General Practice Access Short Life Working Group

General Practice Access Principles

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Scottish Government
Riaghaltas na h-Alba

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Access Principles

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1. Preface

Currently, General Practice is under significant pressure. Like many parts of the health and social care system, it is experiencing increased demand and higher public expectations post-pandemic alongside continuing challenges recruiting and retaining General Practitioners (GPs) and other members of the practice team (clinical and administrative). These challenges are making it difficult for the public, in some parts of Scotland, to access the care they need from General Practice when they need it.

Even before the pandemic, General Practice was having to change the way it provided services to meet the needs of the public with changes in technology, the expansion of the clinical and administrative teams, and the introduction of new systems and processes. Lack of awareness and public understanding about these changes, how the system works, who could you be seen by and where people can access care have all created a complicated, confusing, and challenging situation. These issues alongside a more complex health and social care landscape have compounded the difficulty people have understanding how best to access the care they need, when they need it.

Despite these issues, General Practices across Scotland continue to strive to deliver high quality care. We recognise that General Practice in Scotland is a core, highly valued part of the integrated primary care landscape, free at point of delivery, and whilst we recognise the challenges it faces. We should also be extremely proud of what General Practice delivers every day to the people of Scotland and their resilience to manage the increase in activity in recent years.

We equally must accept that in some areas General Practice is struggling to deliver what we would all aspire it to deliver under current pressures. We recognise that the capacity of General Practice teams will always be the fundamental constraint on how well practices are able to meet the needs of their patients. The following Access Principles have been developed to help practices consider how to best meet the needs of their communities in differing and sometimes difficult circumstances.

At the heart of General Practice is the desire to meet the needs of their patients in the best way that General Practitioners and practice teams possibly can. However, General Practice's reputation for doing this can sometimes be threatened by patients' expectations and widespread criticism that it is too hard to access appointments when people wish them or need them. This criticism compounds the pressures noted above and has a direct effect on the General Practice team's morale and the retention of staff.

For many people, online access to services, including their General Practice, is a normal part of their everyday activities. We are moving to an increasingly digital world with digital technology empowering some people to access the care they need more easily. Developments such as Near Me video consultations and NHS Inform can be useful for some.

In addition there has been an increase in what many General Practices offer including on their practice websites, online appointment booking and repeat prescription ordering, Digital Asynchronous Consulting Systems such as eConsult®,

AskMyGP® or online reviews on MedLink® to name a few. These have become the norm in many areas, allowing patients to have more choice around how and when they access care.

Following a request from the Cabinet Secretary for Health and Social Care we have collaborated with key stakeholders to develop high level core Access Principles to support and enhance people's experience of accessing 'The Right Care, Right Time, Right Place'.

In his letter to General Practices in November 2022 the then Cabinet Secretary said:

> "I have been clear in the past that any suggestion that GPs have not been seeing people face-to-face because they did not want to was false and dangerous. I have absolutely rejected that suggestion and condemned the abuse that has been directed towards General Practice staff. I have also been clear that introducing any arbitrary targets for face-to-face appointments would not be helpful because every practices' patients have different needs and the best mix of appointment types to the right member of the team is something that requires the judgement of professionals who have a long term responsibility for their patients.
>
> That is still my position.
>
> However, I continue to receive regular correspondence and feedback from elected members with concerns being raised about access to General Practice. The perception that General Practices are closed, do not provide face to face appointments and are unwilling to provide pre-bookable appointments for patients is damaging the reputation of General Practice and I am keen to work with the sector to demonstrate the good work we know is happening in General Practice and work collaboratively on where improvement still needs to be made."

We hope that working with the Access Principles will give General Practices a way to clearly demonstrate that they provide the best care and service for their community that they possibly can. We also hope that these Principles will help the public to understand what, how and why their General Practice is delivering care in the way that they are. An Easy Read version of the principles will be available in due course.

We wish to be clear that these Access Principles are **not** standards that General Practice will be measured or judged against in any way. Rather these are Principles that we hope all General Practices will aspire and strive to deliver - indeed many already deliver them. Ultimately, we hope these principles will be utilised across the wider healthcare system with General Practice as the leading example and that they will be utilised as a basis for improvement.

