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BOROUGH COUNCIL

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Adult Social Care and Health Select Committee

Scrutiny Review of Access to GPs and Primary Medical Care

DRAFT Final Report

May 2024

Adult Social Care and Health Select Committee
Stockton-on-Tees Borough Council
Municipal Buildings
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Contents

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Acknowledgements

The Committee would like to thank the following people for contributing to its work:

- Emma Joyeux (Primary Care Commissioning Manager – Tees Valley) – North East and North Cumbria Integrated Care Board (NENC ICB)
- Sarah Bowman-Abouna (Director of Public Health) – Stockton-on-Tees Borough Council (SBC)
- Dr Rachel McMahon (Interim CEO and Company Secretary) – Cleveland Local Medical Committee (LMC)
- Fiona Adamson (Chief Executive) – Hartlepool & Stockton Health (H&SH)
- Carl Gowland (Head of Operations and Service Delivery) – H&SH
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- Moira Rowlett (Inspector – North Region) – Care Quality Commission
- Natasha Douglas (Project Lead) – Healthwatch Stockton-on-Tees

Plus:

- All those Patient Participation Groups (PPGs) across the Borough who responded to the Committee's survey that was conducted as part of this review.

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Foreword

TBC

Cllr Marc Besford
Chair
Adult Social Care and Health
Select Committee

Cllr Nathan Gale
Vice-Chair
Adult Social Care and Health
Select Committee

Original Brief

Which of our strategic corporate objectives does this topic address?

The review will contribute to the following Council Plan 2023-2026 key objectives (and associated 2023-2024 priorities):

A place where people are healthy, safe and protected from harm

- Support people to live healthy lives and address health inequalities through a focus on early prevention, long-term conditions, substance misuse, smoking, obesity, physical activity and mental health.
- … continue to collaborate with the NHS to ensure health and care services work effectively together.
- Work with our communities and partners to develop our approach to healthy places, in the context of regeneration plans and the Health and Wellbeing Strategy.

What are the main issues and overall aim of this review?

Accessing the help and advice of General Practitioners (GPs) and other professionals working in primary care general medical practices within the UK has long elicited a range of experiences and, indeed, opinions. Exacerbated by the recent COVID-19 pandemic and its subsequent knock-on effect to all health and care providers, the ability to make contact with and then use such services in the context of changed systems, working practices and workforce capacity has further sharpened views on this topic.

Conscious of the ongoing debate around these existing challenges, the Government released a new plan in May 2023 to make it easier for patients to see their GP and, in collaboration with the NHS, recently announced a major new primary care access recovery plan which aims to facilitate faster, more convenient care. Regionally, the North East and North Cumbria Integrated Care Board (NENC ICB) publicised a three-year programme bringing together the NHS and Councils with voluntary, community and social enterprise (VCSE) organisations to tackle long-standing inequalities and poor health, an investment which included extra support for the 'Deep End' network of GP practices in the region's most deprived communities, and steps to attract and retain more GPs to work in deprived areas, with extra training and support to encourage trainee doctors to build their careers in these practices.

Locally, this scrutiny topic was proposed back in February 2022 (though was unable to be undertaken during the 2022-2023 municipal year due to competing work programme demands). At that point, several related concerns were highlighted around processes involved in accessing general practice, including call wait times, the need to complete online questionnaires, and the initial requirement to tell call-handlers of very personal issues before receiving an appointment. Whilst it is acknowledged that work will have taken place in relation to this topic since early-2022, recent national and regional announcements regarding primary care (general practice) access demonstrates the ongoing high-profile nature of what is a key frontline health service.

The aim of this review will be to:

- Understand the existing local ‘access to GPs’ landscape in the context of national / regional developments around this ongoing issue.

- Ascertain current systems for accessing general practice services, the communication of these to the public, and how effective they are (including any variations across the Borough's providers).
- Determine any areas which may assist in improving the experience of the local population, and practices themselves, when individuals wish to contact and / or access general practice services.
- Share any identified good practice within the Borough's Primary Care Networks (PCNs).

The Committee will undertake the following key lines of enquiry:

What is meant by 'primary care' (including definitions of terminology to be used within the review such as general practice, primary medical care, general practitioners (GPs), etc.)?

How does primary care (general practice) work – how is it commissioned / paid for; what are the contractual mechanisms / expectations? Who are the key stakeholders around the issue of general practice access and what role do they play (individually and in partnership)?

What is, and who decides on, the population density, spread and location of the Borough's practices? How are professionals allocated to practices? Who are practices accountable to / regulated by?

How has access to general practice changed since the COVID-19 pandemic emerged (as a result of either national policy or local decisions)? What systems can the public use to contact their practice; how are these communicated (by who, how, how often)? Do these create barriers to access?

When are practices accessible / open, and how do they manage patient contact (prioritisation / triage)? How effective is this?

What do we know about issues within the Borough – are these confined to specific areas? Do experiences vary when contact is made with practices at different times of the day?

Is there a variation in access according to population characteristic (e.g. disproportionate impact on more deprived, those with disabilities, different ethnic groups, older people)?

How is the public encouraged to raise concerns about access? What mechanisms are in place to report issues and how are these communicated?

Do practices actively seek feedback from its registered patients around access – if so, how has this informed arrangements?

What views do GPs and other practice staff have about access to their expertise? What contact is reasonable when balancing available resources with patient demand, and how has this changed over time?

What are the key priorities within nationally published recovery plans for local stakeholders and how are these being implemented? What are the associated opportunities (e.g. reducing demand on hospitals) and challenges / risks?

Provide an initial view as to how this review could lead to efficiencies, improvements and/or transformation:

- Better understanding of primary care / GP pressures.
- Helping optimise appropriate use of primary care by the public.
- Encouraging that feedback on general practice access is done in a respectful / informed way.
- Understanding and addressing inequitable access across communities.
- Input of communities to work on improving access to general practice.

1.0 Executive Summary

1.1 This report outlines the findings and recommendations following the Adult Social Care and Health Select Committee's scrutiny review of Access to GPs and Primary Medical Care.

1.2 Accessing the help and advice of General Practitioners (GPs) and other professionals working in primary care general medical practices within the UK has long elicited a range of experiences and, indeed, opinions. Exacerbated by the recent COVID-19 pandemic and its subsequent knock-on effect to all health and care providers, the ability to make contact with and then use such services in the context of changed systems, working practices and workforce capacity has further sharpened views on this topic.

1.3 Conscious of the ongoing debate around these existing challenges, the Government released a new plan in May 2023 to make it easier for patients to see their GP and, in collaboration with the NHS, then announced a major new primary care access recovery plan which aimed to facilitate faster, more convenient care. Regionally, the North East and North Cumbria Integrated Care Board (NENC ICB) publicised a three-year programme in June 2023 bringing together the NHS and Councils with voluntary, community and social enterprise (VCSE) organisations to tackle long-standing inequalities and poor health. This investment included extra support for the 'Deep End' network of GP practices in the region's most deprived communities, and steps to attract and retain more GPs to work in deprived areas, with extra training and support to encourage trainee doctors to build their careers in these practices.

1.4 Locally, this scrutiny topic was proposed back in February 2022 (though was unable to be undertaken during the 2022-2023 municipal year due to competing work programme demands). At that point, several related concerns were highlighted around processes involved in accessing general practice, including call wait times, the need to complete online questionnaires, and the initial requirement to tell call-handlers of very personal issues before receiving an appointment. Whilst it is acknowledged that work will have taken place in relation to this topic since early-2022, recent national and regional announcements regarding primary care (general practice) access demonstrates the ongoing high-profile nature of what is a key frontline health service.

1.5 The main aims of this review were to firstly understand the existing local 'access to GPs' landscape in the context of national / regional developments around this ongoing issue. The Committee then sought to ascertain current systems for accessing general practice services, how these were communicated to the public, and how effective they were. Finally, and most importantly, determining any areas which may assist in improving the experience of the local population, and practices themselves, when individuals wish to contact and / or access general practice services was established.

1.6 The Committee heard that 'primary care' functions are the entrance to the healthcare system (acting as the 'front door' of the NHS), and include general practice, community pharmacy, dental, and optometry (eye health) services. General practices are the first point of contact with healthcare for many patients and act as gatekeepers to secondary care – they exist as individual businesses whose services are contracted by NHS commissioners to provide generalist medical services in a geographical or population area. Responsibility for

commissioning primary care services, including general practice, sits formally with NHS England – however, Integrated Care Boards (ICBs) have taken on full delegation of these commissioning requirements.

1.7 GP contracts are complex, with three different types used by NHS commissioners in England. There are, however, core requirements for all general practices, one of which is an expectation for public and patient involvement in shaping service delivery. Whilst the existing GP contract stated that 'practices must provide essential services at such times, within core hours (8.00am until 6.30pm, Monday to Friday, except Good Friday, Christmas Day or bank holidays), as are appropriate to meet the reasonable needs of its patients', there was no precise definition as to what constituted 'essential' nor 'reasonable needs'. It was recognised that practices, as independent businesses, were able to (and indeed many did) meet their core contract requirements differently depending on registered population demographic needs and skill mix of staff (as well as enhance service provision depending on appetite to deliver additionally commissioned services), though this was not a standard offer across the Borough and could lead to the impression that some residents were getting better / worse services than others. From a practice perspective, frequent changes to contract expectations (often resulting in further pressures on financial and / or staffing resources) were not helpful.

1.8 The crucial issue of funding for general practice was explored, with providers able to supplement core 'Global Sum' payments (based on an estimate of a practice's patient workload and certain unavoidable costs, not on the actual recorded delivery of services) with several other potential income streams. Some of these can be accessed independently by a practice (e.g. Quality and Outcomes Framework (QOF)), whereas others involve collaboration as part of a wider Primary Care Network (PCN) (groups of practices working together which are led by a Clinical Director). There are four PCNs within Stockton-on-Tees which are expected to deliver nationally directed enhanced services (DES) in addition to what practices need to provide as part of core contracts – one of the requirements of the PCN DES since October 2022 is 'enhanced access' (evening and weekend) obligations.

1.9 21 general practices exist across Stockton-on-Tees providing a range of services, with an average list size of 9,808 (as at January 2023). The Committee heard that a list size of 7,000-8,000 was considered financially sustainable, though there were significant fluctuations across the Borough, with the largest list size being 21,555, and the smallest 2,303.

1.10 Despite the publication of the national Primary Care Access Recovery Plan (PCARP) in May 2023, it was important to recognise that the high-profile aim to tackle the '8.00am rush' did not translate verbatim into the existing GP contract, nor did it mean that an individual would get an appointment on the same day, despite some elements of the media interpreting this so (however, if there was a clinically urgent need, a person should be offered an appointment appropriate to that need, which could be on the same day). That said, several other national measures were in place to support providers, including the General Practice Improvement Programme (GPIP), the Additional Role Reimbursement Scheme (ARRS) which provided funding to recruit to 18 roles (June 2023 data showed an additional 61 headcount (58.04 WTE) across the Borough through this scheme), and cloud-based telephony / digital tools funding. Local providers had been proactive in seeking involvement in these, and other, initiatives.

1.11 Whilst practices themselves, supported by various health bodies, were trying to facilitate better access to services, there were several issues influencing these efforts. An overriding factor was the ongoing legacy of the COVID pandemic which, as had been well documented nationally, led to greater demands on the health system, with associated problems arising in terms of a backlog of patients requiring often increasingly complex care and staffing challenges (sickness and recruitment / retention difficulties) – this had, in turn, affected many patients' attitudes towards, and experiences of, contacting their local general practice, with frustrations growing about access limitations (e.g. higher call waiting times), and increases in reported abuse of practice staff. From a practice perspective, other external events were also at play, with cost-of-living / inflationary pressures (increasing staff wages) contributing significantly to a tough period for the sector.

1.12 As the representative body for all general practices and GPs within Tees, Cleveland Local Medical Committee (LMC) emphasised its focus on 'workforce' considerations (i.e. capacity, workload, ensuring patient safety) as opposed to 'access', with improvements to the latter being inextricably linked to progress on the former. However, ensuring an appropriate staffing resource across the Tees Valley was not aided by trainees preferring to work in larger city areas, nor the case that around 18% of GPs were over the age of 55 (a significant loss of expertise was therefore looming which, without action, would exacerbate existing workforce concerns). Interestingly, Cleveland LMC stated that there were a number of GPs seeking work / additional work within Teesside who practices could not afford to employ due to financial restrictions.

1.13 With regards care navigation, Cleveland LMC highlighted that call handlers did not like having to ask questions of those contacting services, and that this was causing problems in relation to the retention of reception staff who were seeking less stressful roles outside the sector. Given reports that patients often feel uncomfortable in having to discuss their (potentially sensitive) health condition to someone over the phone (albeit that this can aid the individual being directed to the most relevant health professional), health authorities and practices themselves should consider what can be done to relieve this burden on all parties.

1.14 Hartlepool & Stockton Health (H&SH) GP Federation provide a vital service in supporting local practices through a variety of initiatives, particularly its digital staffing pool which providers could tap into if experiencing workforce pressures (the acquisition of a bus to assist in taking healthcare into the community was another innovative development which may help engagement with hard-to-reach individuals). In terms of ongoing challenges, H&SH expressed concerns around nursing numbers (an issue raised by PCNs and Cleveland LMC), an element of the workforce which serviced many of the populations day-to-day needs rather than GPs.

1.15 The Borough's four PCNs provided their collective views on the current situation around access to services, and the Committee was encouraged by the broad acknowledgement that patients must not be digitally excluded and that practices must continue to think of those who may not be technologically minded / able when designing contact / access pathways. Echoing concerns raised by the Cleveland LMC, PCNs noted delays to secondary care resulting in patients contacting primary care providers for support in the interim, a situation which amplifies how pressures in one part of the healthcare system can impact on other elements. Of course, this can also work the other way round, with those

struggling to access general practices sometimes attending secondary services (e.g. A&E) when not necessarily appropriate.

1.16 Given concerns evident in the national media, it was perhaps not surprising to hear of local frustrations around a lack of face-to-face appointments from the public / patients, as well as issues in using technology (particularly for older residents) which had been brought in to enhance access to services. Worryingly, 2023 GP patient survey feedback showed significant difficulties for individuals trying to get through on the phone to a good proportion of local practices, an experience which data showed had become a deteriorating trend for many over recent years. On a more positive note, public / patient feedback also demonstrated a number of welcome developments that were acknowledged by those contacting / accessing services. As is often the case, experiences can be very individual, and what health bodies introduce / change can suit some whilst at the same time cause difficulties for others. Patient Participation Groups (PPGs) reporting that they felt listened to by their practices is therefore an encouraging and necessary finding, particularly when shaping current and future service delivery.

1.17 National leaders continue to wrestle with this highly charged scrutiny topic, and finding solutions to fundamental issues (headlined by the need for consensus around GP contract content / funding) at a local level is extremely difficult. However, this review has shone yet another light on a sector which remains under significant strain, principally due to the twin pressures of sustained high-level demand and ongoing workforce challenges (which could get worse). Despite this, stakeholders were being proactive in trying to ensure that local people could access general practice services in a timely fashion via multiple routes (both digitally and in-person), and the challenge remains to help the public understand who to contact and which services they should be trying to access depending on their presenting condition. Whether enough health staff are in place to meet that need is, however, a much more significant concern moving forward.

Recommendations

The Committee recommend that:

General

1) All relevant health bodies (NENC ICB, Cleveland LMC, H&SH, NHS Trusts, and general practices) engage regularly and constructively around the issues raised as part of this review to ensure that patients are approaching / receiving care from the most appropriate services based on need.

Communications

2) All relevant health bodies continue efforts to increase public / patient understanding about accessing the most appropriate services (including in the context of the *Pharmacy First* initiative), using all available communication mechanisms (both print and digital) and links through local community networks (e.g. community partnerships), to ensure key messages are reinforced.

(continued overleaf…)

Recommendations (continued)

The Committee recommend that:

3) Councillors be supported in helping with these communication messages as leaders in their communities (as well as their role in raising concerns expressed by the community), and encourage positive feedback as well as concerns (to help share and spread learning and best practice).

4) The value and importance of all general practice roles are highlighted and publicised by health bodies and practices themselves.

5) Local practices be recognised for continuing to deliver primary medical care services safely in Stockton-on-Tees despite the ongoing challenges raised during this review.

Operational

6) All general practices move towards providing the full use of digital telephony capabilities (including call-back functionality), with appropriate staff in place to support these arrangements.

7) All general practices be encouraged to review and refresh care navigation processes, ensuring adequate training is in place to support implementation to ensure both staff and patients are comfortable with the approach.

8) To ensure appropriate workforce capacity is in place to maximise the local general practice offer:

a) NENC ICB continue to support / encourage uptake of the ARRS scheme, particularly amongst those PCNs which had not accessed this initiative.

b) All relevant health bodies continue to explore further and develop options to increase GP recruitment and retention in the Borough.

c) Options to increase nursing numbers (including strengthening training offers and uptake) be explored further.

9) The Borough's four PCNs be encouraged and supported to work together collaboratively to share and adopt good practice.

Public / patient feedback

10) Relevant health stakeholders be proactive in encouraging involvement of patients in practice Patient Participation Groups (PPGs), aim to ensure these are representative of a practice's patient list demographic, and consider fostering links between the Borough's PPGs to assist in identifying / addressing any access issues.

11) NENC ICB consider its complaint / compliment reporting mechanisms so future data can be provided at a local general practice level.

2.0 Introduction

2.1 This report outlines the findings and recommendations following the Adult Social Care and Health Select Committee's scrutiny review of Access to GPs and Primary Medical Care.

2.2 The main aims of this review were to firstly understand the existing local 'access to GPs' landscape in the context of national / regional developments around this ongoing issue. The Committee then sought to ascertain current systems for accessing general practice services, how these were communicated to the public, and how effective they were. Finally, and most importantly, determining any areas which may assist in improving the experience of the local population, and practices themselves, when individuals wish to contact and / or access general practice services was established.

2.3 The Committee identified the following key lines of enquiry:

- What is meant by 'primary care' (including definitions of terminology to be used within the review such as general practice, primary medical care, general practitioners (GPs), etc.)?
- How does primary care (general practice) work – how is it commissioned / paid for; what are the contractual mechanisms / expectations? Who are the key stakeholders around the issue of general practice access and what role do they play (individually and in partnership)?
- What is, and who decides on, the population density, spread and location of the Borough's practices? How are professionals allocated to practices? Who are practices accountable to / regulated by?
- How has access to general practice changed since the COVID-19 pandemic emerged (as a result of either national policy or local decisions)? What systems can the public use to contact their practice; how are these communicated (by who, how, how often)? Do these create barriers to access?
- When are practices accessible / open, and how do they manage patient contact (prioritisation / triage)? How effective is this?
- What do we know about issues within the Borough – are these confined to specific areas? Do experiences vary when contact is made with practices at different times of the day?
- Is there a variation in access according to population characteristic (e.g. disproportionate impact on more deprived, those with disabilities, different ethnic groups, older people)?
- How is the public encouraged to raise concerns about access? What mechanisms are in place to report issues and how are these communicated?
- Do practices actively seek feedback from its registered patients around access – if so, how has this informed arrangements?

