesome or wasteful.

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.

Clinical audit[48]

Practice audit

1. Title
2. Reason for audit
3. Decide your criteria
4. Set realistic standard to achieve
5. Prepare and plan
6. Data collection 1
7. Change or intervention
8. Data collection 2
9. Learning and reflection

Great for clinical topics

A QI methodology many of us are familiar with

SMART aims

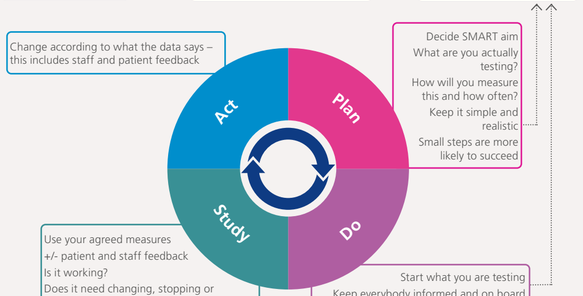
Specific	Measurable	Achievable	Realistic	Timed
Clarity on what you are aiming to improve, how much and by when – just writing this down can help	Agree a measure for your improvement	What is achievable with your available resources and time?	Check that your plans are realistic for all members of the team	Set specific time points to review progress

PDSA

Aim: What do we want to accomplish?

Measure: How do we know if a change is an improvement?

Change: What changes can we make to improve?



Resources

QI Improvement Guide for General Practice, RCGP

Introduction to Quality Improvement in General Practice, NHSE

Quality improvement made simple, The Health Foundation

What measures?

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.

A new nationwide patient experience measure 'as real time as possible' is due to be introduced in 2021.[49]

Patient experience measures

Don't ask unless you are able and prepared to act on what you hear

Your practice may collect its own measures, e.g. 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 helps you think about what measures are needed for the process, outputs and outcomes of a project, recognising that the further down the chain you are the harder it is to attribute changes to the improvement you made. Different measures can be applied to different parts of your change process. You may measure the number of staff who have received training for a change, the cost of clinician time to make a change, or the impact of a change on, e.g. patient satisfaction.

What measures? Adapted from WHO results chain

What?	Inputs	Activities	Outputs	Outcomes	Impact
What measures?	Process measures		Output measures	Outcome measures	Impact measures
Using online consultants as an example	Online consulting tool identified Staff, clinician time costed	Tools in place All staff trained Patient engagement event held	Number of online consultants as a proportion of all contacts	Patient satisfaction measure Appointment wait Staff satisfaction	Improved health outcomes

The further you move along the chain the harder it is to attribute the change directly to the inputs

See pages 64-78 of the manual

Suggest improvement projects

Projects	Smallish steps	Larger steps
Matching capacity and demand Section 2 General practice activity	Daily audit at reception of requests for contacts over a minimum of 2 weeks. Suggested QI method: Audit.	Comprehensive review of appointment system – aligned projects looking at: • capacity and demand • blend of appointment types • DNAs • contingency planning Suggested QI method: Audit, PDSA, external QI support +/- tool. Case study: Redesigning care, The Robert Darbishire Practice, Manchester
Stable capacity Section 2 General practice activity	Aim for stable clinical capacity over the year. Agree a leave policy with clinicians. Suggested QI method: process mapping + PDSA.	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.
Identify bottlenecks Section 2 General practice activity	Map the appointment system to identify troublesome points. Suggested QI method: brief process mapping.	Review practice appointment pathway and how it aligns with 111, Extended Primary Care Services (EPCS) and other external provider systems. Identify troublesome points, work collaboratively to identify and test potential solutions. Suggested QI method: process mapping +/- external support and tools.
Patients who need additional, tailored approach Section 3 Patients	Opportunistic referral of patients with complex social needs who have frequent contacts to SPLW. Suggested QI method: use of measurement and data to identify cohort of interest.	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
Reducing avoidable clinical workload Section 4 The team	Front-desk staff to check and manage any administrative tasks requested by patients.	Comprehensive change in document management, moving from a predominantly GP task to administrative and pharmacy members of the team. Case study: Clerical staff processing letters, Wincanton Health Centre
Continuity of care Section 4 The team	Front-desk team to ask patients for their preferred clinician and code. Suggested QI methods: Process map and PDSA.	Measure, by sampling, episodic continuity for patients attending above average for the practice over a 3-month period. Case study: Proactive medication reviews, The Robert Darbishire Practice
Identifying groups at risk of health inequality Section 3 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.	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.

For a more comprehensive list
see pages 80-84 of the manual

Abbreviations

A&E Accident & Emergency
AfC Agenda for Change
ARRS Additional Roles Reimbursement Scheme
BMA British Medical Association
CCG Clinical Commissioning Group
CMC Coordinate My Care
CPCS Community Pharmacy Consultation Service
CQC Care Quality Commission
DNA Did Not Attend
DoS Directory of Service
EPCS Extended Primary Care Services
EPP Expert Patient Programmes
EQUIP Education & Quality in Practice
e-RS Electronic Referral Service
FFT Friends and Family Test
GP General Practice/Practitioner
GPAD General Practice Appointment Data
GPAF GP Access Fund
HLP Healthy London Partnership
LMC Local Medical Committee
LTC Long Term Conditions
LTP Long Term Plan
MDT Multi-Disciplinary Team
NHSE NHS England
NHSI NHS Improvement
OOH Out of Hours
PAM Patient Activation Measures
PCN Primary Care Network
PDSA Plan Do Study Act
PHE Public Health England
PPG Patient Participation Group
QI Quality improvement
RCGP Royal College of General Practitioners
SBAR Situation, Background, Assessment, Recommendation
SMART Specific, Measurable, Achievable, Realistic and Timed
SPLW Social Prescribing Link Worker
STP Sustainability and Transformation Partnership
UTC Urgent Treatment Centre
WHO World Health Organization

Appendix 1: References

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Healthy London Partnership