These Access Principles have been developed collaboratively with key stakeholders from General Practice, Health Boards and Health and Social Care Partnerships (HSCPs), professional bodies (RCGP and SGPC(BMA) and most importantly, the public. The work of the Healthcare Improvement Scotland (HIS) Community Engagement Team in facilitating focus groups and their Citizens' Panel has been extremely important and helpful in developing the principles.

It is important to note that from the HIS Community Engagement Report[1] the public described their ideal General Practice as **–**

> "accessible, equitable, flexible, inclusive, responsive, approachable, welcoming and non-judgemental."

We believe this is what everyone working in and with General Practice and the wider healthcare system would hope for and aspire to.

When asked, the public said that the most important things to them regarding access to General Practice were:

1. Being able to access appropriate care in a reasonable time (45%)
2. Followed by a reliable appointment system (31%)
3. And appointments with appropriate healthcare practitioners (26%)

We would like to strongly encourage all General Practices across Scotland to read this paper and consider the Access Principles with an open mind and consider the principles in the most appropriate way for them to support people to access the care they need when they need it.

We would ask the public to support their General Practice and treat the practice team with dignity and respect. Violence and aggression (both verbal and physical) towards any member of the practice team is not acceptable and could have severe consequences. We would encourage General Practices to welcome feedback from people (both informally and formally) and use that in a positive way to learn, develop and improve their services.

We would like to thank everyone who has been involved and given their time, knowledge, and experience to help shape the Principles.

Finally, we would like to thank our Scottish Government colleagues who have supported us through this work, Michael Taylor, Nicola Rae, and the rest of the Primary Care Directorate and to our colleagues in the HIS Community Engagement Team for their amazing work capturing the public's voice.

Thank you.

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[1] Link to report completed by HIS investigating public perception of General Practice Access proposed principles.

2. The Principles

1. Access to General Practice is inclusive and equitable for people, based on the principles of Realistic Medicine and Value Based Health & Care. Care will be person-centred and based on what matters to the individual.

2. People should have a reasonable choice about how they access services.

3. Services should be approachable, sensitive, compassionate, and considerate to need.

4. General Practices should help people to get the right care from the best and most appropriate person or team to care for them (Right Care, Right Place, Right Time).

Supplementary Principles

a) People should be enabled and supported to maximise their own health and wellbeing through:
• Self-management of their condition
• Using online resources such as NHS Inform
• Accessing other primary care services where these are suitable such as their local Community Pharmacy, Optometry (Opticians) or Dentists

b) When capacity and appointment availability is limited, General Practices should ensure that those with the most urgent care needs are met.

c) Methods of access to General Practices teams should be clear, understandable, and transparent for people to access the right service for their needs

d) The role of trained practice administrative staff (receptionists) to help people find the most appropriate service (both within and out with the practice) to meet the person's needs, is the norm. (sometimes called Signposting or Care Navigation).

e) Receiving care from the wider General Practice team (other than the doctor) is the norm (sometimes called the multi-disciplinary team (MDT))

f) People should be able to understand and trust the different roles in General Practice and wider team and that they won't always need to see a GP (doctor).

g) People who have complex health needs or who live with frailty should be supported to receive continuity of care through a known and trusted healthcare professional or team.

h) General Practice should be delivering holistic healthcare (the treatment of the whole person), considering psychological and social determinants of health, rather than just the symptoms of illness.

i) People should have a positive and trusting relationship with their General Practice team. Practices should actively seek, welcome, learn and act upon feedback (formal and informal) from people about their experience of accessing care.

j) General Practices will use digital resources (Information Technology), where appropriate and when people choose, to meet people's needs. The needs of people who struggle with digital technology will also be considered and addressed by General Practices.

3. Introduction and Background

Even before the Covid 19 pandemic, access to General Practice has been a longstanding challenge for the public across Scotland. Over many years, there have been a number of national attempts at improving this with initiatives like the RCGP Practice Accreditation Scheme, the Primary Care Access Collaborative, Productive General Practice, and the inclusion of access indicators in the Quality & Outcomes Framework (QOF). More recently there has been the work of Healthcare Improvement Scotland (HIS) with the development of the Practice Administrative Staff Collaborative (PASC) to support the introduction of Care Navigation[2] and Workflow Optimisation[3] toolkits and the more recent Primary Care Access Programme[4] (PCAP).