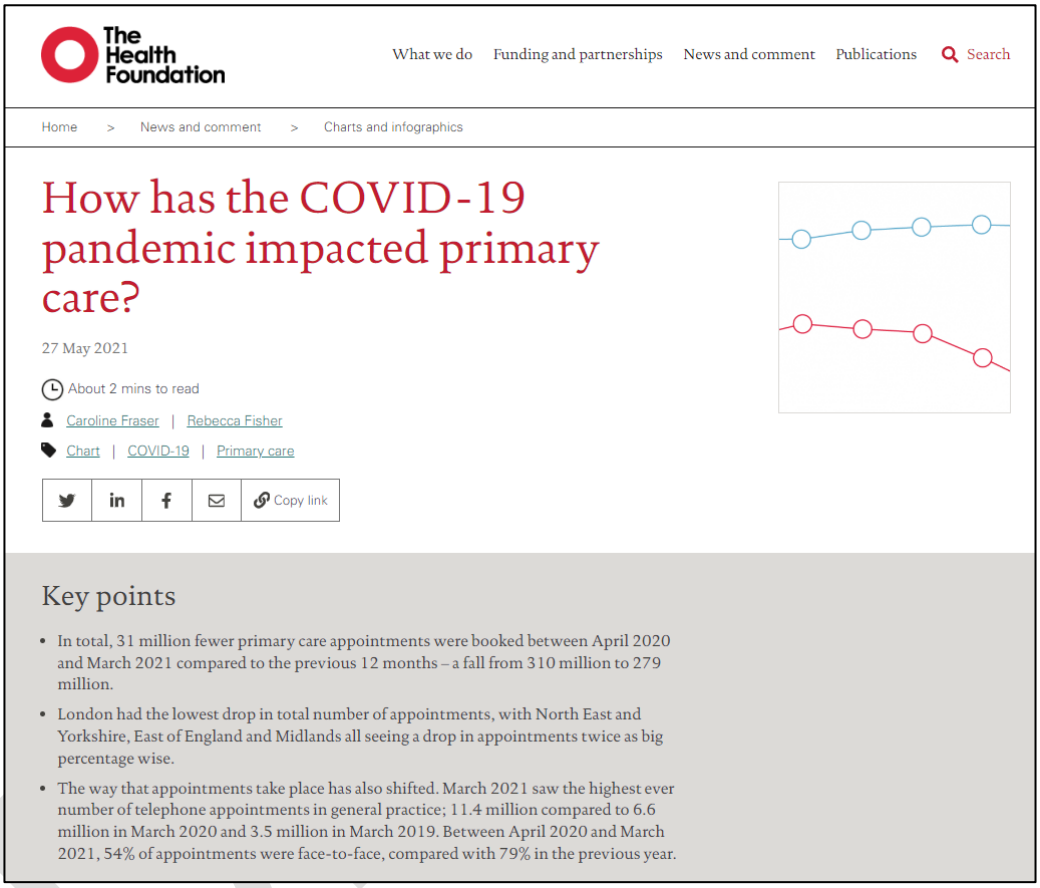
- What views do GPs and other practice staff have about access to their expertise? What contact is reasonable when balancing available resources with patient demand, and how has this changed over time?

- What are the key priorities within nationally published recovery plans for local stakeholders and how are these being implemented? What are the associated opportunities (e.g. reducing demand on hospitals) and challenges / risks?

2.4 The Committee took evidence from several relevant health bodies including the North East and North Cumbria Integrated Care Board (NENC ICB), Cleveland Local Medical Committee (LMC), Hartlepool & Stockton Health (H&SH) GP Federation, and the Borough's four Primary Care Networks (PCNs). To ascertain experiences of contacting / accessing local practices, public / patient views were sought and considered from a variety of sources including the Care Quality Commission (CQC), NENC ICB, Healthwatch Stockton-on-Tees, and Patient Participation Groups (PPGs) from the Borough's general practices. GP patient survey data was also reflected upon.

3.0 Background

3.1 Accessing the help and advice of General Practitioners (GPs) and other professionals working in primary care general medical practices within the UK has long elicited a range of experiences and, indeed, opinions. Exacerbated by the recent COVID-19 pandemic and its subsequent knock-on effect to all health and care providers, the ability to make contact with and then use such services in the context of changed systems, working practices and workforce capacity has further sharpened views on this topic.



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How has the COVID-19 pandemic impacted primary care?

27 May 2021

About 2 mins to read

Caroline Fraser | Rebecca Fisher

Chart | COVID-19 | Primary care

Copy link

Key points

- In total, 31 million fewer primary care appointments were booked between April 2020 and March 2021 compared to the previous 12 months – a fall from 310 million to 279 million.
- London had the lowest drop in total number of appointments, with North East and Yorkshire, East of England and Midlands all seeing a drop in appointments twice as big percentage wise.
- The way that appointments take place has also shifted. March 2021 saw the highest ever number of telephone appointments in general practice; 11.4 million compared to 6.6 million in March 2020 and 3.5 million in March 2019. Between April 2020 and March 2021, 54% of appointments were face-to-face, compared with 79% in the previous year.

3.2 Conscious of the ongoing debate around these existing challenges, the Government released a new plan in May 2023 to make it easier for patients to see their GP and, in collaboration with the NHS, then announced a major new primary care access recovery plan which aimed to facilitate faster, more convenient care.

3.3 Regionally, the North East and North Cumbria Integrated Care Board (NENC ICB) publicised a three-year programme in June 2023 bringing together the NHS and Councils with voluntary, community and social enterprise (VCSE) organisations to tackle long-standing inequalities and poor health. This investment included extra support for the 'Deep End' network of GP practices in the region's most deprived communities, and steps to attract and retain more GPs to work in deprived areas, with extra training and support to encourage trainee doctors to build their careers in these practices (https://northeastnorthcumbria.nhs.uk/news/posts/35m-plan-to-improve-health-in-region-s-most-deprived-areas/).

3.4 Locally, this scrutiny topic was proposed back in February 2022 (though was unable to be undertaken during the 2022-2023 municipal year due to competing work programme demands). At that point, several related concerns were highlighted around processes involved in accessing general practice, including call wait times, the need to complete online questionnaires, and the initial requirement to tell call-handlers of very personal issues before receiving an appointment. Whilst it is acknowledged that work will have taken place in relation to this topic since early-2022, recent national and regional announcements regarding primary care (general practice) access demonstrates the ongoing high-profile nature of what is a key frontline health service.

4.0 Findings

Primary Care & General Practice

4.1 The following key definitions pertinent to this review were established from the outset:

- Primary Care: Services providing the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.

- Primary Medical Care: Refers to medical services provided under Part 4 of the NHS Act 2006 by a general practice. This is sometimes referred to as a 'GP practice' or 'GP surgery'.

- General Practices: The small to medium-sized businesses whose services are contracted by NHS commissioners to provide generalist medical services in a geographical or population area. Some practices are operated by an individual General Practitioner (GP) and some by provider organisations (e.g. IntraHealth) – most, though, are run by a GP partnership which involves two or more GPs working together as business partners, employing staff, and together owning a stake in the practice business. Every individual or partnership of GPs must hold an NHS GP contract. GP partners are jointly responsible for meeting the requirements set out in the contract for their practice and share the income it provides.

4.2 General practice is the first point of contact with healthcare for many patients, and act as gatekeepers to secondary care. As generalists, practices see the whole patient and even whole patient's families. Responsibility for commissioning primary care services, including general practice, sits formally with NHS England – however, Integrated Care Boards (ICBs) have taken on full delegation of these commissioning responsibilities.

GP Contracts (https://www.england.nhs.uk/gp/investment/gp-contract/23-24/)

4.3 There are three different types of GP contract arrangements used by NHS commissioners in England:

- General Medical Services (GMS) Contract: The national standard GP contract to deliver 'core' medical services. This contract is negotiated nationally every year between NHS England and the General Practice Committee (GPC England) of the British Medical Association (BMA), the trade union representative of GPs in England. A GMS contract is held in perpetuity by the practice.

- Personal Medical Services (PMS) Agreement: Another form of core contract but, unlike the GMS contract, is negotiated and agreed locally by ICBs or NHS England with a practice or practices. This offers commissioners more flexibility to tailor requirements to local need while also keeping within national guidelines and legislation. The PMS agreement is again held in perpetuity but by individuals, not a partnership (six months' notice to terminate can be given). All PMS contracts transferred to GMS conditions.

- Alternative Provider Medical Services (APMS): Offers greater flexibility than the other two contract types. The APMS framework allows contracts with organisations (such as private companies or third-sector providers) other than GPs / partnerships of GPs to provide primary care services. APMS contracts can also be used to commission other types of primary care service, beyond that of 'core' general practice. These contracts are time limited.

4.4 All three contract types set out mandatory requirements and services for all general practices. The core parts of the GP contract include:

- Agreeing a geographical or population area the practice will cover.
- Maintaining of a list of patients for the area and setting out specific circumstances a patient might be removed from it.
- Provision of essential medical services to registered patients.
- Standards for premises and workforce and requirements for inspection and oversight.
- Expectations for public and patient involvement.
- Key policy requirements including indemnity, complaints, liability, insurance, clinical governance and contract termination conditions.

4.5 General practices must provide essential services at such times, within core hours (8.00am until 6.30pm, Monday to Friday, except Good Friday, Christmas Day, or bank holidays), as are appropriate to meet the reasonable needs of its patients. However, it was noted that there was no precise definition as to what constituted 'essential' nor 'reasonable needs' ('core hours' were specified, though).

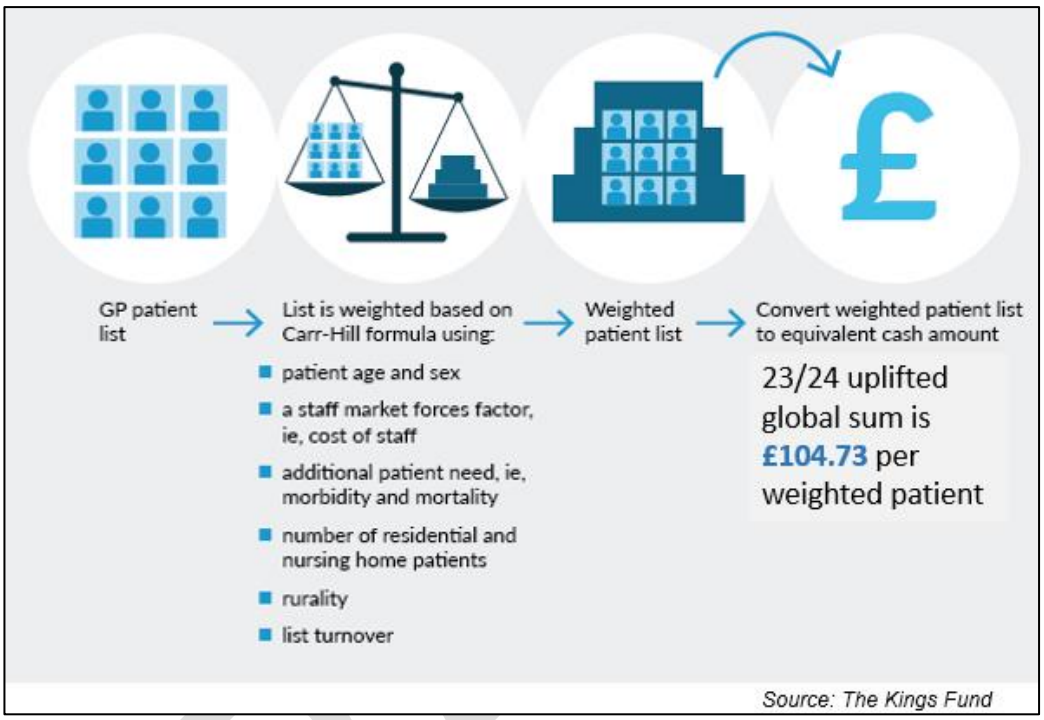
4.6 Practices must also keep aside appointments for NHS 111 to book, and must offer and promote online consultations and video consultations. The current five-year contract was in its final year, and although the 2024-2025 contract was not yet published, a summary of contract changes for 2024-2025 were made available on 28 February 2024 (see 'Recent / Future Developments' section on page 43).

Regulation

4.7 The Care Quality Commission (CQC) is the regulator of primary medical care and is responsible for the inspection of general practices in England in order to monitor standards against set key areas. Each practice must be registered with the CQC and appoint a registered manager, and is expected to be able to evidence how it is run in considerable detail, helped by the prior preparation of a series of policy documents, protocols and procedures.

Funding

4.8 Much of a practice's income comes from its core contract agreements known as the Global Sum payment. This is based on an estimate of a practice's patient workload and certain unavoidable costs (e.g. the additional costs of serving a rural or remote area or the effect of geography on staff markets and pay), **not on the actual recorded delivery of services** (see graphic below).



The Statement of Financial Entitlements (SFEs) sets out what general practice can be reimbursed for (*note: most practice income is paid to the practice rather than to individual GPs*) and many practices also top up their NHS funding with fees for private services, such as medicals and travel prescribing that is outside of commissioned services.

4.9 In addition to the core funding via the Global Sum, practices rely on other forms of income to cover expenditure. Other potential income streams include:

- Quality and Outcomes Framework (QOF): A voluntary scheme that provides funding to support aspiration to, and achievement of, a range of quality standards by rewarding practices for the volume and quality of care delivered to their patients. Practices earn points according to their levels of achievement and payments are calculated on the points the practices achieve – the value of a QOF point in 2023-2024 is £213.43 (the scheme has 635 points). Whilst not part of the core contract, QOF can be beneficial for practices and is therefore rarely ignored.

- Directed Enhanced Services (DES): Each DES attracts a separate payment amount as set out in the SFEs. The Network Contract DES offers practices further income opportunities through the formation of Primary Care Networks (PCNs), including (for the period 1 April 2023 to 31 March 2024):

- Clinical Director Payment: £0.72963 per registered patient per annum.
- Core PCN Funding: £1.50 multiplied by the PCN registered list size.
- Enhanced Access Payment: £7.578 multiplied by the PCNs adjusted population. From 1 October 2022, each Primary Care Network (PCN) is required to provide 60 minutes of additional general practice capacity per 1,000 adjusted population between 6.30pm-8.00pm on weekday evenings and 9.00am-5.00pm on Saturdays (see **Appendix 1** for Enhanced Access provision / utilisation across the Borough as of October 2023).
- Care Home Premium: Calculated on the basis of £120 per bed. The number of beds will be based on CQC data on beds within services that are registered as care home services with nursing (CHN) and care home services without nursing (CHS) in England. Primary Care Support England (PCSE) will make monthly payments based on care home bed numbers provided by commissioners. Payments are made at a rate of £10 per bed per month based on the number of relevant beds in the PCN's Aligned Care Homes.
- PCN Leadership and Management Payment: £0.684 multiplied by the PCNs adjusted population.
- Capacity and Access Support Payment: £2.765 multiplied by the PCNs adjusted population.

In addition, the Investment and Impact Fund (IIF) is a points-based scheme similar to QOF. Redesigned for 2023-2024 to focus on five indicators (vaccinations and immunisations (two), tackling health inequalities, cancer, and access), it is worth £59 million nationally.

- Additional Role Reimbursement Scheme (ARRS): PCNs can claim ARRS funding to bring in a new workforce to support primary care to ensure a multi-disciplinary team (MDT) approach. Staff funded through ARRS must be used to support the DES requirements and be in addition to current practice workforce. PCNs across Tees Valley have employed / engaged 303 ARRS staff (277.17 WTE) as at the end of Q1 (June 2023) from the roles available – June 2023 data shows an additional 61 headcount (58.04 WTE) across Stockton-on-Tees as follows:

ADDITIONAL ROLES (as of June 23)	
12 x Clinical Pharmacists	4 x Pharmacy Technicians
18 x Social Prescribing Link Workers	1 x Physician Associates
1 x Children and Young Peoples Practitioner [Band 7]	4 x First Contact Physiotherapists
7 x Mental Health Practitioners [3 at Band 4, 4 at Band 7]	5 x Trainee Nurse Associate
1 x Care Co-ordinators	6 x Health and Wellbeing Coaches
2 x Digital and Transformation Lead	

Primary Care Networks (PCNs)

4.10 Established in July 2019, PCNs are groups of practices working together to deliver nationally directed enhanced services (DES) which are offered to each individual practice as the legal entity agreeing participation. They are required to provide the following services (in addition to what practices are expected to deliver as part of core GMS contracts):

Services	
Enhanced Access	Medication reviews and medicines optimisation
Enhanced Health in Care Homes	Early Cancer Diagnosis
Social Prescribing Service	Tackling neighbourhood health inequalities
Personalised Care [including reviewing shared decision-making audit]	Cardiovascular disease and prevention

4.11 PCNs are not organisations or legal entities, and each PCN is led by a Clinical Director who represents the group of practices. PCNs have their own governance arrangements agreed through collaborative agreements across the grouping in relation to decision-making and operational arrangements, and there are four PCNs in Stockton-on-Tees. PCNs have taken a fundamental role in the COVID-19 vaccination programme, establishing local vaccination services as PCN groupings and the provision of enhanced access. PCNs have risen to these challenges, continuing to develop their relationships between practices and across the system to develop new ways of working.

Other Key Agencies

4.12 Local Medical Committee (LMC): A LMC is the body statutorily recognised by successive NHS Acts as the professional organisation representing individual NHS GPs and GPs as a whole in NHS England, including primary care organisations. A LMC is the only elected professional body that represents the views of local GPs and practice teams, at a national and local level, on issues of local interest in general practice, and NHS England and ICBs have a statutory responsibility to recognise local practitioner committees. A LMC is an independent, self-financing body (with statutory functions) funded via a levy paid by each practice. Representatives of LMCs meet at an annual conference which makes policy which the General Practitioners Committee is mandated to effect through negotiating with NHS Employers and the Departments of Health and Social Care (DHSC).

4.13 GP Federations: Groups of primary care providers which form a single organisational entity and work together as economies of scale to deliver services for their combined patient communities.

4.14 Healthwatch: The independent champion for people who use health and social care services. Funded by the DHSC through local Councils, they use patient feedback to better understand the challenges facing the NHS and other care providers nationally, make sure patient experiences improve health and care services for everyone, and also have a role helping patients to get information and advice, signposting patients to available support. As an independent statutory body, Healthwatch have the power to make sure NHS leaders and other decision-makers listen to patient feedback and improve standards of care.

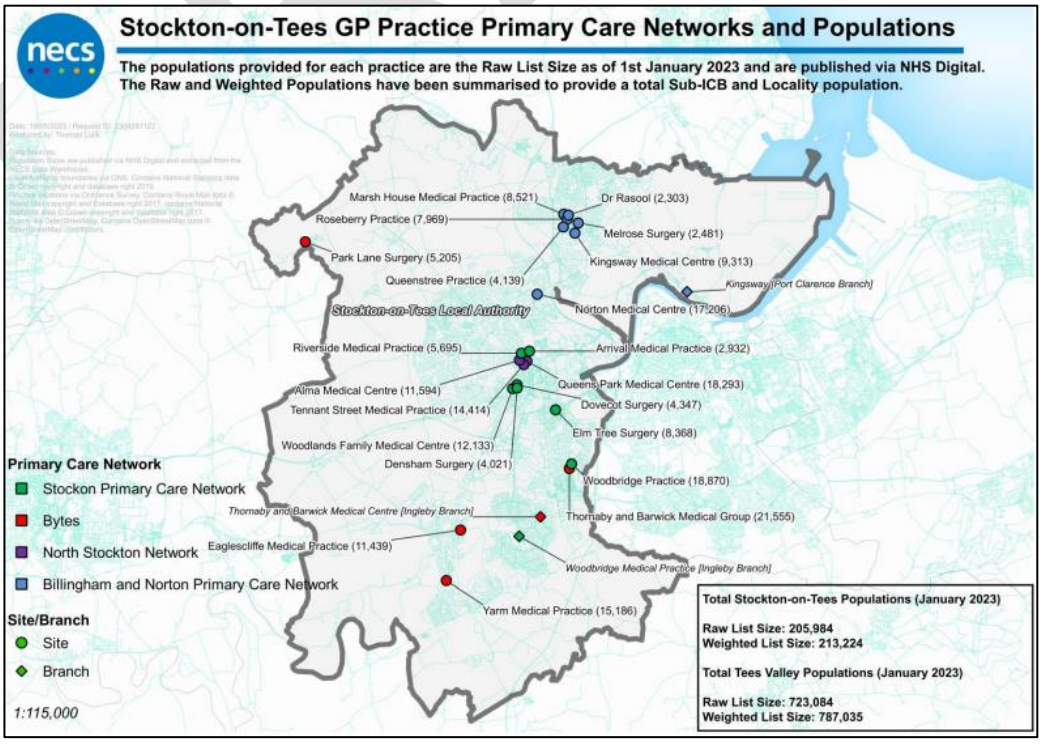
Stockton-on-Tees Provision

4.15 As of January 2023, 78 general practices (each affiliated to one of 14 Primary Care Networks (PCNs)) were operating across the five Tees Valley Local Authority areas:

Locality	No. of practices	Smallest list size	Largest list size	Average list size	Number of PCNs
Hartlepool	11	3,806	18,728	8,865	3
Stockton	21	2,303	21,555	9,808	4
Darlington	11	4,718	15,302	10,185	1
Middlesbrough	20	751	20,117	8,125	3
Redcar	15	3,342	14,615	8,530	3

In Stockton-on-Tees, there were 21 practices covering a registered population of 205,984 (206,858 as of August 2023). A patient list size of around 7,000-8,000 was considered financially sustainable – locally, the average list size was 9,808 (the smallest being 2,303 and the largest 21,555). Four PCNs existed within the Borough:

Billingham and Norton PCN	**North Stockton PCN**
BYTES PCN	**Stockton PCN**



4.16 A 'Stockton-on-Tees Data Pack' was provided to the Committee which included the previous map of the Borough's general practices, branch sites, and practice list sizes. Opening hours (as of August 2023) sourced from practice websites were also highlighted as follows:

Practice	Opening Hours (August 2023)
Marsh House Medical Practice	Monday to Friday: 08:00 - 18:00
The Roseberry Practice	Monday to Friday: 08:00 - 18:00 *(Closed between 13:00 - 14:00 on a Wednesday)*
Dr Rasool's Practice	Monday: 08:00 - 20:00 Tuesday, Wednesday and Friday: 08:00 - 17:00 Thursday: 08:00 - 13:00 and 14:00 - 17:00
Kingsway Medical Centre	Monday to Friday: 08:00 - 18:00
Melrose Surgery	Monday & Wednesday: 08:00 - 18:00 Tuesday & Friday: 07:30 - 18:00 Thursday: 07:30 - 13:00 (emergencies only 13:00 - 18:00)
Queenstree Practice	Monday to Friday: 08:30 - 18:00 Monday to Thursday: 07:35 - 08:30 (pre-booked only)
Norton Medical Centre	Monday to Friday: 08:00 - 18:00
Eaglescliffe Medical Practice	Monday to Friday: 08:00 - 18:00
Park Lane Surgery	Monday to Friday: 08:00 - 18:00
Thornaby & Barwick Medical Group	Monday to Friday: 08:00 - 18:00
Yarm Medical Practice	Monday to Friday: 08:00 - 18:00
Alma Medical Centre	Monday to Friday: 08:30 - 18:00 (*Closed Wednesday 12:00 - 13:45 for staff training*)
Tennant Street Medical Practice	Monday to Friday: 08:00 - 18:00
Queens Park Medical Centre	Monday to Friday: 08:30 - 18:00
Woodlands Family Medical Centre	Monday to Friday: 08:00 - 18:00 Thursday: 18:30 - 20:30
Dovecot Surgery	Monday to Friday: 08:30 - 18:00
Densham Surgery	Monday to Friday: 08:30 - 18:00
Riverside Practice	Monday, Tuesday, Wednesday & Friday: 08:00 - 18:00 Thursday: 08:00 - 14:30
Arrival Medical Practice	Monday to Friday: 08:30 - 18:00
Elm Tree Surgery	Monday to Friday: 08:00 - 18:00
Woodbridge Medical Practice	Monday to Friday: 08:00 - 18:00

4.17 Other relevant information of note included:

- CQC ratings: Of the Borough's 21 general practices, 17 had an overall rating of 'Good', and 4 had an overall rating of 'Outstanding'. Whilst the CQC had reviewed the vast majority of practices during 2023, it had been several years since the latest inspection of most Stockton-on-Tees settings.

- Staffing levels & GP numbers (headcount and full-time equivalent as a ratio to patient list size): According to August 2023 general practice workforce data (General Practice Workforce - NHS Digital) and August 2023 patient list sizes (Patients Registered at a GP Practice - NHS Digital), Stockton-on-Tees had a GP (headcount) to patient ratio of 1:1,360 patients (Tees Valley was 1:1,409 patients) compared to England which had a ratio of 1:1,288 patients.

- Directed Enhanced Services (DES): 17 of the 21 practices in Stockton-on-Tees were signed up to the Minor Surgery, Learning Disability and Weight Management Direct Enhanced Services. Three of the 21 had signed up to the Out of Area DES, whilst one practice had only signed up to the Minor Surgery and Weight Management DES (see graphic below).

Direct Enhanced Services (DESs) are nationally agreed and must be offered to all GP practices in England. Practices can decide whether they sign up to a DES or not, but they must be offered the opportunity to do so.

Minor Surgery DES: Allows GPs to conduct minor surgical procedures, including injections and incisions or excisions, which helps increase patient satisfaction in general practice.

Learning Disabilities DES: Designed to encourage practices to identify patients aged 14 and over with learning disabilities, to maintain a learning disability 'health check' register, and offer an annual health check, which will include a health action plan.

Weight Management DES: The COVID-19 pandemic focused on obesity and weight management, which led to the introduction of a new DES in 2022-2023. The aim of this DES was to introduce new measures to tackle obesity.

Out of Area DES: All GP practices are free to register new patients who live outside their practice area without any obligation on the practice to provide home visits for such patients when the patient is at home, away from, and unable to attend, their registered practice. The purpose of the DES is for the practice to provide primary medical services to patients in their home area during core hours if they have an urgent care need and if they cannot reasonably be expected to attend their registered practice.

- Appointment data (including Patient Online Management Information (POMI)): Appointment rates per 1,000 (all appointments) between October 2022 and August 2023 were broadly consistent for the Borough's practices, with slightly higher levels in November 2022 and March 2023 (*note: general practice appointment data for individual practices was not published by NHS Digital until October 2022, therefore local appointment rates per 1,000 cannot be compared to pre-pandemic levels*). Further Stockton-on-Tees appointment activity for April 2023 to August 2023 was provided as follows:

Primary care appointment activity

Stockton practices	April 2023	May 2023	June 2023	July 2023	Aug 2023
Total number of appointments	73,727	83,357	89,189	82,848	83,408
Total appointments per 1,000 population	357.1	403.7	431.7	400.7	403.2
% of appointments where the time between booking and the date of the appointment was either same day or 1 day	46%	45.6%	44.5%	44.8%	44.9%
% of appointments where the time between booking and the date of the appointment was up to 2 weeks	38%	38.5%	38.6%	39.4%	38.4%
% of appointments where the time between booking and the date of the appointment was over 2 weeks	12.7%	12.9%	13.1%	12.0%	12.7%
% of appointments categorised as face to face	84.9%	85%	84.2%	83.6%	82.6%
% of appointments categorised as telephone or video	12.4%	12%	12.9%	13.3%	14.2%
Number of appointments recorded as Did Not Attend (DNA)	3,590	4,067	4,036	4,003	3,694

4.18 Reflecting on the list of Stockton-on-Tees practices, the Committee asked where the Lawson Street provision fitted into the local offer. It was confirmed that whilst there were two practices located within the Lawson Street premises, other services that were delivered from there were not part of general practice services.

4.19 A query was raised as to whether a register of the different services offered by each practice was kept (reported confusion as to which services offered flu and / or COVID vaccinations was relayed by Members). The Committee was reminded about the difficulty within the GP contract in articulating what 'essential services' included – as such, practice websites and patient leaflets were the main source of information.

4.20 Regarding the primary care appointment activity noted within the data pack, the data did not include 'dropped' calls which had previously been difficult to track – however, new telephony systems (as part of the phasing out of analogue phones) do collect this information, and the Borough's practices could be asked to supply this data if required. Statistics in relation to enhanced access utilisation (see **Appendix 1**) indicated that significantly less people used the Sunday service in Eaglescliffe (it was stated that patients should be offered appointments during core hours as well as enhanced access options).

4.21 The Committee drew attention to the Patient Online Management Information (POMI) statistics included within the data pack and noted the varying level of patients accessing their records remotely (which would be interesting to compare with any available regional / national figures). Members were informed that, from 31 October 2023, there was a new contract requirement that all people should have access to future (not past) records, though this had created some nervousness amongst practices with regards potential safeguarding issues – the ICB continued to work with providers on this. In terms of the different levels of online bookings / cancellations and repeat prescription ordering, variances in relation to the level of awareness / promotion of remote options may explain data fluctuations, and there was not an ambition to get this close or up to 100% – this was merely just a way of expanding patient choice.

Addressing Access Issues

4.22 The Primary Care Access Recovery Plan (PCARP) was published on 9 May 2023 and aimed to tackle the 8.00am rush and reduce the number of people struggling to contact their practice, as well as ensure patients know on the day they contact their practice how their request will be managed. The 2023-2024 focus was on:

- Empowering patients to manage their own health: improving information and NHS App functionality, increasing self-directed care, and expanding community pharmacy services.

- Implementing Modern General Practice Access (MGPA): better digital telephony, simpler online requests, and faster navigation, assessment and response).

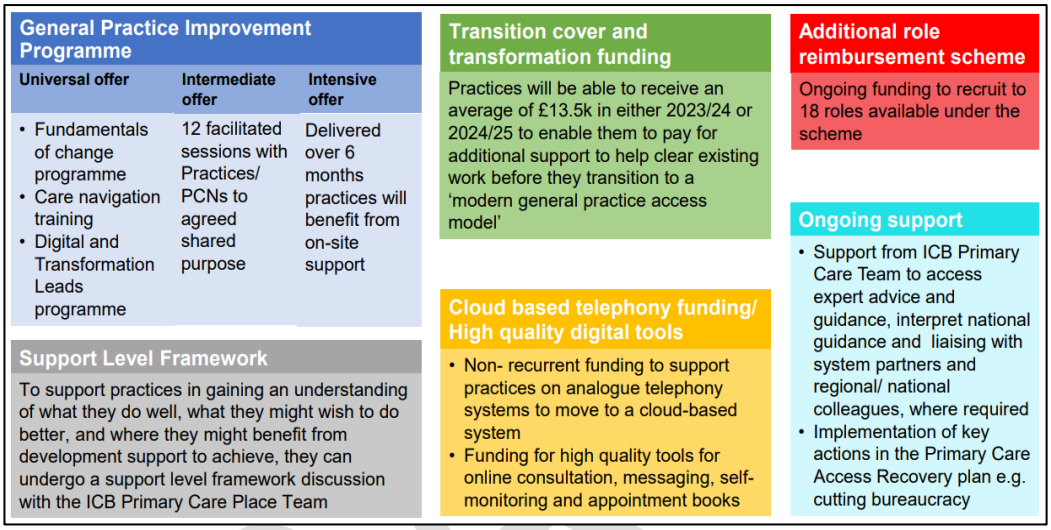
- Building capacity: larger multi-disciplinary teams, more new doctors, and retention / return of experienced doctors).

- Cutting bureaucracy: improving the primary-secondary care interface regarding onward referrals (e.g. for patients referred into secondary care who need another referral (for an immediate or a related issue), the secondary care provider should make this for them, rather than sending the

patient back to the GP to refer), call / recall systems, and clear points of contact.

4.23 The Committee heard that the high-profile aim to tackle the 8.00am rush did not translate verbatim into the existing GP contract, nor did it mean that an individual would get an appointment on the same day (despite some elements of the media interpreting this so). However, if there was a clinically urgent need, a person should be offered an appointment appropriate to that need, which could be on the same day.

4.24 Other national support measures were outlined as follows:



4.25 From a Stockton-on-Tees perspective, progress on strengthening access to services (as of October 2023) included:

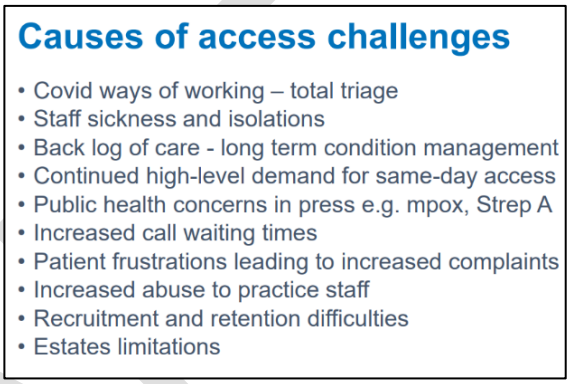
- Telephony: Five practices had been identified for priority transfer from analogue to digital.
- General Practice Improvement Programme (GPIP): Five practices had signed up to the intensive 26-week programme.
- National Care Navigation Training: 13 practices had signed up to access the training.
- Modern General Practice Access (MGPA): 13 practices had indicated they intended to move to MGPA in the next two years and three practices felt that they had already implemented this.
- Support Level Framework: One practice had participated in a discussion to identify areas of focus when developing and redesigning practice processes and procedures.
- Digital: Seven practices were working with the ICB Digital Team to make improvements to websites.
- Digital: Improved use of social media and other communication methods to inform patients of the changes to practice and the benefits of these changes. Five practices in Stockton were enrolled with the 'register with a GP' online service.
- PCN Capacity and Access Improvement Plans (CAIP): Approved and being implemented for March 2024.

4.26 In addition, phase one of a six-month national public relations campaign to promote improvements in GP access was tentatively due to launch mid-October 2023. The campaign will focus on care navigation and the multi-disciplinary approach, with case studies from the most commonly occurring roles in the general practice team (clinical pharmacists, paramedics, physios, social prescribers, care coordinators, health and wellbeing coaches, mental health practitioners, physician associates and nurses).

Views of Health Bodies

North East and North Cumbria Integrated Care Board (NENC ICB)

4.27 Access challenges were outlined (see graphic right), with ways of working impacted by the COVID pandemic (i.e. digital / online offers significantly accelerated), and the appetite for medical training limited in the context of other career opportunities (something the ICB was trying to address). It was emphasised that GPs were 'generalists' and see people about anything and everything – however, some individuals with more urgent needs were trying to access them instead of more appropriate services.



4.28 The most significant challenge was arguably the ongoing recruitment and retention difficulties for both clinical and administrative roles. Practices were not an attractive place to work at present, and the abuse of staff was a real issue. Cost-of-living factors also added to the pressure on services, with increases in wages not covered by practice income. Ultimately, practices were limited in terms of changing their operations and financial reimbursements were not huge (despite practices giving very high value-for-money).

4.29 Assurance was given that local practices were proactively changing the way they delivered their services, and several examples of progress were highlighted (see 'Addressing Access Issues' theme above). In addition, a national campaign in association with Healthwatch had been initiated with regards access, and the ICB was in the process of contacting practices to verify the accuracy of their opening times on websites / public platforms.

Cleveland Local Medical Committee (LMC)

4.30 Fully recognising that GP access was currently a priority issue for the public, Cleveland LMC emphasised that the existing situation within Stockton-on-Tees was very much aligned to the national picture when it came to challenges associated with accessing services. During an overview of the differing strands of the overarching general practice offer, it was noted that the digital GP option was not hugely popular locally (compared to take-up within bigger cities such as London and Birmingham), and that private GP use was also low within the Borough due to a lack of demand (perhaps reflective of it being a less affluent area).

4.31 As the representative body for all general practices and GPs within Tees, having the authority to speak and negotiate on behalf of so many can present its own challenges. Cleveland LMC was funded solely by its practices on a voluntary basis and was independent of other organisations (there were no conflicts of interest) and any political party (though did take an interest in political developments).

4.32 Cleveland LMC supported its constituents in multiple ways, including the dissemination of formal guidance (e.g. another Local Authority area had experienced issues around people getting registered with practices), escalating concerns to national negotiators, and providing contract implementation advice. It also assisted with dispute resolution (which was currently a frequent occurrence), fed into the British Medical Association (BMA), and was linked-in with national communications teams. Cleveland LMC was well respected by the BMA, but its views were not as well received by the Government or NHS England – the imposition of contracts being a particular concern at present.

4.33 Also acting as a job advert service, it was normal to have more than 10 GP vacancies at any one time, with recruitment proving more challenging in Teesside than in other regions (young trainees had shown a tendency to want to work in Newcastle or York). As such, access was not seen as a huge priority for practices – the focus was much more on workload, workforce capacity, reducing regulation, financial stability / sustainability, and ensuring patient safety. Whilst it liaised with other LMCs across the country, Cleveland LMC would like to meet more frequently with regional / local stakeholders to ensure positive outcomes (not just for the sake of meeting).

4.34 National trends around GP access painted a very concerning picture. Population growth and a reduction in GP numbers had combined to put significant pressure on the sector, and many GPs had resorted to working three-day weeks (though very long days) to control stress levels within the context of a tough working environment. Retention of staff had also become a problem, and it was important to note that 18% of GPs were over the age of 55 – whilst some were working full-time into their 70s, a big gap was looming once they leave the profession, and though the ageing workforce issue had been known for some time, there remains no solution.