We also recognise that the availability of good medical care can vary inversely with the need for it in the population served. This is known as the Inverse Care Law[5] and was first described in 1971. Difficulties in access in more socio-economically deprived areas are known to be driven by a number of factors: higher levels of need, lower levels of workforce, and higher consultation rates. Any proposed solutions to improve access to primary healthcare must consider these factors (ref: The Inverse Care Law - The Lancet. See also this Editorial DOI publication regarding Inverse Care Law[6]).

Prior to the pandemic, the way people accessed General Practice was already changing in some areas with the introduction of telephone first approaches (sometimes called telephone triage), video consultations (usually known as Near Me in Scotland), Digital Asynchronous Consulting systems (DACs) such as eConsult® and AskMYGP® with online appointment booking and online reviews of conditions using platforms such as MedLink®. These developments varied across the country with many practices continuing with traditional ways of providing care with most appointments made by telephone and consultations provided face to face.

At the beginning of the pandemic, National Infection Prevention Control measures, including screening healthcare requests over the telephone before attending a practice, were introduced. While General Practice remained open, these changes made General Practice more difficult to access at times and created a misperception that General Practice was closed to the public and that services were not operating. This misperception has endured in some areas, even for General Practices where access has diversified and improved and these more stringent Infection Prevention Control measures have long since eased.

The way care is provided by General Practice has also changed with the introduction of the Primary Care Improvement Fund established in 2018 resourcing a large expansion of the wider MDT(Advanced Nurse Practitioners, Pharmacists, Physiotherapists, Mental Health Workers, Community Link Workers etc.) in addition to the traditional practice team of General Practitioners (GPs), General Practice

[2] Care navigation toolkit
[3] Workflow optimisation toolkit
[4] Details of PCAP programme
[5] Lancet publication on Inverse Care Law
[6] DOI Publication regarding Inverse Care Law

Nurses and Health Care Support Workers. This has meant that services may be notably different compared with five years ago. There is now an increased range of how, and where, people can access care, but these changes are not always well understood by the public, nor are they always easy to explain.

These developments have meant that the need for practice administration staff, such as Receptionists, to support people to find the most appropriate service or member of the team to meet their needs has greatly increased. These new roles are now widespread and are sometimes known as signposting or Care Navigation. These roles are not clinical decision making roles but support the clinicians to prioritise the care they provide, particularly when there is limited capacity.

Some practices have, in addition to Care Navigation, introduced triage systems to manage the daily demand to prioritise those who are most in need, particularly where there is limited clinical capacity. Triage is defined in the OED as[7] :

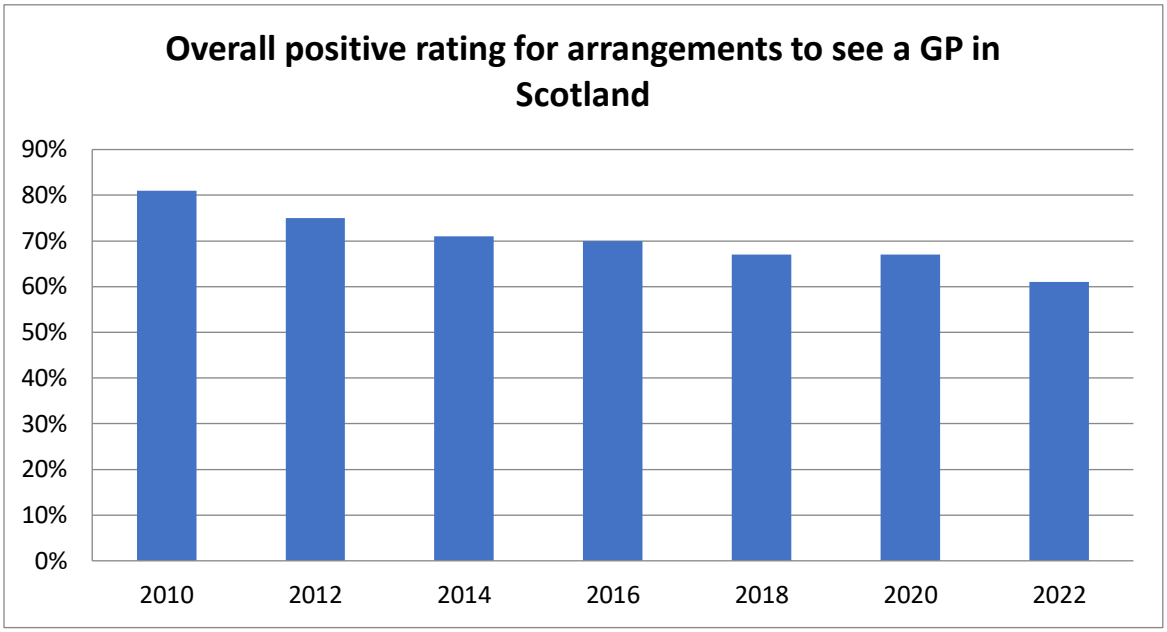
'To perform a preliminary assessment of (a patient) in order to determine the nature and degree of urgency of treatment required.'