4.35 Awareness was raised around the national 'Rebuild General Practice' campaign which challenged the way things were sometimes portrayed in the media. Several concerning statements around risks to patients, inadequate time available to spend with patients, and recruitment and retention issues were highlighted, though it was acknowledged that the statistics reflected a national survey, and local data was not yet available (*note: it was subsequently confirmed that the LMC was not aware of any local statistics, and that the locality was not specifically collected within the national survey*). There was also a desire for more continuity regarding contact with patients (which the current contracting mechanism prohibited) as evidence suggested that better outcomes follow when people see the same GP each time they access services.

4.36 It was important to recognise that more appointments than ever were being delivered, with the average appointments per year for every registered patient (6) now 50% more than what the funding was intended for (4 per year). Ultimately, it was not safe to deliver more appointments, hence the push for a greater focus on patient safety – the move to 15-minute slots (rather than 10-

minute) was an attempt to assist in this regard, and also reflected the increasing complexity of cases that GPs were being approached about. As previously noted, the existing problem was not about access – it was more to do with capacity and demand. Expectations around GP capacity were not possible within the present funding envelope.

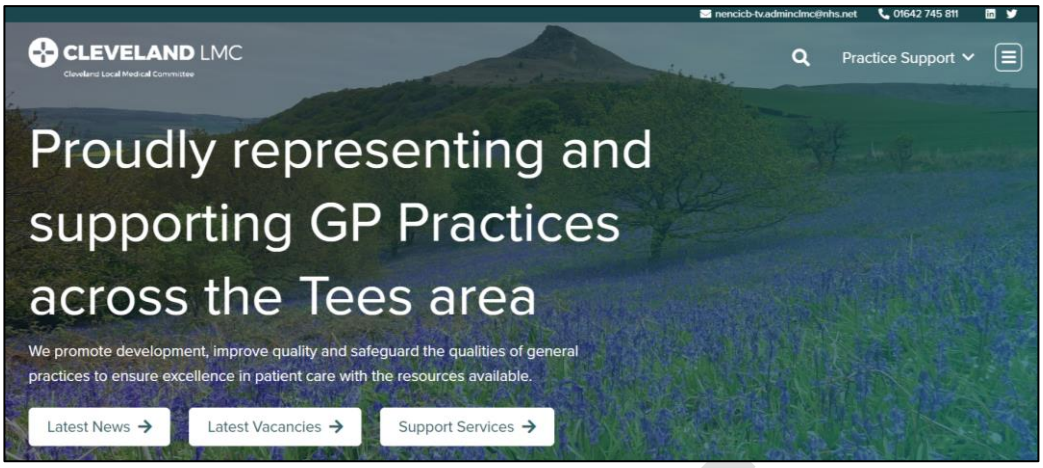
4.37 In terms of funding, media headlines tended to focus on primary care as opposed to general practice (which was only one part of the former). That said, primary care received just 8% of the NHS budget, with a greater focus now on investment into hospital services. Core GP funding did not take into account the increase in appointments, and overheads (which had been impacted by recent inflationary pressures) needed to be deducted from this income – this situation leads to workforce reductions as practices try to balance their books. The limitations of the Additional Roles Reimbursement Scheme (ARRS) were outlined, with funding in relation to this initiative unable to be spent on core staff and any underspends being lost (this was a particular issue across Teesside). Other funding issues concerned investment being focused on Primary Care Networks (PCNs) as opposed to individual practice needs (an arrangement which could see poor performance from a neighbouring practice impact on others), and the provision of enough computers to support additional staff.

4.38 Regarding care navigation, it was emphasised that call handlers did not like having to ask questions of those contacting services, and that it was hard for them to manage patient demand in light of existing capacity – indeed, this was causing problems in relation to the retention of reception staff who were seeking less stressful roles outside the sector. In related matters, the need for more non-GP roles within practices also created increased supervisory requirements – this in turn further limited patient contact time.

4.39 With regards the national recovery plan for GP access, Cleveland LMC felt this would have limited impact as it failed to address the underlying issues around funding and workload. Practices needed more staff but were prohibited from increasing their workforce due to financial restrictions – indeed, there were GPs currently seeking work / additional work within Teesside who practices could not afford to employ.

This latter claim was subsequently followed-up, where it was stated (in late-November 2023) that Cleveland LMC were aware of 16 GPs (across Tees) who had contacted the LMC in the past month or so looking for work and unable to find any, or were available for additional shifts on top of their regular work. This was a national problem that was impacting in Tees. A link to the LMCs job adverts page was provided (https://clevelandlmc.org.uk/vacancies/) – as of late-November 2023, there were two active vacancies in Stockton-on-Tees, and the LMC was aware of an additional two vacancies (in the Borough) not being currently advertised and another Stockton-on-Tees practice who was planning to recruit a GP in January 2024.

4.40 In addition, a greater focus on the interface with secondary care would be welcomed as much work was done in practices that should be undertaken by secondary providers (a recent audit of practices had shown that 170 hours per week were being lost across Teesside – this report was subsequently shared with the Committee for information).



4.41 Reflecting on the presentation, the Committee expressed unease about the gloomy picture being portrayed and was particularly concerned about the call for more frequent dialogue with stakeholders as this appeared to indicate a communications issue. Cleveland LMC confirmed that other organisations had been cancelling planned meetings at short notice, with no meetings held with NHS Trusts for some time, and the North East and North Cumbria Integrated Care Board (NENC ICB) standing down previously scheduled engagements. A NENC ICB representative commented that meetings may be affected due to workload clashes and that there was an ongoing organisational restructure which may be impacting upon capacity – this would be taken back to colleagues to ensure any cancelled meetings were rearranged.

4.42 Members probed the increase in dispute resolution cases being dealt with by Cleveland LMC (hearing that these involved not only GPs but also nursing and reception staff), as well as the composition of its elected Board in terms of how the Borough was represented (there was presence from each of the four Local Authority areas and Stockton-on-Tees was generally over-represented).

4.43 Focus shifted to the reported appointment statistics, with the Committee querying the reference to '*more being delivered than ever before'*. It was explained that some of this increase could be attributed to an initial telephone appointment (which would be logged as one contact) being raised to a face-to-face consultation (which would be logged as another contact even though it concerned the same individual). When it came to the type of contact with patients, practices had the scope to deliver services in whichever way they felt was best (this was very much supported by Cleveland LMC), though whilst telephone consultations were quicker, there was often more value in an in-person appointment (which remained the standard option). The ICB added that it would be interested in knowing if there was a gap in services at any practice, and it was noted by the Committee that phlebotomy was a real challenge within the Borough (staffing provided by NHS Trusts, but issues around the arrangement of appointments for when staff were available).

4.44 Continuing the theme of appointment types, the Committee was reminded that, prior to the COVID-19 pandemic, there was a strategy regarding a telephone-first approach. Some practices had already adopted this option and therefore adapted to the impact of COVID more easily. Members highlighted their awareness of residents receiving call-backs from practices which was widely welcomed – this did, however, require dedicated staff to return calls.

4.45 The current funding landscape led the Committee to query if decisions on financial support for practices was pushing provision towards privatisation. It was acknowledged that some within the sector did indeed have that impression and felt that there was a policy to force GPs into a salaried role. In response to a question on incentives for greater access, it was stated that practices received 70% of the capacity and access improvement funding (see paragraph 4.9) up-front (an average of £11,500 per PCN), with the remaining 30% given upon delivery of their agreed plan covering patient experience of contact, ease of access and demand management, and accuracy of recording in appointment books – this was allocated as part of a PCN arrangement rather than on an individual basis.

4.46 The Additional Roles Reimbursement Scheme (ARRS) was explored further, with particular attention focusing on the stated underspend in previous years. Cleveland LMC noted that it was difficult to get clarity on spending as the funding for this initiative was held centrally rather than by the ICB. A NENC ICB representative advised that around 75% of available ARRS funding for this year had been spent in Stockton-on-Tees, and there had been an attempt to incentivise PCNs in relation to this scheme. It was acknowledged that some PCNs were more proactive than others with regards collective working and the sharing of best practice / learning, with Members reminded that practices were, ultimately, individual businesses.

4.47 Discussion ensued around access to / visibility of Practice Managers. It was stated that this role was one of the most pressurised within the sector and was the biggest pinch-point in terms of retention – as such, much resource was given to supporting them. Two Practice Managers were on Cleveland LMCs elected Board, as well as PCN Clinical Directors (who the Committee would also be attempting to engage with as part of this ongoing review).

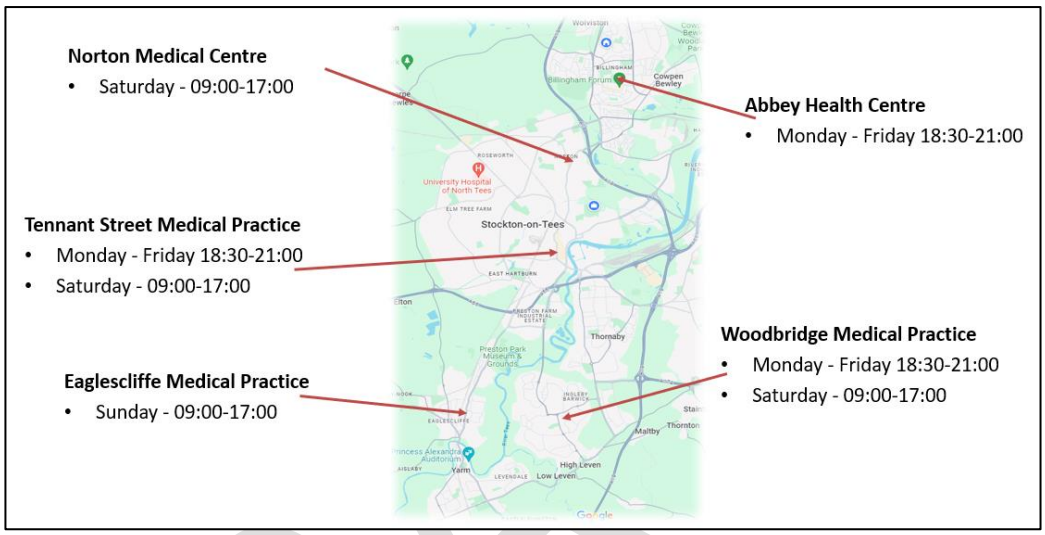
4.48 The Committee was reminded by the NENC ICB that, despite the references to risks to patient safety within the presentation, all of the Borough's general practices were deemed safe by the Care Quality Commission (CQC).

Hartlepool & Stockton Health (H&SH)

4.49 Formed in 2016, H&SH was a traditional GP Federation set-up based upon the former Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) footprint. Some of its services were Stockton-on-Tees-specific, whilst others served the Tees Valley as a whole. Elected (bi-annually) by peers, three of its (minimum of) six Board Directors need to be GPs, and one must be a general practice manager. H&SH received no statutory funding, nor financial support from practices (all of which were members) – any funds it created were invested back into services / practices.

4.50 Holding itself to account to ensure it adds value rather than acts as a burden to the overarching health system, the vision of H&SH was to improve the health and wellbeing of local people. Key missions included the championing of general practice and supporting Primary Care Networks (PCNs) to continue their development – engagement as a trusted partner (via local NHS Trusts and Health and Wellbeing Boards) was also an important duty. In terms of its goals, H&SH was limited in its ability to pay high remuneration rates to its staff – the organisation therefore focused on staff wellbeing and creating a positive culture in which to work, thus aiding recruitment and retention.

4.51 Several services were provided as part of the overall H&SH offer, a key element of which was the 7Day Enhanced Access to general practice (contributing 217.5 hours-per-week and more than 32,000 appointments per year across Stockton-on-Tees) – indeed, this was a crucial driver behind the original formation of H&SH as practices did not want private companies providing out-of-hours access. Commissioned by PCNs (previously this was done through the CCG) who all engaged with H&SH, 7Day Enhanced Access had been operating since 2017 – within the Borough, the 'core' locations were Tennant Street Medical Practice and Woodbridge Medical Practice, with further weekend / evening access available at Abbey Health Centre, Eaglescliffe Medical Practice, and Norton Medical Centre (see graphic below).



4.52 Data showing the number of appointments for various health reasons / types across a typical month for the 7Day Enhanced Access offer was listed, as well as corresponding 'did not attend' (DNA) cases for each element. Access to see a GP was comfortably the highest (1,081, with 100 DNAs), followed by appointments for a treatment room (628) and a complex treatment room (459). The recent addition of a menopause clinic was highlighted (this was in response to PCNs being unable to cope with the level of demand for menopause support and was proving very popular), and it was noted that H&SH worked with PCNs to establish pressure points (e.g. there was significant demand for complex wound care). With regards DNAs, H&SH was relatively comfortable with current rates, though did try to identify specific sites where this was occurring and whether the way in which an appointment was booked impacted upon attendance (e.g. appointments booked too far in advance often resulted in more DNAs – the window to be able to book had therefore been reduced). It was also acknowledged that those accessing weekend / evening appointments would likely be attending a practice which was not normally their own.

4.53 H&SH was also responsible for / involved in a number of other services, including Footsteps (a nationally rare teen health one-stop-shop which was based within Eaglescliffe Medical Practice), the Integrated Urgent Care Service (GP-led from both Hartlepool and Stockton sites and currently up for recommissioning), and COVID vaccination services / clinics and oximetry@home. The Outreach Nursing Service (Public Health) was able to support those who found it difficult to engage with practices (H&SH aimed to build on the current model and had recently acquired a bus to assist in taking healthcare into the community), and PCNs were supported with regards human

resources and any background work in relation to the numerous roles practices could appoint to.

4.54 In terms of workforce, H&SH oversaw a digital staffing pool which comprised a bank of professionals (all of whom were checked / audited) that practices could access if required – this assisted around 5-10 practices per month and was particularly useful if there was any planned care. GP and Nurse Fellowships (career start schemes) were also highlighted, involving education, projects to run, peer support, and learning from older, more experienced practitioners – features designed to make the locality a great place in which to work. Other workforce initiatives included a GP retention scheme (Tees Valley RISE), PCN personalised care teams (for those without a clinical need), a primary care training hub, and delivery of healthcare apprenticeships (in particular, senior healthcare support workers).

4.55 Further to the digital staffing pool, H&SH supported access to GP services through the Operational Pressure Escalation Level (OPEL) framework, a mechanism by which practices rated themselves as to the level of pressure they were under, potentially leading to them being signposted to H&SH for assistance. The organisation had also put on extra appointments during the winter period (which it paid for itself on behalf of local practices), and a respiratory-specific service would be operating from Ingleby Barwick this year for a 10-week block (seven days-a-week) – this would provide 130 appointments per week, would be GP-led alongside a nurse, and was expected to support a high number of children. Access to services on Sundays had existed since 2017 and it was hoped that next year would see an increase in provision on this day of the week. A new contract for 7Day Enhanced Access was due to start in April 2024, though a key issue remained around the lack of places to put in additional services due to limits on space and funding.

4.56 The Committee questioned the existing, and future, workforce situation and heard that any GPs working locally had the option to support H&SH service provision (though had to go through rigorous checks). H&SH created opportunities for local practices to take on weekend / evening work and gave employment possibilities for medical students (e.g. shadowing work within the Urgent Care Centres in their final year), allowing the building of local relationships which may assist with them remaining within the area once they formally qualify.

4.57 Members asked what had been learnt from the recent vaccine rollout which had resulted in challenges around the availability and administration of the COVID and flu jabs during the same appointment (thereby impacting on the need to access services more than once). H&SH stated that the infrastructure / booking system behind the national NHS England vaccination programme was problematic and that, whilst most PCNs had opted-in to offering both vaccines at the same appointment, there had been issues in getting enough doses to the right places at the right times (particularly the COVID vaccine which had to be stored and handled differently). Assurance was given that most care home / housebound residents got both vaccines at the same time, and that views had been fed back to national bodies to ensure a more efficient process next year – indeed, the new vaccination strategy gave more opportunity for decisions on future rollout to be directed by local agencies, and the Enhanced Health in Care Homes (EHCH) framework provided further avenues to support the delivery of healthcare within care home settings.

4.58 Attention turned to the younger population and the unusual, yet highly valued, Footsteps service. The Committee heard that this was the idea of a local GP who was seeing an increase in eating disorder and anxiety cases among teenagers. An outreach 'council' for young people was created which had since won an award, and the service was accessible to any teenager within the Borough.

4.59 Referring to the 7Day Enhanced Access appointment data, Members highlighted the 'diabetes review' numbers and noted that some people had gone without a review since the emergence of COVID. H&SH confirmed that nursing numbers gave a particular cause of concern as it was this element of the workforce which serviced many of the populations day-to-day needs rather than GPs. The desire was for more specialist-trained long-term condition nurses, though ensuring sufficient workforce capacity and expertise was complicated by the forthcoming end to the PCNs first five-year contract in March 2024 – it was therefore hoped that future workforce arrangements could be more firmly planned once post-March 2024 PCN funding was established.

4.60 Discussion ensued around phlebotomy services and the feedback of results if bloods were taken in a setting outside a person's normal practice. A NENC ICB representative stated that results should go back to whoever requested the blood test (unless a shared care arrangement was in place).

4.61 The Committee praised H&SHs digital staffing pool and asking if there was any way in which this could support local services more. H&SH advised that practices were able to request the use of this pool at any time and that communications were sent out to practices reminding them of this option.

Views of Primary Care Networks (PCNs)

4.62 Contributions from the Borough's four Primary Care Networks (PCNs) were sought. Clinical Directors and / or Operational Leads for each PCN addressed the Committee in relation to their submitted responses (see **Appendix 2**) to the following key lines of enquiry:

Awareness of any access issues within your PCN area

4.63 Several elements were having an impact on GP access – these included a post-pandemic backlog (for both physical and mental health problems), long waits for secondary care which was resulting in patients contacting primary care providers for support in the interim, and the loss of experienced staff and the subsequent lag in training new staff to fill this void (who, in the short-term at least, were unable to work at the level of those older professionals who had left general practice). That said, PCN representatives also acknowledged improvements to access, some of which had come as a result of COVID-19 and the need to work in different ways – innovation, particularly through the use of technology, had led to the emergence of alternative pathways regarding access to services, though this in turn further increased demand which was very challenging to meet given the lack of an uplift in resources. As such, waiting times were further compromised.

All practices aware of the ongoing issues with many facing the same issues. Regardless of the size of the practice there has been an impact. Sickness is the biggest impact. One of the practices has recently changed to a total triage model and sickness has affected how this model works and the effectiveness of this.

Billingham and Norton PCN

The impact of the COVID pandemic on primary care is multifaceted. Productivity has increased as digital access has expanded with increased usage of virtual consulting, electronic messaging and self-care supported by home monitoring. However, the pandemic coincided with a period when training opportunities were restricted and, as a result, new staff in particular practice nursing teams have lost experienced staff. There is a lag in reskilling team members.

BYTES PCN

In terms of access, practices have increased the number of appointments offered by GPs and continue to monitor appointment systems to ensure the correct balance of same day and pre-bookable appointments.

North Stockton PCN

Patient demand does continue to grow. However, practices within our PCN area respond to this increased demand by reviewing data as to when the greatest patient demand occurs; for example, on the telephone, e-consultations, patient footfall within the practice, or through patient questionnaire responses in what services are being requested by patients at what times suitable to them. Consequently, in response, practices within our PCN area do alter staffing rotas to accommodate the changes in access demand to ensure additional non-clinical and clinical staffing at peak times (i.e. early morning or after school hours) to ensure the access to our services can be successfully managed.

Stockton PCN

4.64 Further to a Committee query, it was confirmed that all PCN areas used the OPEL system to monitor pressures which individual practices were under – this enabled any critical needs to be identified, something which the Hartlepool & Stockton Health (H&SH) GP Federation could assist with in terms of its digital staffing pool (it was noted that H&SH did not charge more for these staff to provide assistance). Members subsequently noted the focus on shortages of nursing staff.

4.65 Reflecting on the various access options outlined within the combined PCN submission, Members welcomed the range of mechanisms available, though also drew attention to the challenges faced by those who were not as technologically minded when it came to online services. Regarding waiting times, the Committee was reminded that this was a national issue, and efforts to mitigate the impact of delayed contact with health providers had resulted in the 'Waiting Well' initiative (a programme offering targeted support to certain groups of patients waiting for treatment).

4.66 Reference was made to a previous evidence session where Members were informed about the difficulties in attracting professionals to the Tees Valley area. One of the PCN Clinical Directors present, who was also a GP trainer, spoke of the challenges of getting practitioners with the right qualities into the region and noted that the training scheme was not overly appealing / rewarding (as such, it was stated that there had been a period when training places were undersubscribed). The Committee heard that those people who had qualified

were not always staying in the area, hence the need to look further afield for the skills required – it was subsequently reported that there was a higher level of international graduates in the North East than in other regions across England.

4.67 Members highlighted the services provided by pharmacies and the impact of this on general practices – there was, however, little mention of this in the PCNs responses to the questions posed by the Committee. PCN representatives gave assurance that practices worked closely with pharmacists as part of their clinical teams, and that pharmacies were very much embedded within the primary care offer. The Committee welcomed this assurance and pointed to the opportunities pharmacies provided to relieve pressure on the overall health system (particularly those based outside town centres), with Members encouraging all practices to value each one equally. In response, it was stated that a number of pharmacies were operating under great strain at present, and that caution was needed around the expectation that they would address access issues – this may lead to unintended consequences.

Management of patient contact (systems, prioritisation, triage)

4.68 PCNs highlighted a variety of in-person, telephone and digital tools / systems which were used to manage patient contact. The need to ensure (as far as possible) continuity of care was emphasised as this led to a more efficient service, with patients saved from having to repeat their story time and again to different professionals – key to this was administrative / reception staff within practices who develop knowledge of / rapport with patients. Whilst electronic options had evolved to further enable contact with practices, PCNs acknowledged that it was important to avoid digital exclusion, particularly in the context of an ageing population and the critical need to ensure access for all. In related matters, it was also vital that those who chose to use digital / online mechanisms were not prioritised over those who preferred alternative, non-electronic methods of communication.

A relatively new system called AccuRx, is used by all Stockton PCN practices and has further supported the management of communication to patients.

Stockton PCN

Prioritisation: reception is signposting patients, trying to work towards appointments being given on a need-basis, not just patient want – GP to spend time in reception helping reception team improve signposting and protected time to establish pathways. Huddles between GP / Nurse Practitioner / Reception Team Lead regarding any capacity access and advice to patients.

Billingham and Norton PCN

Electronic Triage and Online Appointments help to reduce the need to contact the practice and can be assessed prior to being assigned to a healthcare professional, helping to reduce avoidable appointments. But, some patients may face challenges using online systems or may not have access to the necessary technology.

BYTES PCN

Some practices have embedded the duty doctor in Reception with access to a PC. They can help triage difficult calls whilst being able to do their own work. It is improving access in terms of patients not always being offered same day when it isn't necessary. It has reduced the number of same-day appointments, but we think this is mitigated by improved appointing of patients.

North Stockton PCN

4.69 The continued focus on providing different forms of contact opportunities for patients was welcomed by the Committee, as was the desire to keep phonelines open (an important factor for elderly residents) – the call-back feature which had been introduced by a number of practices was also praised. Previous complications in achieving the dual rollout of COVID and flu vaccines within practices was noted – Members were reminded that these vaccines were commissioned and stored differently, hence the challenges in them being administered during the same appointment. However, health bodies would try to ensure future rollout was as streamlined as possible.

4.70 The Committee noted the recent national rise in reported cases of measles and asked if this was translating into increased contact with local practices. It was stated that, although there were yet to be any significant outbreaks of measles across Teesside, discussions had taken place at the Stockton-on-Tees Health and Wellbeing Board, and a UK-wide vaccination catch-up campaign was in the pipeline. One of the main issues was a lack of vaccination uptake within inner-cities, as well as the usual lower inoculation rates in areas of greater deprivation.

Mechanisms for the public to raise concerns about access issues and how this is communicated / managed / responded to

4.71 Again, multiple opportunities for patients to raise issues were outlined via written, verbal or online means. Patient Participation Groups (PPGs) within each practice were also highlighted. One PCN area had recently undertaken work to identify the best route for providing comments on practices – this was resulting in enhanced options for digital feedback, though not at the expense of more traditional ways.

4.72 Difficulties in being able to liaise with a Practice Manager were flagged by the Committee, though it was cautioned that getting involved in individual cases would be very time-consuming for these professionals and would add to the significant pressure they were already under. Assurance was given that practices tried to absorb feedback from as many sources as they can, including annual surveys (which are usually circulated to a small sample of patients), suggestion boxes, the Friends and Family Test, and PPGs. It was also emphasised that practices do not have to wait for negative feedback to take action in order to improve services.

4.73 The NENC ICB drew attention to the requirement to improve patient experience and contact within the national capacity and access improvement plans previously shared with the Committee – Members were informed that all practices continued to work on this. PCN representatives also confirmed that comments in relation to practices were available on publicly accessible platforms (e.g. Google reviews).

Do practices seek feedback around access and how has this informed arrangements?

4.74 All PCNs outlined the proactive measures in place to capture views from patients, and examples were given as to how this had led to changes in service delivery, including improvements to telephony systems and clarity around out-of-hours access provision.

Patient questionnaires were sent out in November and will send out a second one in February to a different group of patients. The first questionnaire did highlight access issues, particularly on the phone, but the problems raised had already been addressed with the advent of a new telephone system and various other processes, and the comments were from legacy access.

North Stockton PCN

[seeking views] helped inform our out-of-hours access provision as to what services at which locations patients wished to see open. This included patients wishing to access those practices out-of-hours, with good public transport links, car park, nurse treatment room procedures and GP appointments for working people.

Stockton PCN

Our practices have sought additional feedback from patients beyond FFT (Friends and Family Test) and the national GP survey. In addition to this data and feedback, to improve patient satisfaction and better understand the challenges that patients face, our practices carried out their own patient satisfaction surveys. The surveys aimed to gather more detailed feedback from patients on their experiences with the practice, as well as identify any areas where improvements may be necessary.

BYTES PCN

This could be better, but the reason behind not obtaining feedback frequently is fully understood. Constant negative feedback lowers staff morale and makes the teams feel that, even though they are working incredibly hard, this isn't good enough. Practices have introduced various improvements that allow for monitoring without negative feedback (i.e. telephony systems that are cloud-based and support patient call-back).

Billingham and Norton PCN

4.75 The issue of patients failing to attend their appointment was raised by the Committee, as were the difficulties that individuals could encounter when trying to cancel an appointment. The merits of following-up with those patients who do not attend was discussed – some practices did make contact, though it was also noted that this could be quite stressful for the patient and a decision to follow-up may need careful consideration based on an individual's case history. NENC ICB personnel added that many practices sent text message reminders prior to appointments which included cancellation options – however, did not attend (DNA) rates remained high.

4.76 Continuing the theme of non-attendance, it was felt that the ability to book appointments a long way in advance had the potential to lead to patients forgetting. Some practices were also placing more emphasis on providing positive statistics (i.e. the percentage of those who had attended as opposed to those who had not) within their waiting areas in the hope that this would further encourage attendance.

Summary of any planned changes within PCN practices to improve access or improve patient experience

4.77 A range of developments were taking place across all PCN areas to further improve access and, crucially, the overall patient experience. Technological advances in terms of cloud-based telephony systems, eConsultations and website strengthening were highlighted, as were considerations around triage, recruitment and estate expansion.

Views of Patients / Public

4.78 To address several of the review's key lines of enquiry that involved ascertaining the experiences of the local population when contacting / accessing general practices, a number of organisations / entities had been approached including:

4.79 Care Quality Commission (CQC): The CQC was asked to provide a summary of compliments and complaints received in relation to Stockton-on-Tees general practices since the start of 2023 – the following was submitted in March 2024:

The data used covers the period from January 2023 to 18 March 2024. As such, the analysis is split between enquiry records on CRM and case records on the Regulatory Platform, the latter replacing the former in July 2023.

Cases
There were 46 cases created at the specified GP practices between 18 July 2023 and 13 March 2024. Of these, 21 were from Elm Tree Medical Centre, with 20 coming under the 'Positive Feedback' case type (19 of these positive feedback cases were received between 28 February and 5 March 2024).

There were 16 cases across all sites with case type listed as 'Concerns about a service', with one further case as 'Complaints and concerns', and another as 'Safeguarding concerns' – of these 18 cases, five were reported at Riverside Medical Practice (more than any other individual location). For the priority level of these 18 cases, one was listed as 'High', 14 as 'Medium', and two as 'Low' (no priority level for 'Complaints and concerns' case).

Enquiries
There were 27 enquiries across all locations in the period, of which 16 were complaints about the provider, with the remaining 11 listed as 'Provision of Evidence'.

Marsh House Medical Centre received the most enquiries with nine, of which eight were positive examples of 'Provision of Evidence', all received between 5 July 2023 and 14 July 2023.

The locations with the most complaints were The Dovecot Surgery (four), followed by The Arrival Practice (three), with no other locations seeing more than one complaint.

4.80 North East and North Cumbria Integrated Care Board (NENC ICB): A request was made to the NENC ICB Primary Care Complaints Team for details of any recent issues raised in relation to Stockton-on-Tees general practices (note: primary care complaints transferred to the NENC ICB from NHS England in July 2023). A response was subsequently received in March 2024 with the NENC ICB stating that '*due to the volume of enquiries, complaints and emails received, we're not in a position at the moment to be able to provide breakdowns by geographical area but reporting of primary care complaints is something that we need to establish going forward and I'm sure we would be happy to share information with OSCs (overview and scrutiny committees)*'.

4.81 Healthwatch Stockton-on-Tees: Responses collected between February 2022 and February 2024 via Healthwatch Stockton-on-Tees' 'Share your views' platform were also considered, with familiar themes around long call-waiting times, a lack of appointments (particularly face-to-face), and difficulties in using technology (introduced to facilitate improved access) all highlighted. Other issues were also raised in relation to practice registration, problems with reception staff, and limited transport options, though several positive comments regarding local practices were also evident.

In related matters, the Healthwatch South Tees '*Top Tips for Accessing Your GP Practice*' guide (August 2023) was shared with the Committee for information. Nationally, Healthwatch also gave its views on the primary care recovery plan (see paragraph 4.22) which was published in May 2023 – see what does it mean for you and your loved ones?.

4.82 GP Patient Survey 2023: Summarised results from the 2023 national GP patient survey were provided – this incorporated national, Tees Valley and Stockton-on-Tees comparisons (see graphic below), as well as data broken down for each of the Borough's general practices (see **Appendix 3**), for selected access- / patient satisfaction-related questions. It was cautioned that the response rate was limited and that this represented a mere snapshot at a given time – it was also noted that the 2024 survey results would be published around July / August 2024.

GP Patient Survey - 2023 results

Survey question	National average	Tees Valley	Stockton	Practice ranges
% of patients surveyed found it easy to get through to someone at their GP practice on the phone	50%	49%	52%	9% - 98%
% of patients surveyed found the receptionists helpful	82%	85%	89%	70% - 99%
% of patients surveyed were satisfied with the GP appointment times available to them	53%	55%	59%	26% - 93%
% of patients surveyed were satisfied with the appointment(s) offered	72%	75%	77%	54% - 96%
% of patients surveyed would describe their experience of making an appointment as good	54%	57%	62%	41% - 96%
% of patients surveyed would describe their overall experience of their GP practice as good	71%	75%	78%	51% - 99%

Key: indicates better than national average; indicates worse than national average

4.83 These statistics were probed by the Committee, though it was noted that the data represented a small sample (around 2,500) of the Borough's 200,000+ population. Focus was given to the percentage of patients who found it easy to get through to someone at their practice on the phone (52% in Stockton-on-Tees compared to 50% nationally), and Members expressed deep concern that most other types of business would not be in operation for long if customers were not answered on such a level (in related matters, Members also raised the problem of people attempting to cancel appointments which led to missed appointments if they failed to get through to notify the practice). In response, the limited sample size was reiterated, as was the fact that access had become an issue across the whole country, hence the national recovery plan. Despite the current situation, there was still a lot of good work going on by practices.

4.84 Patient Participation Groups (PPGs): Further to the request / collection of the existing patient / public feedback above, the Committee also issued its own survey to each of the 21 local practices' PPGs (entities that general practices must establish and maintain (comprising some of its registered patients) for the purposes of obtaining the views of patients who have attended the contractor's practice about the services delivered by the contractor, and enabling the contractor to obtain feedback from its registered patients about those services). Responses to the following questions were sought:

1) *As a PPG, do you feel listened to by your practice?*

2) *In the last year, what are the main issues that the PPG has identified / raised in relation to access to GP services?*

3) *Have any changes been made as a result of the PPG bringing issues regarding access to the practice's attention?*

4) *In your view, how best could your practice improve access to GP services?*

5) *How, and how often, does the PPG seek new members?*

4.85 11 completed surveys were received (covering a total of 10 practices) with some surveys appearing to have been sent on behalf of a PPG, whereas others were individual views from a member of a PPG (see **Appendix 4** – responses colour-coded to indicate which PCN the PPG was aligned to).

Billingham and Norton PCN 7 practices – responses from 4 PPGs*	**North Stockton PCN** 3 practices – responses from 1 PPG
BYTES PCN 4 practices – responses from 2 PPGs	**Stockton PCN** 7 practices – responses from 3 PPGs

* two received from same PPG

4.86 Similar to the Healthwatch Stockton-on-Tees 'Share your views' feedback, identifiable themes in relation to GP access included shortages of / challenges in getting appointments, delays in getting telephone calls answered, and technology challenges for patients (particularly older people). That said, PPGs had appeared to positively influence the development of practices' telephone systems and improvements in communications / website / signposting. Encouragingly, the large majority of respondents felt that their PPG was listened to by their practice.

4.87 When analysing responses to the question on how best practices could improve access to GP services, it was evident from the wide range of suggestions that each practice was experiencing different challenges – this confirmed the fact that practices were individual businesses which faced a variety of issues based on numerous system-wide and localised factors.

4.88 Reflecting on this latter point, the Committee questioned if Practice Managers shared / had the opportunity to share good practice. A NENC ICB representative confirmed that such mechanisms did exist, though the ICB (despite offering) did not tend to be present during these exchanges.

Recent / Future Developments

Pharmacy revolution (Jan 24)

4.89 A recent proposal allowing pharmacies to treat seven common conditions hopes to free up 10 million GP appointments a year. It will allow pharmacists to treat sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections. This comes in an effort to reduce waiting NHS waiting lists and end the "8am scramble" for GP appointments.

https://practicebusiness.co.uk/news-pharmacy-first-revolution-changing-patient-care#:~:text=The%20plans%20aim%20to%20enable,on%20referrals%20for%20minor%20illness.

Arrangements for the GP contract in 2024-2025

4.90 Although the 2024-2025 contract was not yet published, a summary of contract changes for 2024-2025 were communicated on 28th February 2024 as follows:

1) Cut bureaucracy for practices by suspending and income protecting 32 out of the 76 Quality and Outcomes Framework (QOF) indicators. The Investment and Impact Fund (IIF) indicators will be reduced from five to two and the Capacity and Access Payment (CAP) will increase by £46m to £292m by retiring three Investment and Impact Fund (IIF) indicators.

2) Help practices with cash flow and increase financial flexibilities by raising the QOF aspiration payment from 70% to 80% in 2024/25 and the Capacity and Access Improvement Payment (CAIP) will now start to be paid at any point in the year, once PCNs confirm they meet the simple criteria for payment.

3) Give Primary Care Networks (PCNs) more staffing flexibility by including enhanced nurses in the Additional Roles Reimbursement Scheme (ARRS) and giving PCNs and GPs more flexibility by removing all caps on all other direct patient care roles.

4) Support practices and PCNs to improve outcomes by simplifying the Directed Enhanced Service (DES) requirements.

5) Improve patient experience of access by reviewing the data that digital telephony systems generate to better understand overall demand on general practice in advance of winter.

- https://www.england.nhs.uk/publication/arrangements-for-the-gp-contract-in-2024-25/
- https://www.england.nhs.uk/publication/update-to-the-gp-contract-agreements-2024-25-financial-implications/
- https://www.england.nhs.uk/gp/investment/gp-contract/network-contract-directed-enhanced-service-des/

Delivery plan for recovering access to primary care: update and actions for 2024-2025

4.91 The NHS is determined to make it easier and quicker for patients to see their GP and members of the primary care team. That is why in May 2023, along with the Department of Health and Social Care (DHSC), it published a two-year delivery plan for recovering access to primary care while taking pressure off general practice.

The second year of the delivery plan for recovering access to primary care (published in April 2024) is about realising the benefits to patients and staff from the foundations it has built since launch in the originally identified four priority areas (see paragraph 4.22).

https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-update-and-actions-for-2024-25/

5.0 Conclusion & Recommendations

5.1 Widespread commentary on the challenges in accessing GPs in England has been prevalent for some time, further heightened as a result of the lingering aftermath of the COVID pandemic which emerged in 2020. This review aimed to understand the existing local 'access to GPs' landscape in the context of national / regional developments and identify any areas which may assist in improving the experience of the local population, and practices themselves, when individuals wish to contact and / or access general practice services.

5.2 'Primary care' functions are the entrance to the healthcare system (acting as the 'front door' of the NHS), and include general practice, community pharmacy, dental, and optometry (eye health) services. General practices are the first point of contact with healthcare for many patients and act as gatekeepers to secondary care – they exist as individual businesses whose services are contracted by NHS commissioners to provide generalist medical services in a geographical or population area. Responsibility for commissioning primary care services, including general practice, sits formally with NHS England – however, Integrated Care Boards (ICBs) have taken on full delegation of these commissioning requirements.