Triage is a clinical role which should normally be conducted by a doctor or other clinician such as an Advanced Nurse Practitioner. Although the information gathered by administrative staff (receptionists), as mentioned above, supports the clinician to carry out the initial triage process before speaking to or seeing the person. Some practices call this 'telephone triage' or have a telephone consultation first system. However, whilst remaining useful for 'on the day care', for routine (non-urgent) care this is reducing with more practices re-introducing systems where people can decide, in discussion with the receptionist/ care navigator, if they wish a face to face or telephone consultation. Every General Practice has a different appointment system depending on their population's needs and available clinical capacity within the practice.

The changes in how General Practice provides care, at a time when both demand for general practice services is understood to be increasing and capacity is constrained (for a number of reasons), has meant that people's experience of accessing care varies depending on the arrangements in their general practice. There are many examples of people receiving good, high quality, person-centred care. However, this may not be the case everywhere, especially in practices with capacity issues.

The Scottish Health and Care Experience Survey[8] (HACE) is run every two years and asks people across Scotland their experiences of accessing and using their General Practice and local Out of Hours services. It provides a national and local picture of the experiences of health and care services from the perspective of those using them. The last survey was carried out in November 2021 with the results for each General Practice, GP Cluster, Health and Social Care Partnership (HSCP) and Health Board[9] published in Spring 2022. Against a backdrop of increasing activity against the number of GPs, overall positivity in arrangements to see a GP in Scotland is steadily decreasing.

[7] OED definition of "Triage"
[8] Scottish Health and Care Experience Survey (HACE)
[9] HACE survey results



Health and Care Experience Survey (available here[10])

General Practice in Scotland

At the time of writing there are approximately 900 General Practices across Scotland (See Public Health Scotland data[11]). There are three main types of General Practice in Scotland. Across each type of contractual arrangement, access can have similar challenges, and successes.

General Medical Services (GMS) contract (17J): these General Practices have a standard, nationally negotiated contract[12] and are normally run by GP partners (although there is an increasing number of other types of partners). Within this, there is some local flexibility for practices to opt out of certain services (such as additional services) or opt into the provision of other services (such as Enhanced Services). Enhanced Services are services which practices are commissioned to provide by their health board under a local service level agreement and are funded in addition to their GMS contract.

Primary Medical Services agreement (17C): these General Practices have locally negotiated agreements, enabling, for example, flexible provision of services in accordance with specific local circumstances.

Directly-run (2C): these General Practices are run directly by the local Health Board rather than by GP partners.

The contractual requirements of access to GMS General Practices) are set out in, The National Health Service (General Medical Services Contracts) (Scotland)

[10] Copy of HACE report
[11] General Practice List size and Demographics
[12] General Medical Services Contract (2018)

Regulations 2018 (legislation.gov.uk)[13] and this forms the basis of all GMS contracts between General Practices and NHS Health Boards.

The Regulations advise that General Practices "must provide the (essential) services… throughout core hours."

"The services described... are… for the management of its registered patients and temporary residents who are, or believe themselves to be—

(a) ill, with conditions from which recovery is generally expected;
(b)terminally ill; or
(c)suffering from chronic disease,

delivered in the manner determined by the practice in discussion with the patient.

"The services … includ[e]..—

(a)the provision of advice in connection with the patient's health, including relevant health promotion advice; and

(b)the referral of the patient for other services under the Act."