5.3 GP contracts are complex, with three different types used by NHS commissioners in England. There are, however, core requirements for all general practices, one of which is an expectation for public and patient involvement in shaping service delivery. Whilst the existing GP contract stated that 'practices must provide essential services at such times, within core hours (8.00am until 6.30pm, Monday to Friday, except Good Friday, Christmas Day or bank holidays), as are appropriate to meet the reasonable needs of its patients', there was no precise definition as to what constituted 'essential' nor 'reasonable needs'. It was recognised that practices, as independent businesses, were able to (and indeed many did) meet their core contract requirements differently depending on registered population demographic needs and skill mix of staff (as well as enhance service provision depending on appetite to deliver additionally commissioned services), though this was not a standard offer across the Borough and could lead to the impression that some residents were getting better / worse services than others. From a practice perspective, frequent changes to contract expectations (often resulting in further pressures on financial and / or staffing resources) were not helpful.

5.4 The crucial issue of funding for general practice was explored, with providers able to supplement core 'Global Sum' payments (based on an estimate of a practice's patient workload and certain unavoidable costs, not on the actual recorded delivery of services) with several other potential income streams. Some of these can be accessed independently by a practice (e.g. Quality and Outcomes Framework (QOF)), whereas others involve collaboration as part of a wider Primary Care Network (PCN) (groups of practices working together which are led by a Clinical Director). There are four PCNs within Stockton-on-Tees which are expected to deliver nationally directed enhanced services (DES) in addition to what practices need to provide as part of core contracts – one of the requirements of the PCN DES since October 2022 is 'enhanced access' (evening and weekend) obligations.

5.5 21 general practices exist across Stockton-on-Tees providing a range of services, with an average list size of 9,808 (as at January 2023). The Committee heard that a list size of 7,000-8,000 was considered financially sustainable, though there were significant fluctuations across the Borough, with the largest list size being 21,555, and the smallest 2,303.

5.6 Despite the publication of the national Primary Care Access Recovery Plan (PCARP) in May 2023, it was important to recognise that the high-profile aim to tackle the '8.00am rush' did not translate verbatim into the existing GP contract, nor did it mean that an individual would get an appointment on the same day, despite some elements of the media interpreting this so (however, if there was a clinically urgent need, a person should be offered an appointment appropriate to that need, which could be on the same day). That said, several other national measures were in place to support providers, including the General Practice Improvement Programme (GPIP), the Additional Role Reimbursement Scheme (ARRS) which provided funding to recruit to 18 roles (June 2023 data showed an additional 61 headcount (58.04 WTE) across the Borough through this scheme), and cloud-based telephony / digital tools funding. Local providers had been proactive in seeking involvement in these, and other, initiatives.

5.7 Whilst practices themselves, supported by various health bodies, were trying to facilitate better access to services, there were several issues influencing these efforts. An overriding factor was the ongoing legacy of the COVID pandemic which, as had been well documented nationally, led to greater demands on the health system, with associated problems arising in terms of a backlog of patients requiring often increasingly complex care and staffing challenges (sickness and recruitment / retention difficulties) – this had, in turn, affected many patients' attitudes towards, and experiences of, contacting their local general practice, with frustrations growing about access limitations (e.g. higher call waiting times), and increases in reported abuse of practice staff. From a practice perspective, other external events were also at play, with cost-of-living / inflationary pressures (increasing staff wages) contributing significantly to a tough period for the sector.

5.8 As the representative body for all general practices and GPs within Tees, Cleveland Local Medical Committee (LMC) emphasised its focus on 'workforce' considerations (i.e. capacity, workload, ensuring patient safety) as opposed to 'access', with improvements to the latter being inextricably linked to progress on the former. However, ensuring an appropriate staffing resource across the Tees Valley was not aided by trainees preferring to work in larger city areas, nor the case that around 18% of GPs were over the age of 55 (a significant loss of expertise was therefore looming which, without action, would exacerbate existing workforce concerns). Interestingly, Cleveland LMC stated that there were a number of GPs seeking work / additional work within Teesside who practices could not afford to employ due to financial restrictions.

5.9 With regards care navigation, Cleveland LMC highlighted that call handlers did not like having to ask questions of those contacting services, and that this was causing problems in relation to the retention of reception staff who were seeking less stressful roles outside the sector. Given reports that patients often feel uncomfortable in having to discuss their (potentially sensitive) health condition to someone over the phone (albeit that this can aid the individual being directed to the most relevant health professional), health authorities and practices themselves should consider what can be done to relieve this burden on all parties.

5.10 Hartlepool & Stockton Health (H&SH) GP Federation provide a vital service in supporting local practices through a variety of initiatives, particularly its digital staffing pool which providers could tap into if experiencing workforce pressures (the acquisition of a bus to assist in taking healthcare into the community was another innovative development which may help engagement with hard-to-reach individuals). In terms of ongoing challenges, H&SH expressed concerns around nursing numbers (an issue raised by PCNs and Cleveland LMC), an element of the workforce which serviced many of the populations day-to-day needs rather than GPs.

5.11 The Borough's four PCNs provided their collective views on the current situation around access to services, and the Committee was encouraged by the broad acknowledgement that patients must not be digitally excluded and that practices must continue to think of those who may not be technologically minded / able when designing contact / access pathways. Echoing concerns raised by the Cleveland LMC, PCNs noted delays to secondary care resulting in patients contacting primary care providers for support in the interim, a situation which amplifies how pressures in one part of the healthcare system can impact on other elements. Of course, this can also work the other way round, with those struggling to access general practices sometimes attending secondary services (e.g. A&E) when not necessarily appropriate.

5.12 Given concerns evident in the national media, it was perhaps not surprising to hear of local frustrations around a lack of face-to-face appointments from the public / patients, as well as issues in using technology (particularly for older residents) which had been brought in to enhance access to services. Worryingly, 2023 GP patient survey feedback showed significant difficulties for individuals trying to get through on the phone to a good proportion of local practices, an experience which data showed had become a deteriorating trend for many over recent years. On a more positive note, public / patient feedback also demonstrated a number of welcome developments that were acknowledged by those contacting / accessing services. As is often the case, experiences can be very individual, and what health bodies introduce / change can suit some whilst at the same time cause difficulties for others. Patient Participation Groups (PPGs) reporting that they felt listened to by their practices is therefore an encouraging and necessary finding, particularly when shaping current and future service delivery.

5.13 National leaders continue to wrestle with this highly charged scrutiny topic, and finding solutions to fundamental issues (headlined by the need for consensus around GP contract content / funding) at a local level is extremely difficult. However, this review has shone yet another light on a sector which remains under significant strain, principally due to the twin pressures of sustained high-level demand and ongoing workforce challenges (which could get worse). Despite this, stakeholders were being proactive in trying to ensure that local people could access general practice services in a timely fashion via multiple routes (both digitally and in-person), and the challenge remains to help the public understand who to contact and which services they should be trying to access depending on their presenting condition. Whether enough health staff are in place to meet that need is, however, a much more significant concern moving forward.

Recommendations

The Committee recommend that:

General

1) All relevant health bodies (NENC ICB, Cleveland LMC, H&SH, NHS Trusts, and general practices) engage regularly and constructively around the issues raised as part of this review to ensure that patients are approaching / receiving care from the most appropriate services based on need.

Communications

2) All relevant health bodies continue efforts to increase public / patient understanding about accessing the most appropriate services (including in the context of the *Pharmacy First* initiative), using all available communication mechanisms (both print and digital) and links through local community networks (e.g. community partnerships), to ensure key messages are reinforced.

3) Councillors be supported in helping with these communication messages as leaders in their communities (as well as their role in raising concerns expressed by the community), and encourage positive feedback as well as concerns (to help share and spread learning and best practice).

4) The value and importance of all general practice roles are highlighted and publicised by health bodies and practices themselves.

5) Local practices be recognised for continuing to deliver primary medical care services safely in Stockton-on-Tees despite the ongoing challenges raised during this review.

Operational

6) All general practices move towards providing the full use of digital telephony capabilities (including call-back functionality), with appropriate staff in place to support these arrangements.

7) All general practices be encouraged to review and refresh care navigation processes, ensuring adequate training is in place to support implementation to ensure both staff and patients are comfortable with the approach.

(continued overleaf…)

Recommendations (continued)

The Committee recommend that:

8) To ensure appropriate workforce capacity is in place to maximise the local general practice offer:

d) NENC ICB continue to support / encourage uptake of the ARRS scheme, particularly amongst those PCNs which had not accessed this initiative.

e) All relevant health bodies continue to explore further and develop options to increase GP recruitment and retention in the Borough.

f) Options to increase nursing numbers (including strengthening training offers and uptake) be explored further.

9) The Borough's four PCNs be encouraged and supported to work together collaboratively to share and adopt good practice.

Public / patient feedback

10) Relevant health stakeholders be proactive in encouraging involvement of patients in practice Patient Participation Groups (PPGs), aim to ensure these are representative of a practice's patient list demographic, and consider fostering links between the Borough's PPGs to assist in identifying / addressing any access issues.

11) NENC ICB consider its complaint / compliment reporting mechanisms so future data can be provided at a local general practice level.

Enhanced Access

Patients registered at GP practice	Opening times and location of Enhanced Access provision		
Marsh House Medical Centre Kingsway Medical Centre Roseberry Practice Queenstree Practice Melrose Medical Centre Dr Rasool Norton medical Centre	Monday to Friday	18:30 - 21:00	Abbey Health Centre
	Saturday	09:00 – 17:00	Norton Medical Centre
Eaglescliffe Medical Practice Park Lane Surgery Yarm Medical Practice	Monday to Friday	18:30- 21:00	Tennant Street and Woodbridge (Ingleby Barwick site)
Thornaby & Barwick Medical Group Queens Park Medical Centre Tennant Street Medical Practice	Saturday	09:00-17:00	Tennant Street and Woodbridge [Ingleby Barwick site)
Alma Street Medical Practice Woodlands Family Medical Centre Dovecot Surgery Densham Surgery Riverside Practice Arrival Medical Practice Elm Tree Surgery Woodbridge Medical Practice	Sunday	09:00 – 17:00	Eaglescliffe

Enhanced access utilisation

PCN Name	Site	Day and time offered	April Booked Utilisation	May Booked Utilisation	June Booked Utilisation	July Booked Utilisation	August Booked Utilisation
Stockton	Woodbridge (Ingleby Barwick)	Monday – Friday: 6:30-9pm Saturday: 9-5pm	78.50%	82.00%	81.70%	86.60%	93.10%
	Tennant Street	Monday – Friday: 6:30-9pm Saturday: 9-5pm	83.20%	81.20%	85.10%	81.90%	90.70%
	Eaglescliffe	Sunday: 9-5pm	56.60%	55.90%	69.60%	58.10%	77.20%
North Stockton	Woodbridge (Ingleby Barwick)	Monday – Friday: 6:30-9pm Saturday: 9-5pm	71.90%	71.10%	73.40%	77.50%	81.80%
	Tennant Street	Monday – Friday: 6:30-9pm Saturday: 9-5pm	86.30%	83.10%	89.90%	87.10%	91.70%
	Eaglescliffe	Sunday: 9-5pm	61.80%	55.60%	71.20%	48.50%	69.80%
BYTES	Woodbridge (Ingleby Barwick)	Monday – Friday: 6:30-9pm Saturday: 9-5pm	85.50%	84.50%	80.70%	86.40%	87.80%
	Tennant Street	Monday – Friday: 6:30-9pm Saturday: 9-5pm	77.10%	83.40%	85.00%	81.70%	83.30%
	Eaglescliffe	Sunday: 9-5pm	68.10%	68.70%	64.70%	63.80%	77.60%
Billingham & Norton	Abbey	Monday – Friday: 6:30-9pm	88.60%	87.40%	93.10%	92.50%	88.60%
	Norton	Saturday 9-5pm	87.00%	72.40%	82.40%	79.70%	93.60%

APPENDIX 2: Primary Care Networks (PCNs) – collated responses (Jan 24)

1. Awareness of any access issues within your PCN area (pressure points at different times of the week / day, impact of COVID, staffing).	
Billingham & Norton	All practices in PCN report on OPEL weekly. All practices aware of the ongoing issues with many facing the same issues. Regardless of the size of the practice there has been an impact. Sickness is the biggest impact. One of the practices has recently changed to a total triage model and sickness has affected how this model works and the effectiveness of this.
BYTES	**Workforce Constraints:** There is a shortage of primary care workers, both clerical and clinical nurses, and this has a significant impact on the ability of practices to provide timely and effective care to all patients. Additionally, the PCN struggles with recruitment and retention, particularly in rural and underserved areas. This is compounded by issues that practices experience in the affordability of recruitment and the inability to compete with other service providers' salaries. Furthermore, the capacity for training and supervision is restricted, both financially and in relation to accessibility, without further reducing access to appointments. **Demand and Capacity Constraints:** Many practices are struggling to keep up with growing patient demand, particularly in areas with rapidly growing populations. This can lead to increased wait times for routine appointments and delays in getting patients the care they need. Additionally, many practices are operating at or near capacity, which can make it difficult to accommodate new patients and expand services. **Estates Facilities:** Expanding services is often hindered by estates and facilities which pose challenges and can also be a barrier to recruitment. Many practices are working with limited room availability and some outdated or inadequate facilities, which can impact the quality of care they are able to provide. Additionally, maintaining and upgrading facilities can be costly, which can strain already limited resources. **Signposting:** Patients accessing signposting often bring with them a set of expectations shaped by their unique needs and personal circumstances. These expectations may include timely access to relevant information, clear guidance on navigating the healthcare system, and efficient referrals to appropriate services. However, the challenge lies in aligning these expectations with the capacity of the healthcare system to meet them. Limited resources, long waiting times, and complex administrative processes can create a mismatch between patient expectations and the system's ability to deliver timely and comprehensive signposting. **Winter pressures:** Significantly impact the capacity and access within practices. During the colder months, there is a notable surge in patient demand due to seasonal illnesses, flu outbreaks, and an increase in chronic conditions exacerbated by the cold weather. This heightened demand places strain on the already limited resources of GP practices, leading to longer waiting times for appointments and potential delays in accessing necessary healthcare services. **Erosion of Funding:** Inflation has had a profound impact on capacity to provide essential healthcare services. As costs rise due to inflation, the real value of funding allocated to GP practices diminishes, making it increasingly challenging to maintain operational efficiency and meet growing patient demands.

	Demand for appointments is highest at the start of the week; practices increase staffing to reflect this. At times of higher demand, more appointments will be available and same day appointments will also be increased. The impact of the COVID pandemic on primary care is multifaceted. Productivity has increased as digital access has expanded with increased usage of virtual consulting, electronic messaging and self-care supported by home monitoring. However, the pandemic coincided with a period when training opportunities were restricted and, as a result, new staff in particular practice nursing teams have lost experienced staff. There is a lag in reskilling team members.
North Stockton	The usual 8.30 rush of phone calls, but this is managed quite well internally by having multiple staff taking calls for the first hour across the practices. COVID is still impacting on staffing at times. Recruitment across the PCN remains very difficult given the inability of practices to offer a meaningful salary to admin staff. In terms of access, practices have increased the number of appointments offered by GPs and continue to monitor appointment systems to ensure the correct balance of same day and pre-bookable appointments.
Stockton	Patient demand does continue to grow. However, practices within our PCN area respond to this increased demand by reviewing data as to when the greatest patient demand occurs; for example, on the telephone, e-consultations, patient footfall within the practice, or through patient questionnaire responses in what services are being requested by patients at what times suitable to them. Consequently, in response, practices within our PCN area do alter staffing rotas to accommodate the changes in access demand to ensure additional non-clinical and clinical staffing at peak times (i.e. early morning or after school hours) to ensure the access to our services can be successfully managed. Collaboration with PCN practices' Patient Participation Groups is also a very useful tool to understand direct from patients how they find accessing practices services and improving where necessary. There have been many success stories (e.g. improving hearing loops and disabled access, large print posters and plain English letters). The impact of COVID is an example of practices within our PCN area still delivering the best possible patient journey to accessing primary care services in a national climate of fear and uncertainty. Practice emergency contingency plans were employed which ensured access to primary care services were not unduly affected, with clinical facetime technology introduced and practice environments adapted with one-way systems, personal protective equipment issued, and hygiene stations assembled. The fortitude and determination from Stockton PCN practices was further exemplified when collaboration of staff was used to deliver the COVID vaccination programme, whilst still delivering access to primary care services.

2. Management of patient contact (systems, prioritisation, triage) – communication to patients / are these effective / any issues?	
Billingham & Norton	Volume of patients on a Monday impact on telephone systems – challenging despite heavy loading of reception and clinical staff on those days. The accumulation of lab results and prescriptions can be overwhelming. S1 and HasH apps book up very quickly and unable to access. HASH Acute Respiratory Clinic is helpful to signpost patients to, but in Ingleby Barwick or Hartlepool, difficult for patients to attend with transport issues. Staffing issues with clinicians at one practice due to absence. Prioritisation: reception is signposting patients, trying to work towards appointments being given on a need-basis, not just patient want – GP to spend time in reception helping reception team improve signposting and protected time to establish pathways. Huddles between GP / Nurse Practitioner / Reception Team Lead regarding any capacity access and advice to patients.
BYTES	**Care Navigation:** By recording their care navigation efforts, administrative staff and front-facing staff help to increase insight into where patients are booked / signposted, etc. **Online Booking:** Where possible, our practices utilise online appointment systems, allowing patients to schedule appointments at their convenience – this reduces the need for phone calls and queues, whilst helping to streamline the booking process. However, this also brings challenges and is sometimes misused by patients. **Phone and Digital Appointments:** In addition to face-to-face appointments, phone and digital appointments provide an alternative for patients with non-urgent concerns, making the most of time for both patients and healthcare professionals. **Electronic Triage Tools:** All our practices use electronic healthcare systems to triage patients based on the information they provide, helping prioritise cases according to urgency and book with alternative healthcare professionals as appropriate. **Urgent vs. Non-Urgent:** Prioritising patients based on the urgency of their medical needs ensures that critical cases are addressed promptly. This might involve same-day appointments for acute issues or chronic conditions that require immediate attention. **Chronic Disease Management:** Implementing systems for regular follow-ups and management of long-term conditions to help prevent exacerbations and improves long-term outcomes. **SMS and Email Reminders:** Automated reminders for appointments help to reduce DNA (did not attend) rates and increase appointment utilisation. **Patient Portals:** Providing access to a secure online portal allows patients to view their medical records, test results, and communicate with healthcare providers. Practices are actively encouraging the use of these systems (e.g. ordering prescriptions via the NHS app). **Social media and websites:** Are increasingly used for the management of patient contact, employing various systems, prioritisation techniques, and triage mechanisms. Through these platforms, practices communicate important information to patients, offer appointment scheduling, and share other health-

	related updates. We have also created a centralised hub as a PCN for patient resources. However, disparities in digital access among patients may pose challenges, potentially excluding some individuals from benefiting. **Incentive schemes:** In primary care, this can sometimes create a delicate balance between promoting effective patient management and maintaining optimal service delivery. While incentive programmes are designed to encourage healthcare providers to meet specific performance targets or prioritise certain aspects of patient care, there is a risk of unintended consequences. Providers may become overly focused on meeting incentivised metrics, potentially leading to a shift away from patient-centred care. Mismatch between incentives and patient management / service delivery. Each of the components all play a part in making practices more effective whilst each presenting challenges. For example, online booking and electronic communication methods enhance accessibility, making it easier for patients to access healthcare, but sometimes these are misused by patients, sometimes having an effect that is contrary to its intended use. In addition, Electronic Triage and Online Appointments help to reduce the need to contact the practice and can be assessed prior to being assigned to a healthcare professional, helping to reduce avoidable appointments. But, some patients may face challenges using online systems or may not have access to the necessary technology.
North Stockton	Offer of every available option for contact is working well: • eConsults • telephone • walk-ins • online booking (for specific appointments slots) Use of AccuRx automated booking has been revolutionary in terms of not only making it easy for patients to make appointments without contacting the practice at all, but has improved response for QOF-related work without using precious admin time. Some practices have embedded the duty doctor in Reception with access to a PC. They can help triage difficult calls whilst being able to do their own work. It is improving access in terms of patients not always being offered same day when it isn't necessary. It has reduced the number of same-day appointments, but we think this is mitigated by improved appointing of patients. AccuRx in general has also revolutionised patient contact and we use this to send out advice and information, including self-help leaflets. We are also about to adopt the TPP equivalent of eConsults (launches around end of January 2024) because this is much improved, less 'clunky' and, because it is embedded within S1, it automatically adds appropriate codes and is a massive improvement on eConsults. We use bulk SMS messaging as much as possible. The ability for bulk responses was taken away when MJOG was decommissioned, but AccuRx has a facility that is not dissimilar, and we have used that with some success. However, a better notice period for the decommissioning of MJOG would have been useful rather than the 10 days we were given to change from MJOG to AccuRx – this required some setting-up work at practice level with no support from the ICB.

Stockton	The management of patient contact is effectively managed within our PCN area. A relatively new system called AccuRx, which is an electronic platform where patients and healthcare professionals communicate, is used by all Stockton PCN practices and has further supported the management of communication to patients. Reception staff are all aware of the prioritisation and triage of patients, which ensures any emergency patients are seen the same day. Overall, the effectiveness is very good, as witnessed through patient questionnaire feedback. The main issues have been ensuring full training occurs in respect of AccuRx, as not all staffing generations are computer savvy. This has resulted in many hours of additional training to reaffirm learning.

3. Mechanisms for the public to raise concerns about access issues and how this is communicated / managed / responded to.	
Billingham & Norton	Patients will raise concern to reception via telephone or f2f and discussed with reception supervisor. If not resolved, directed to the PM – offered to either put in writing or speak via telephone or F2F. We review the complaints at CG meetings and look to potential action points. Raise at PPG and ask for ideas. All patients attending appointments are asked for feedback routinely; electronic communication sent to patient. Feedback is discussed internally.
BYTES	**Patient Feedback Forms:** Practices provide patient feedback forms, either in physical or electronic formats, where patients can express their concerns regarding access issues, such as difficulty scheduling appointments or delays in receiving care. **Online Platforms:** Practices use online platforms or portals where patients can submit feedback and concerns outside of opening times. **Information Campaigns:** Practices run information campaigns to educate patients about the available channels for expressing concerns. This can include posters in waiting areas, information on the practice's website, or announcements through social media. **Clear Guidelines:** Practices have well-defined procedures outlining how patients can raise concerns, the steps involved, and the expected timelines for responses. **Complaints Officer:** Designating a specific staff member responsible for managing and responding to patient concerns helps streamline the process. **Front Desk Engagement:** Reception staff play a crucial role in addressing immediate concerns. They can help gather information about the issue and guide patients on the appropriate steps to formally submit their concerns. **Continuous Improvement:** Feedback is used for, and contributes to, continuous improvement and reinforces the practice's commitment to providing quality care. **External Bodies:** In case concerns are not adequately addressed within the practice, patients are made aware of external bodies (such as the CQC) who they can approach for further assistance. **Patient Participation Groups (PPGs):** Forums for responding to patient issues rather than solely relying on these groups to raise concerns – addressing constructive feedback, demonstrating transparency, and providing the ability to implement improvements based on patient feedback.

North Stockton	Practices have complaints forms at Reception; patients are provided with the generic email and there is a facility for feedback on the practice websites. Most practices have a Facebook page, and some allow feedback / comments. The managers will also meet any patient on request face-to-face in the practice. All such feedback is treated as a complaint, and we follow the established complaints process to address them. Google reviews are also responded to by some practices.
Stockton	Patients are able to raise concerns direct to individual practices for investigation by an independent clinician who will formulate a written response. This procedure is communicated within practice leaflets, when patients join a practice, on practice websites, and through practices Patient Participation Group newsletters (to act as a reminder).

4. Do practices seek feedback around access – how has this informed arrangements?	
Billingham & Norton	Yes. Telephone waiting systems have been changed by practices (variety). One practice has move to consult triage. This could be better, but the reason behind not obtaining feedback frequently is fully understood. Constant negative feedback lowers staff morale and makes the teams feel that, even though they are working incredibly hard, this isn't good enough. Practices have introduced various improvements that allow for monitoring without negative feedback (i.e. telephony systems that are cloud-based and support patient call-back).
BYTES	Yes – Our practices have sought additional feedback from patients beyond FFT (Friends and Family Test) and the national GP survey. In addition to this data and feedback, to improve patient satisfaction and better understand the challenges that patients face, our practices carried out their own patient satisfaction surveys. The surveys aimed to gather more detailed feedback from patients on their experiences with the practice, as well as identify any areas where improvements may be necessary. The survey helped to provide practices with deeper insights into what patients experienced and what areas of appointments they felt needed improvement. The feedback received has been used in assessing changes and improvements to the services provided by the practice, ultimately resulting in a better overall patient experience. Adding to this, the number of respondents to the practice level satisfaction surveys was much greater than those who responded to the Friends and Family Test and included a greater level of detail than other surveys, aiding practices with actionable feedback. By gathering feedback from patients and making improvements based on that feedback, practices can ensure that they are providing the best possible care to their patients and improving patient outcomes. Practices also have Patient Participation Groups which provide a forum for discussion and feedback.
North Stockton	Patient questionnaires were sent out in November and will send out a second one in February to a different group of patients. • The first questionnaire did highlight access issues, particularly on the phone, but the problems raised had already been addressed with the advent of a new telephone system and various other processes, and the comments were from legacy access. Use of Mjog for Friends and Family questionnaires, which as you are aware is a stipulation of our capacity and access plan, and it did take some work to get this set up in Accurx.
Stockton	Yes, we are obliged to consult with our patients to seek their views on our services. This is achieved through questionnaires, focus groups, patient access data and external sources (i.e. Healthwatch). The above helped inform our out-of-hours access provision as to what services at which locations patients wished to see open. This included patients wishing to access those practices out-of-hours, with good public transport links, car park, nurse treatment room procedures and GP appointments for working people.

5. Summary of any planned changes within PCN practices to improve access or improve patient experience (e.g., linked to capacity and access plan, modern general practice access models, etc.).	
Billingham & Norton	Adoption of cloud-based telephony systems – including for some practice call-back. Review of the consult triage experience. In consult re FC physio to increase apps. Wish list – pharmacists to do med reviews and change patients to repeat dispensing. KMC is trying to increase use of digital tools to free-up phone lines (i.e. work on website to simplify for patients). Work on increasing use of NHS app to request telephone appointment, request medication, view results to not have to contact the surgery unnecessarily. KMC granted online registration for patients to save them coming down to the surgery to register, and working on General Practice Improvement Programme working to streamline processes and improve patient experience / journey by reducing duplicating, making every contact count, and improving efficiency. New telephone systems have helped but demand is still high. One of the practices has adopted the total triage model which has generated positive feedback from the patients and the practice team. Practices are constantly aware of the access issues and the patient experience. Great ARRS team (Pharmacy, FCP, MHP, Personalised Care) to support the patients and teams in practice.
BYTES	• Increased recruitment efforts • Scope out business models such as incorporation to reduce risk to practices • Improving our digital front door • Improving awareness of / access to digital solutions (addressing inequalities and digital poverty) • Optimising the effectiveness of existing systems • Explore additional estates solutions
North Stockton	• As stated, we are about to begin to use the new TPP version of eConsultations. We have worked tirelessly in the last 6 months to improve access for patients, and I can report a much-improved service. • One practice has re-purposed two rooms into clinical rooms to accommodate extra appointments via an HCA apprentice and an FCP, but this has hit a brick wall because the ICB is refusing to provide new IT equipment, and we are expected to pay the over-inflated prices of IT equipment from NECS ourselves.
Stockton	Stockton PCN has an exciting array of changes to improve access or improve patient experience – this is seen via the capacity and access plan and modern general practice access models. A selection of our targets are: • To create stronger PCN Patient Participation Group links to inform global patient journey feedback. • To promote the Friends and Family Tests throughout all practices. • To migrate to cloud-based telephony which includes call-back and call queuing functionality. • To review and update any unmapped and inconsistent mapping in all practices. • To enhance and update their websites with signposting and patient journey advice (this includes triage online). • To further promote Electronic Repeat Dispensing and AccuRx text messaging in all member practices.

APPENDIX 3: GP Patient Survey 2023 – results per Stockton-on-Tees general practice for access-related questions (Sep 23)

Data Source: GP Patient Survey (gp-patient.co.uk)

		Q32. Overall, how would you describe your experience of your GP practice?			Q1. Generally, how easy is it to get through to someone at your GP practice on the phone?			Q16. Were you satisfied with the type of appointment you were offered?			Q21. Overall, how would you describe your experience making an appointment?			Q6. How satisfied are you with the general practice appointment times that are available to you?		
		National Average 2023		71%	National Average 2023		50%	National Average 2023		72%	National Average 2023		54%	National Average 2023		53%
Practice Code	Practice	2023	2022	+/- ve	2023	2022	+/- ve	2023	2022	+/- ve	2023	2022	+/- ve	2023	2022	+/- ve
A81001	The Densham Surgery	65%	85%	-20%	48%	51%	-3%	79%	71%	8%	54%	53%	1%	48%	66%	-18%
A81002	Queens Park Medical Centre	73%	62%	12%	26%	24%	3%	73%	62%	11%	51%	36%	14%	41%	43%	-1%
A81006	Tennant Street Medical Practice	89%	75%	14%	27%	16%	11%	75%	66%	10%	56%	39%	16%	53%	36%	17%
A81014	Queenstree Practice	79%	84%	-5%	60%	77%	-17%	74%	71%	3%	65%	70%	-5%	57%	67%	-10%
A81017	Woodbridge Practice	64%	50%	13%	47%	27%	20%	74%	52%	22%	59%	35%	24%	50%	30%	21%
A81025	The Dovecot Surgery	60%	70%	-10%	23%	37%	-14%	60%	76%	-16%	45%	52%	-7%	42%	64%	-22%
A81027	Yarm Medical Practice	77%	67%	10%	27%	31%	-4%	72%	72%	0%	40%	47%	-7%	51%	46%	6%
A81034	Thornaby & Barwick Medical Group	74%	67%	8%	23%	21%	2%	72%	59%	13%	56%	47%	9%	46%	51%	-6%
A81036	Norton Medical Centre	51%	62%	-10%	9%	7%	2%	61%	49%	12%	23%	23%	0%	26%	23%	3%
A81039	Eaglescliffe Medical Practice	90%	87%	2%	63%	62%	1%	86%	82%	5%	67%	68%	0%	70%	56%	14%
A81040	Marsh House Medical Practice	70%	75%	-5%	37%	36%	2%	54%	60%	-6%	43%	46%	-3%	40%	58%	-18%
A81046	Woodlands Family Medical Practice	55%	61%	-6%	30%	42%	-12%	66%	63%	3%	42%	49%	-7%	43%	54%	-11%
A81056	Melrose Surgery	93%	89%	4%	96%	92%	3%	96%	88%	8%	87%	83%	4%	92%	77%	14%
A81057	Kingsway Medical Centre	83%	75%	9%	61%	55%	6%	84%	71%	13%	70%	62%	8%	64%	60%	3%
A81066	Park Lane Surgery	94%	95%	-1%	83%	94%	-11%	83%	91%	-8%	83%	84%	-1%	76%	80%	-3%
A81067	Alma Medical Centre	88%	80%	9%	32%	26%	6%	86%	81%	5%	60%	58%	3%	55%	56%	-1%
A81602	Dr Rasool	99%	98%	1%	98%	96%	2%	96%	99%	-3%	96%	91%	5%	90%	84%	6%
A81608	Elm Tree Surgery	91%	91%	0%	97%	93%	4%	96%	93%	2%	94%	91%	2%	93%	82%	11%
A81610	The Roseberry Practice	58%	63%	-6%	33%	43%	-9%	60%	74%	-14%	41%	56%	-15%	39%	46%	-7%
A81629	Riverside Medical Centre	92%	96%	-5%	90%	92%	-2%	89%	93%	-4%	88%	89%	-1%	84%	90%	-5%
A81634	The Arrival Practice	87%	83%	4%	81%	82%	0%	83%	81%	2%	76%	78%	-2%	80%	87%	-7%

The table above is a comparison of the results from 2023 to 2022.

		Q32. Overall, how would you describe your experience of your GP practice?				Q1. Generally, how easy is it to get through to someone at your GP practice on the phone?				Q16. Were you satisfied with the type of appointment you were offered?				Q21. Overall, how would you describe your experience making an appointment?				Q6. How satisfied are you with the general practice appointment times that are available to you?			
		National Average 2023		71%		National Average 2023		50%		National Average 2023		72%		National Average 2023		54%		National Average 2023		53%	
Practice Code	Practice	PCN Av	2023	2022	2021	PCN Av	2023	2022	2021	PCN Av	2023	2022	2021	PCN Av	2023	2022	2021	PCN Av	2023	2022	2021
A81001	The Densham Surgery	73%	65%	85%	88%	59%	48%	51%	56%	78%	79%	71%	86%	65%	54%	53%	66%	63%	48%	66%	58%
A81002	Queens Park Medical Centre	84%	73%	62%	89%	28%	26%	24%	49%	78%	73%	62%	88%	56%	51%	36%	66%	50%	41%	43%	64%
A81006	Tennant Street Medical Practice	84%	89%	75%	88%	28%	27%	16%	39%	78%	75%	66%	84%	56%	56%	39%	64%	50%	53%	36%	69%
A81014	Queenstree Practice	76%	79%	84%	91%	56%	60%	77%	87%	75%	74%	71%	91%	61%	65%	70%	88%	58%	57%	67%	86%
A81017	Woodbridge Practice	73%	64%	50%	73%	59%	47%	27%	53%	78%	74%	52%	79%	65%	59%	35%	63%	63%	50%	30%	51%
A81025	The Dovecot Surgery	73%	60%	70%	82%	59%	23%	37%	56%	78%	60%	76%	87%	65%	45%	52%	64%	63%	42%	64%	67%
A81027	Yarm Medical Practice	84%	77%	67%	88%	49%	27%	31%	68%	79%	72%	72%	87%	62%	40%	47%	80%	61%	51%	46%	67%
A81034	Thornaby & Barwick Medical Group	84%	74%	67%	79%	49%	23%	21%	42%	79%	72%	59%	81%	62%	56%	47%	62%	61%	46%	51%	62%
A81036	Norton Medical Centre	76%	51%	62%	78%	56%	9%	7%	47%	75%	61%	49%	79%	61%	23%	23%	57%	58%	26%	23%	64%
A81039	Eaglescliffe Medical Practice	84%	90%	87%	86%	49%	63%	62%	78%	79%	86%	82%	86%	62%	67%	68%	81%	61%	70%	56%	74%
A81040	Marsh House Medical Practice	76%	70%	75%	82%	56%	37%	36%	75%	75%	54%	60%	82%	61%	43%	46%	69%	58%	40%	58%	64%
A81046	Woodlands Family Medical	73%	55%	61%	76%	59%	30%	42%	46%	78%	66%	63%	77%	65%	42%	49%	59%	63%	43%	54%	63%
A81056	Melrose Surgery	76%	93%	89%	94%	56%	96%	92%	97%	75%	96%	88%	92%	61%	87%	83%	90%	58%	92%	77%	85%
A81057	Kingsway Medical Centre	76%	83%	75%	90%	56%	61%	55%	80%	75%	84%	71%	82%	61%	70%	62%	82%	58%	64%	60%	69%
A81066	Park Lane Surgery	84%	94%	95%	94%	49%	83%	94%	98%	79%	83%	91%	97%	62%	83%	84%	94%	61%	76%	80%	85%
A81067	Alma Medical Centre	84%	88%	80%	95%	28%	32%	28%	55%	78%	86%	81%	92%	56%	60%	58%	81%	50%	55%	56%	83%
A81602	Dr Rasool	76%	99%	98%	97%	56%	98%	96%	100%	75%	96%	99%	99%	61%	96%	91%	99%	58%	90%	84%	95%
A81608	Elm Tree Surgery	73%	91%	91%	95%	59%	97%	93%	96%	78%	96%	93%	91%	65%	94%	91%	96%	63%	93%	82%	90%
A81610	The Roseberry Practice	76%	58%	63%	80%	56%	33%	43%	56%	75%	60%	74%	74%	61%	41%	56%	64%	58%	39%	46%	55%
A81629	Riverside Medical Centre	73%	92%	96%	90%	59%	90%	92%	92%	78%	89%	93%	88%	65%	88%	89%	90%	63%	84%	90%	91%
A81634	The Arrival Practice	73%	87%	83%	89%	59%	81%	82%	86%	78%	83%	81%	86%	65%	76%	78%	87%	63%	80%	87%	79%

The table above is a heat map of the GP Patient survey results from 2021 to 2023 for Stockton-on-Tees.