General Practices with GMS contracts (17J) or Primary Medical Services agreements (17C) are known as "independent contractors". As independent contractors, General Practices decide how they want to make services available to their patients. The type of telephone system, number of telephone lines, number, and type of appointments available and other access arrangements, such as number of receptionists, are for the General Practice to determine depending on the needs of their local populations and available capacity with the practice team.

Neither a GMS contract nor a Primary Medical Services agreement stipulates the form that arrangements should take, only that they should be "delivered in the manner determined by the practice in discussion with the patient" as set out above in the GMS contract.

Independent contractors (the GP partners) also employ their own staff such as Practice Managers, Administrative staff (receptionists) and General Practice Nurses. As such, access arrangements in each General Practice are different depending on a number of factors including workforce configuration, overall capacity, premises, telephony systems, digital systems and people's needs set within local geographic and demographic factors.

The GMS contract also sets out other requirements such as compliance with the Patient Rights (Scotland) Act 2011[14] (which sets out how complaints should be

[13] The National Health Services (General Medical Services Contracts and Primary Medical Services Contract 17C Agreements) legislation
[14] Patient Right's (Scotland) Act 2011 legislation

managed – more guidance from SPSO is available online[15]), Health and Safety at Work etc. Act 1974[16] and other legislation.

As part of their contract, General Practices must be available to their registered patients from 8 am – 6.30 pm (core hours or as previously agreed through local negotiation) Monday-Friday (NHS24 and the Out of Hours service will be available out with these hours). General Practice contracts also specify the practice area which the practice covers and sets out where the practice will accept new patients from. General Practices can refuse applications from people to join the practice if they live out with this practice area.

Finally, people register with a General Practice and not with a specific named GP although patients can often express a preference for a particular doctor when they are making an appointment. As set out in the Scottish Government registration guidance[17] to practices in 2018, two key principles underpin universal access to primary care:

1. No documents are required to register with a General Practice. The inability by a person to provide identification or proof of address is not considered reasonable grounds to refuse or delay registering a person.

2. Anybody in Scotland may access primary care services at a General Practice without charge.

General Practices struggling with capacity may temporarily close their lists to new patient registrations with their Health Board's agreement. This is difficult for practices and can be distressing for people. Although a critical issue and related to a practice's ability to provide access, addressing capacity issues with contractual mechanisms, such as closing lists or changing practice boundaries, is out with scope of this work or the Access Principles.

2018 GMS Contract

In 2018, the Scottish Government negotiated a new GMS (GP) Contract with the Scottish GP Committee (BMA), the 2018 GMS contract[18] and associated Memorandum of Understanding (MoU), which includes GMS Contract Implementation in the context of Primary Care Service Redesign[19] and GMS Contract Implementation for Primary Care Improvement[20].

The 2018 GMS contract[21] set out a transformative new direction for Primary Care services in Scotland, as well as putting in place investment and support for Scotland's General Practices.

[15] Scottish Public Services Ombudsman Complaints Handling Procedure
[16] Health and Safety at work act (1974)
[17] Registration Guidance to General Practice
[18] General Medical Services Contract(2018)
[19] Memorandum of Understanding
[20] Memorandum of Understanding (2021)
[21] General Medical Services Contract (2018)

The contract came into effect in April 2018 and included service redesign to establish health board-employed MDTs providing the following services:

- Pharmacotherapy
- Vaccination Transformation Programme (VTP)
- Community Treatment and Care Services (CTAC)
- Community Links Workers
- Additional Professional Roles (including MSK physiotherapists and mental health workers)
- Urgent Care Services

Access

Access to general practice has become an increasingly high-profile issue since Infection Prevention Control measures were implemented at the beginning of the pandemic. Although the need for these measures has ended, there is a continuing perception among the public in some areas that it is difficult to access care from General Practice.

While complaints about getting face to face appointments have eased, difficulties getting through on the telephone, concerns about the questions asked by practice receptionists and the availability of appointments continue. General Practices also report an increase in difficult and challenging behaviour from people, sometimes resulting in violence and aggression. These complaints are, of course, far from universal and should not detract from the excellent work done by General Practices across Scotland to provide high quality person-centred care in challenging circumstances but unfortunately, a perception that access to General Practice is poor and difficult, is widely reported (such as in this news paper article[22]).