APPENDIX 3: GP Patient Survey 2023 – results per Stockton-on-Tees general practice for access-related questions (Sep 23) (*continued*)

		Q32. Overall, how would you describe your experience of your GP practice?		Q1. Generally, how easy is it to get through to someone at your GP practice on the phone?		Q16. Were you satisfied with the type of appointment you were offered?		Q21. Overall, how would you describe your experience making an appointment?		Q8. How satisfied are you with the general practice appointment times that are available to you?	
		National Average 2023	71%	National Average 2023	50%	National Average 2023	72%	National Average 2023	54%	National Average 2023	53%
Practice Code	Practice	TV Av. 2023	2023	TV Av. 2023	2023	TV Av. 2023	2023	TV Av. 2023	2023	TV Av. 2023	2023
A81001	The Densham Surgery	74%	65%	49%	46%	75%	79%	57%	54%	55%	46%
A81002	Queens Park Medical Centre	74%	73%	49%	26%	75%	73%	57%	51%	55%	41%
A81006	Tennant Street Medical Practice	74%	89%	49%	27%	75%	75%	57%	56%	55%	53%
A81014	Queenstree Practice	74%	79%	49%	60%	75%	74%	57%	65%	55%	57%
A81017	Woodbridge Practice	74%	64%	49%	47%	75%	74%	57%	59%	55%	50%
A81025	The Dovecot Surgery	74%	60%	49%	23%	75%	60%	57%	45%	55%	42%
A81027	Yarm Medical Practice	74%	77%	49%	27%	75%	72%	57%	40%	55%	51%
A81034	Thornaby & Barwick Medical Group	74%	74%	49%	23%	75%	72%	57%	56%	55%	46%
A81036	Norton Medical Centre	74%	51%	49%	9%	75%	61%	57%	23%	55%	26%
A81039	Eaglescliffe Medical Practice	74%	90%	49%	63%	75%	86%	57%	67%	55%	70%
A81040	Marsh House Medical Practice	74%	70%	49%	37%	75%	54%	57%	43%	55%	40%
A81046	Woodlands Family Medical Practice	74%	55%	49%	30%	75%	66%	57%	42%	55%	43%
A81056	Melrose Surgery	74%	93%	49%	96%	75%	96%	57%	87%	55%	92%
A81057	Kingsway Medical Centre	74%	83%	49%	61%	75%	84%	57%	70%	55%	64%
A81066	Park Lane Surgery	74%	94%	49%	83%	75%	83%	57%	83%	55%	76%
A81067	Alma Medical Centre	74%	88%	49%	32%	75%	86%	57%	60%	55%	55%
A81602	Dr Rasool	74%	99%	49%	98%	75%	96%	57%	96%	55%	90%
A81608	Elm Tree Surgery	74%	91%	49%	97%	75%	96%	57%	94%	55%	93%
A81610	The Roseberry Practice	74%	58%	49%	33%	75%	60%	57%	41%	55%	39%
A81629	Riverside Medical Centre	74%	92%	49%	90%	75%	89%	57%	88%	55%	84%
A81634	The Arrival Practice	74%	87%	49%	81%	75%	83%	57%	76%	55%	80%

The table above show the Stockton-on-Tees practices' results in 2023 compared to the Tees Valley average.

APPENDIX 4: Patient Participation Group (PPG) Survey – collated responses (Mar 24)

	1. As a PPG, do you feel listened to by your practice? (please explain your answer)
1	Yes, the Practice Manager and clinical representative attends every PPG Meeting and they do listen and act very quickly upon with any concerns we have. XXXXXXXX Practice is very caring and proactive practice and works very closely with the PPG members.
2	Yes, very much so, I receive regular emails & SMS messages regarding changes & services available.
3	It is too early for me to make a yes or no decision on this as only joined at end of last year and I have attended a group meeting. The GP and Practice manager noted suggestions me and the other member made and verbally responded to them as well.
4	Most definitely. I have family and friends who are patients at the practice and whenever an issue is raised (which is rare), I know I can speak with the practice manager to discuss the issue. Also when I have highlighted an area for improvement the practice have listened and over time improved the patient experience. An example being contacting the practice on the telephone to make an appointment. The line used to be constantly engaged and a patient had to redial to make the call. Now it is a queuing system which also gives an option for the patient to get a call back when it is their turn in the queue. Online prescriptions have been introduced, thus eliminating the need to attend the practice. Plus this is managed extremely timely with the prescription being electronically sent to the nominated pharmacist. An ongoing issue is access to appointments at times of high demand. The practice is aware and has informed me this is being addressed. Access hasn't helped with one of the doctors being on long term sick leave, however locums have helped. As an ex Police Inspector with Cleveland, I was responsible for authorising drug destruction which included prescribed medication recovered from sudden deaths. At one of my meetings with the practice manager I highlighted this. To reduce patients stockpiling un-needed drugs the practice has a pharmacist that reviews medication which is reported back to the GP. I have personally had a review whereby my medications were reduced thus saving the NHS money.
5	Having been a member of this PPG since its creation many years ago I can say, with confidence, that issues discussed and suggestions advanced have, as appropriate and possible, been listened to and acted upon. Dialogue between the Gps and Management and the PPG has never been a problem. Consequently there is co-operation in both directions.
6	It depends what is meant by “listened to”. The PPG staff are very polite and friendly, and appear to be both open and receptive. However, I have formed the opinion so far that they are merely going through the motions. Before Covid the PPG agreed to hold meetings every two months, to give some continuity. However there have only been two meetings since then, one at such short notice that I was unable to attend. We last met in October, and the next meeting was due in December, but because of Christmas etc. this was put off until January. It is now February and there is still no word of a meeting. I do get the feeling that the practice considers that, at best, the meetings are a waste of time, and at worst a potential source of interference in the running of the practice. It seems they would be happy with one or two meetings a year and only bother at all because they have a contractual obligation. Attempts have been made to request management and statistical information about the general running of the practice, but so far these requests have fallen on stony ground. The practice has provided access to a social media site called ‘Slack’ which I assume they hope PPG members will use. It may be useful in some ways, but does not permit the PPG as a whole to discuss and reach meaningful conclusions.
7	After much consideration / debate the group believe that the practice do listen but they’re often not in a position to resolve ‘things’ at that point in time and as such it may appear that they’re not interested. One possible way in which communication could be improved would be if a clinician attended our meetings more frequently, we fully appreciate their workloads so they’d only have to stay a short while. However we’d also like to add that if something was raised and some months down the line nothing appeared to have been progressed we would certainly feel ‘safe’ in raising the issue again.

8	Yes, we advised that XXXXXXXXXXXXX should promote the role of the Advanced Nurse Practitioner, what they are able to treat and that they can prescribe medications. An area on the display board in the Practice waiting area was allocated with information about the Advanced Nurse Practitioner on it. The practice was responsive to our suggestions.
9	Yes as a member of the PPG I feel listened to. A request for agenda items is made to all members prior to the meeting. A recent example is that we suggested that a group member could chair the meeting rather than one of the GP's, this would allow the GP's to take part in the meeting better and be totally impartial. This was tried out at our last meeting and worked successfully.
10	Yes. At our regular meetings, everyone has opportunity to contribute to discussions on practice activities and any proposed changes. Where possible, suggestions are acted upon and results fed back to the group. Any concerns raised are also dealt with by appropriate staff members. Some newer members are not sure how much GPS take note of the PPG concerns and opinions.
11	Yes. Issues raised at PPG meetings have been addressed where possible. Bearing in mind of course that some issues cannot be for many reasons, but issues have been explained.

2. In the last year, what are the main issues that the PPG has identified / raised in relation to <u>access</u> to GP services?	
1	• The current telephone system is outdated and needs an update, so patients can have a call back, rather than waiting. • Giving patients a choice of a face-to-face or telephone appointment. • Having in-house created posters in bigger fonts, so patients can see more clearly how to access GP services. • Updating the practice website with more clinical/signposting information, so patients can access GP services, knowing which clinician they need to speak to.
2	During holiday periods there has been a shortage of GP appointments & its difficult when trying to contact the Surgery by telephone.
3	I only became a member of the PPG at the end of last year so have only had one meeting so I am unable to say anything about meetings earlier in year. The lack of Face-to-Face appointments was the main subject as many people are not happy about having to discuss over the phone or fully able to describe symptoms. And feel more reassured when able to see a GP or Nursing staff. Also, the telephones are always busy so looking into the booking of appointment online [patient access] or ability to cancel by email.
4	• Following COVID the Phlebotomy Service was moved from the practice to another surgery. Concerns were raised regarding the new venue and now the service has returned to the practice. • As mentioned at 1 above, the telephone contact service has been improve significantly. • Access to appointments sometimes is problematic due to high demand. Mostly you can be seen or spoken to that same day however when this is not possible the reception team will do their best to accommodate the patient on the second or third day of calling. • Calls are triaged by the trained reception team to ensure the most appropriate member of the clinical service deals with the patient.

5	This PPG has been through a rocky time in terms of membership. Age and ill health has carried away many of our most active members and Covid created a stagnant period where member replacement did not get off the ground. The result was a reduction in the range of subject discussion and those two concerns common to the nation were on the table. 1. Telephone answering delay and 2. Timely access to a GP appointment. 3. Membership. Any other issues were small by comparison and were easily dealt with However, membership is now starting to climb meaning that the scope of discussion can be broadened.
6	None, for the reasons explained in 1. above.
7	The main issues at XXXXXXXXXX, probably like many other practices, are: 1) The ability to 'book' an appointment. This is a constant concern for patients. 2) The phone system, always in a queue for ages.
8	• The main issue that has been raised is access to the Practice via the telephone line. Patients are having to call multiple times to get through to the Practice once they do get through, they are happy with the service. The Practice has increased its clinicians by recently recruiting 2 Advanced Nurse Practitioners (ANP) therefore increasing appointments for acute problems. • The PPG gave feedback on the role of the ANP, not all members were aware of this role and it was agreed that patients should have more information and understanding on what they can consult the ANP with.
9	• Appointment availability • Getting through on the telephone • The topic of access to appointments is discussed at most meetings and the practice continually tried different ways of improving access. This is not always 100% successful but my take on this is that the increase in population around the XXXXXXXXXXX area has not been matched by the same level of resource. When I first moved to the area 10 years ago it was easy to access Primary care appointments, its now very difficult.
10	1) Difficulties in getting through to the practice on the telephones. 2) Lack of appointments if patients can get through to reception 3) Difficulty using e-consult 4) Practice changed to Total Triage system to try and combat the access issues. The practice reported this has improved the process at their end but we frequently receive reports from the community that they cannot contact the practice. The e-consult closes very quickly and patients have to keep trying until they can complete a form. They have 3 access points but we think more communication with the patients on how to navigate the systems is needed. Telephone bookings are almost impossible. 5) We have received reports that older patients in particular have given up trying to get an appointment and are not accessing GP services which is concerning.
11	PPG meetings stopped when Covid struck, and only started again recently. At the last PPG meeting a full explanation was given about the Extended Hours service, how to access it, and why the GP surgery was being used on a Sunday, and that appointments were needed for that. Also the work of H&SH in different appointments within the PCN (and what a PCN was, and which we were in).

3. Have any changes been made as a result of the PPG bringing issues regarding <u>access</u> to the practice's attention?	
1	Yes, as follows: • **The current telephone system is outdated and needs an update, so patients can have a call back rather than waiting.** A new telephone system is being installed soon with this functionality and the PPG are working with the practice to publicise. • **Giving patients a choice of a face-to-face or telephone appointment.** The practice has altered its rotas so there is now patient choice of how they access the GP services. • **Having in-house created posters in bigger fonts, so patients can see more clearly how to access GP services.** Bigger posters have been created by the practice. • **Updating the practice website with more clinical/signposting information, so patients can access GP services, knowing which clinician they need to speak to.** The website has been fully redesigned and now offers a lot more information.
2	The telephone system was updated and now cloud based telephone system is in situ. Extra appointments were added to each session moving from 12 to 16 appointments including daily consultations. The practice is also developing a facebook page with the aim to receive more real time contact.
3	There have been some changes to the website which I raised. And the email cancellation situation is being investigated.
4	The PPG highlighted the telephone introduction service was slightly outdated in relation to COVID and masks. This is to be rectified. As mentioned previously, the contact telephone number used to be continually engaged. The new system was introduced which is significantly improved the process of making an appointment. A HCA is now taking blood at the practice thereby saving patients from going to another premises.
5	Over time the number of Registrars has been increased thus increasing the number of appointments available. Another advantage of having Registrars is that they have a longer consulting period allotted which can be seen as a benefit by the patient. The telephone problem is one which the Practice has had for a long time and has its roots in the history of the XXXXXXXXXXX as it was set up at the outset. The PPG has constantly nagged about the situation and whenever possible the system has been tweaked to improve but these tweaks have had little overall effect. At long last, a solution appears to be in place to be implemented in March 2024. An astounding cost is tied up in improving the system and is one of the main reasons for there being a delayed solution.
6	No, for the reasons explained in 1 above.
7	The practice appreciate patients concerns and in an attempt to improve the patients perception they wanted to explain the various ways in which they could be contacted / they could 'speed up' advice and or assistance. This was done via notice boards, electronic screen and newsletters (produced by XXXXXXXX). This course of action was decided upon as it would hopefully give a more instant improvement in not only perception but more importantly service. As for the phone system they continually look at it in order to look at ways to improve its overall effectiveness, this is something that will (I'm sure) continually have to be done in order to make sure that it's the best for all concerned.

8	From April 2024 the Practice are ceasing to accept prescription requests over the telephone. Patients have been given a newsletter regarding this and assistance has been given to patients to register for online services so that they can order their prescriptions this way. Hopefully this will reduce the number of telephone calls going through to the Practice and patients will be able to get through to make appointments and seek advice.
9	Different ways of managing slots have been tried. We have suggested publicising the different methods of access which I understand has been done. The group suggested that a way of leaving a voice message to cancel an appointment could be used, this is now an option on the voice system. On the back of this and also not releasing appointment slots too early the DNA rate has been reduced. Its regrettable that more online appointments are not available for patients to book but I understand this is because the limited slots need to be closely managed to ensure that they are used efficiently and available for urgent needs.
10	See above re: Total Triage. Some communications have improved e.g. changing the introductory messaging and looking at the website. However, after initial meetings to look at the options with ICB staff, the website has not improved and the changes we expected have not come about. This is to be raised at the next meeting. Local reports about the new system will also be raised at the next meeting.
11	It is a long time, pre covid, since the last regular PPG meetings, but issues raised there must have made a difference, as there are much better systems for appointments, and with the help of a PPG member the website is now much clearer and usable in explaining the appointment systems. At the very last pre covid meeting a full explanation was made and questions answered about e-consult, which proved to be invaluable for some during covid.

4. In your view, how best could your practice improve <u>access</u> to GP services?	
1	The PPG know XXXXXXXXXXXX is doing all it can to improve access to GP services. They continually ask the PPG how their access to GP services can be improved during the day, evening, and weekend.
2	On discussion the only improvement that could be made is employing a female Doctor.
3	More face-to-face appointments rather than the triage phone call. Even if each of the GPs had an allotted day for face to face it would be more helpful than current system. Not everyone has access to the internet especially older people and so are missing eConsult etc that are on the website. Many try to be independent and do not want to rely on a relative or friend to do things for them and of course do not want to discuss private matters. [If you look on any social media, no matter which local surgery it is. The main complaint is still why can't I see my GP face to face like it was before lockdown. And until this is sorted there will be criticism of access to the GP. I still find it strange that I can have 5 minutes or so on the phone to GP and then I am requested to go to the surgery for them to examine me thus taking another 5-10 minutes. Surely a better use of their time would be to see any patient who requests a face to face.]

4	Possible introduction of an online booking service for some routine appointments which will improve access. However, this could be detrimental to patients who are unable to use the online service for a variety of reasons. Probably as for the vast majority of practices, there continues to be an issue with recruitment of trained practitioners. I am aware the practice is actively looking at this area. With regard to staff retention, I am aware that most of the staff at the practice have been in post for a number of years, which is reassuring for the patients. From a personal point of view, the service I get from this practice is exceptional. If I ring at 8am I may be in a queue, however, I have never not been able to get a call-back appointment from a doctor to deal with the matter or an appointment with the nurse. I have been involved in the PPG for a number of years and have confidence that the practice listens to and acts upon my raised concerns with a view to improving the patient experience. One of the doctors has been on sick leave for a considerable period of time. The same locums have been employed to cover this absence and have been retained for this period for continuity of the patients.
5	I cannot answer that question. The Practice is doing what it can to the best of its ability within the parameters currently obtaining. Now, if individuals learned more about health and followed the well advertised health guidance then perhaps their need for medical intervention would be vastly reduced. So, my best advice is not aimed at the hard working Practices but at the patients who present so often with self inflicted health problems.
6	Without sufficient information about the priorities, constraints, policies and demands placed on the practice, it is not possible to develop opinions on this.
7	As previously stated we believe that getting an appointment is one of the major concerns for our patients, as we assume is a familiar story at other practices. Therefore the practice needs to make the most of what is already in place and as such must continually look for ways in which to improve what currently exists, in other words they need to be innovative as far as is possible. (note: I feel I must say that I'm convinced that all the staff, immaterial of role, want to make sure XXXXXXXXXXX provide an excellent service.)
8	Hopefully the new prescription system will improve the telephone access and patients will also use the skills of the Advanced Nurse Practitioners.
9	More online appointment slots. That they be given resource in line with the local population.
10	More staff are needed. They meet minimum requirements, but demand is greater on the service. Need to increase the number of full-time GPs. Too many part=timers, meaning no continuity of medical care. Also need to recruit at least an extra .5 GP. Need to be more responsive to phone calls.
11	Wider dissemination of the information on the website on how to book an appointment, and also the different additional staff that are able to see patients with specific needs. We appreciate and raised at the last PPG meeting that this is difficult when so many patients are not internet enabled and not all that are realise that there is a lot of useful information on the website. Maybe some borough wide publicity on where to find information would be helpful, if all GP practices had good and usable information.

	5. How, and how often, does the PPG seek new members?
1	There is a constant advert for new members displayed in the practice on the patient call board.
2	• Continuous verbal invitation through appointments. • New patient registration forms. • Website. • Information posters at reception & waiting areas.
3	• They have it permanently on the ticker "appointment screen "asking for people to join. . • They also have it on the website and have had a poster on the reception desk. • Mine was by seeing the poster on the reception desk when making an appointment and asking the receptionist about it. My details were passed on and I was contacted within a few hours of this.
4	There is a notice in the waiting room asking people if they would be interested in joining the PPG plus new patients are given an information sheet. I am aware that take-up is poor and this is something which could be improved upon in future.
5	This is and has always been an ongoing endeavour. Word of mouth, running invitations on the Practice video, newsletters, invitations to be an email member, moving meeting times. The catchment area of this Practice contains a large number of individuals who have little or no interest in health matters or who do not have time to spare to attend a PPG. At this time we appear to have gained a few interested people for which we are very grateful. I believe this has been by word of mouth.
6	There is a rather obscure mention on the practice website, which is how I heard about it.
7	This has been continually done since 2011, when the group was created, and it's done in a variety of ways:- 1) The electronic notice board / screen. 2) The notice board. 3) The practice website. 4) Newsletters. 5) Minutes.
8	There is a notice in the patient waiting room and also a link on XXXXXXXX website to recruit patients onto the PPG.
9	New members are always encouraged.
10	There is a permanent notice on the board in reception inviting patients to join. We also put out occasional extra calls on the website to join. We also put it on social media.
11	Currently, since the covid break, there is a campaign to get more members for the PPG. There are notices in the waiting room, and a link on the website to encourage new members to join. At the last meeting a lot (maybe about 40) people came along in addition to the half dozen or so existing members.