This is also at a time when General Practice is under increasing pressure with increased demand for services for a number of reasons: the residual impact of the pandemic on hospital waiting times; an increase in mental health issues and other health issues such as respiratory infections; an aging demographic; people living longer with multimorbidity and more care being transferred from hospital to primary care; alongside an increase in people's expectations of healthcare services.

Concerned that this perception of General Practice was damaging general practice and primary care, the then Cabinet Secretary for Health and Social Care wrote to all General Practices across Scotland on 15 November 2022 announcing the formation of the General Practice Access Short Life Working .

> "The group, jointly led by Dr Scott Jamieson, a GP Partner and Quality and Safety Fellow, and Fiona Duff, an experienced Primary Care and Practice Manager, aims to understand the challenges and issues affecting access to General Practice and will establish high level core principles to support and enhance patients' experience of accessing 'The Right Care, Right Time, Right Place'."

[22] Scottish Daily Express article regarding General Practice Access

Access to General Practice continues to be a highly emotive subject and has been for many years. It is a topic of discussion by all health and social care staff, people and service users, their families and carers, wider society, politicians, policy makers and the media. There is seldom commonality of definition of what access is or what it should deliver. 'Appropriate access' is not universally understood and on the back of a pandemic which revolutionised practice processes, it is sensible to consider exactly what we aim to deliver from a limited, but critically important part, of our National Health Service in Scotland.

There is a sparsity of evidence or policy, especially post-pandemic, regarding what General Practice access should deliver or how this is best achieved. We know, contrary to some perceptions, some people in certain situations value continuity over speed of access and are willing to accept a longer wait for a clinician they know over rapid on the day of access (Gerard K, 2008). Continuity of care reduces the burden of illness and mortality and is especially important to prioritise for those groups who may be less vocal in expressing their needs e.g., those with complex long-term conditions, those with mental health conditions, those with complex health and social care needs. This is key to any service delivery model. British Journal General Practice Feb 2022[23] has several articles outlining how continuity reduces Out of Hours use, improves mortality and reduces acute hospitalisation. Royal College of General Practitioners (RCGP) also has a Toolkit to improve continuity[24].

[23] BJGP article regarding continuity of care effects with continuity of care
[24] RCGP E-Learning continuity toolkit

4. General Practice Access Short Life Working Group and Workshop

The General Practice Access Group met remotely for the first time on Thursday 17th November 2022. The meeting agreed the terms of reference for the group (**Appendix 1**), including the scope of the group and the process for developing Access Principles to capture the voice of General Practice teams, clinicians, Health Boards, HSCPs, professional bodies, other key stakeholders, and people.

To gather the breadth of input required, a workshop (on Microsoft® Teams) was held to explore what the Access Principles should be for General Practice from the practice teams' and clinicians' perspective.

The workshop began by setting out the purpose of the workshop and confirmed what was in and out with scope. These are outlined below:

Within Scope:

- All General Practices across Scotland
- All people, citizens

Out-with Scope:

- The needs of particular groups of patients
- Finding answers/ solutions to access
- Fixing demand and capacity issues in General Practice

Areas are out of scope, not because these issues are not important, but to maintain focus on what was going to be a complex issue.

Chris Corkish, a representative of the RCGP Scottish Patient Forum and patient representative on the group, shared some personal reflections on access from a number of people's perspectives. It was noted that there would be separate work to ensure the people's voice would be heard and included in the principles (see 5. People Engagement).

The workshop was then split into three parts.

- An initial whole group discussion to define access and explore what 'bad access' looks like.
- Eight break-out rooms with 8-12 people in each to review access across a 5-step person journey.
- Summarising this together from the practice and person perspective considering the challenges, successes and ideas relating to steps in the access process.

We used Microsoft® Teams and a Miro® interactive white board to capture the contributions.

4.1 Defining access

In terms of General Practices, provided the following feedback.

By more common terms, 'access' as a noun is defined by the Cambridge Dictionary as:

"the method or possibility of getting near to a place or person" or "the right or opportunity to use or look at something."

As a verb: "to be able to get to or get inside a place."

The main themes to define access in terms of General Practice included:

- Access is a journey of multiple routes
- Access is a way for people to get the help/care they need when they need it
- Care and how it is accessed should be appropriate (although who and how do we define what is appropriate?)
- Access should be easy, clear, transparent and people should understand how to access the care they need, so they can effectively use services
- Care should be accessed at a mutually agreeable time (for both the service and service user)
- Access should be "Fair for all"
- There should be a single point of contact for people
- Information on services should be easily available
- "I am taken seriously and listened to"
- A person's expectations for care are met (good clinical outcomes)
- Timeliness of availability should be suitable

From these themes and taking into account the feedback of the group, Access for the purposes of this work is defined as:

> "**the method by which people can get to the appropriate clinical care that they need, when they need it."**

4.2 What does bad Access look like?

Thinking of the worst possible process can help directly identify the solutions for each step of a problem. This is known as a TRIZ (Theory of Inventive Problem Solving[25]) process. It encourages reflective abstract thinking.

In this case, we considered access from the practice and the person's perspective. Although it is meant to be purely theoretical, it is there to encourage courageous thinking and how we would challenge or confront the worst processes we could imagine. Like the definition process, all participants did this as a single group.

The scenario discussed was 'Stephanie has IBS [irritable bowel syndrome]. Her symptoms have been worse of late. She calls the practice on Monday.'

The questions asked:

1. 'What would the worst access to care from practice perspective look like?'; and
2. 'What would the worst access to care for Stephanie look like?'

[25] Wikipedia explanation of TRIZ theory

The main themes of worst access included:

- People don't know or understand the system and how to use it
- People are unable to get through on the telephone (for a variety of reasons)
- The Practice tells people what it cannot do rather than what it can
- People's perceptions of need/ capacity discourage them from accessing care
- Uncaring and negative response from practice staff
- General Practice does not understand or respond to a person's needs
- People are not aware of other forms of accessing help such as NHS Inform

4.3 The Five Steps

In 2013, the International Journey for Equity in Health published Patient-centred access to health care: conceptualising access at the interface of health systems and populations[26] Levesque proposed a framework of person-centred access to health-care. From Levesque's model, the group considered access and access improvement in five steps from two different perspectives – that of the person (service user was Levesque's term) and that of the General Practice. In each step the group looked at the challenges, ideas, and successes we have experienced.

	Practice Side	**Service User**
Question 1	What does good approachable care look like?	How do I put better support around me to improve my health?
Question 2	What does acceptable access look like?	How I seek and access the care I need?
Question 3	What does availability of access to care look like?	I successfully reach the care I need.
Question 4	What does inappropriate deliverable care look like?	What Personal 'cost' can there be or me to access healthcare?
Question 5	What does inappropriate access to care look like?	How do I put better support around me to improve my health?

A summary of the main themes from the discussions on each question is available in **Appendix 2**.

From reviewing the responses to the five questions above, we identified the following common areas as key themes to be considered in the development of access principles:

- Ease of access (convenient, timely, flexible)

[26] Equity Health article regarding access to Primary Medical Care.

- Maximise the use of technology/digital, multiple channels to single point of access
- Care navigation and role of the receptionist
- Understanding the role of the MDT and it is not just the GP
- Equity and ‘Fair for all’
- People’s understanding of the system, availability of information (health literacy, digital exclusion)
- Urgent care versus routine care
- Want versus need
- Demand versus capacity
- Preventative and proactive versus reactive
- Variation versus standardisation

5. People Engagement

The Healthcare Improvement Scotland (HIS) - Community Engagement team gathered feedback from the public through face-to-face interviews and group discussions. The team also emailed a short electronic survey to all members of the Citizens' Panel. This work was conducted in March 2023. A link to the full report is in **Appendix 3**.

5.1 Face to Face and Group feedback

Healthcare Improvement Scotland - Community Engagement offices gathered views using a mix of face-to-face interviews and group discussions. In total, thirty people shared their feedback. The team recruited people from community groups including Patient Participation Groups in Tayside and Ayrshire, Coll Collaborative Group, NHS Western Isles Patient Panel, South Lanarkshire Health & Social Care Forum and Chance to Change Group (Glasgow).

When the team asked participants what mattered to them about accessing a general practice, they said it was important to be able to contact "the right person" and being able to speak to someone or access services when they needed to. They stressed the importance of getting "timely support" whether that be from the GP or another member of the MDT. There were issues raised about timely access via telephone, appointment availability and concerns about confidentiality.

Participants discussed what good access would look like and compared this to where it would, in their opinion, fall short.

Participants considered the Scottish Government's draft principles and overall, they felt that they were positive and much needed. There was some feedback about accessibility and the language used and this is documented in the full report Appendix 3. The participants considered each of the principles in turn and the feedback captured.

Participants felt the principles were "good, clear, concise and easily understood," providing some of the terms and wording was changed to add clarity. Some participants though felt the principles were "too clinical and operational" and questioned whether they would be meaningful to all people. They also felt that there needed to be monitoring of the implementation of the principles and there should not be a reliance on patient complaints to assess whether they were working or not. Participants expressed the need for choices for accessing services should be more available for everyone and recognition that not everyone had or could access a telephone or IT (digital) facilities.

Some participants said that it was "quite disheartening" to know that ways of working were not as described by the principles already. They felt the principles needed to be in Easy Read and Plain English and others wondered whether the principles were aimed at professionals or the public because of the way the principles were currently worded and not easily understood by people.

Within the discussion participants considered what a practice meeting all the principles would look like and said that it would be one which was:

> "accessible, equitable, flexible, inclusive, responsive, approachable, welcoming and non-judgemental."

People needed information about "who does what" within the practice – one participant said that a lot of people do not understand who the different staff were nor how to access them.

Whilst the discussions centred on gathering views on the draft principles, it was clear that there was an appetite to discuss how people can access general practice services, more generally, and a real willingness to share their experiences.

5.2 Feedback from Citizens' Panel

Following the face to face and group work described above, the team emailed a survey to all 938 existing panel members for whom HIS hold email addresses. The team received a total of 449 responses (48% response rate) by email. This level of return provides data which is statistically robust at national population level and representative of sex, age, deprivation, and housing tenure.

The survey opened by asking respondents what they believe matters most when accessing their general practice. Most important to panel members was:

1. being able to access appropriate care in a reasonable time (45%),
2. followed by a reliable appointment system (31%)
3. and appointments with appropriate healthcare practitioners (26%).

The team asked respondents for their opinions on the main principles to accessing their General Practice and whether they agree or disagree with them. Almost all respondents agreed or agreed strongly with each of the principles with respondents being most likely to strongly agree that access to General Practice for people should be easy, clear and fair and at a time in keeping with need (89%). Slightly fewer respondents strongly agreed that General Practices should help people to be seen by the best and most appropriate person (85%) or that people should have a reasonable choice about how they access services, and that services should be approachable, sensitive, and considerate to needs (77%).

The team showed panel members a list of principles and statements and asked which were most important to them. The three principles which panel members identified as being most important were:

1. When appointment availability is limited, General Practices should ensure that those with the most urgent care needs are met (72%).
2. People and General Practices should have a positive and trusting relationship (66%).
3. People who live with frailty and health needs must have a known and trusted member of the General Practice team aligned with their care (60%).

Most panel members (59%) agreed fully that the principles were clear and understandable and a further 38% agreed somewhat. Only 3% felt that the principles were not clear and understandable and 1% were unsure.

The team asked those panel members who said the principles were not clear or understandable how the principles could be improved. Around a third of comments were where respondents felt the principles should be clearer (33%), and a further 21% felt they should be understandable to everyone. Other suggestions were for the team to provide examples setting out what the statements mean (18%) and where they questioned what the statements mean in practice (17%).

The team asked all panel members if there was anything else they would like to see included in the principles or statements. Over half of respondents who answered said there was nothing else they would like to see included (54%). The most common suggestions were regarding lengthy waits for appointments or on the telephone (10%), accessing appropriate care (9%) and regarding the role of receptionists as gatekeepers (6%).

Finally, the team asked panel members how they think General Practices should raise awareness of when people should use the services of the MDT rather than the GP. The most common response was that information should be provided on the General Practice website (54%) and this was followed by information made available at the General Practice, for example via leaflets or posters (50%) or directly from the receptionist (44%).

Recommendations

Based on the feedback above, it is recommend that:

- General practices across Scotland are encouraged by Scottish Government and professional leaders to increase the involvement of people in changes to services.
- General practices look towards the development of new ways, systems and processes for capturing people's experience particularly in the design of services and change ideas.
- As a matter of course, General Practices use the Access Principles when engaging with their practice population.
- Scottish Government and HIS – Community Engagement considers whether a further Gathering Views exercise on access to General Practice services would be beneficial in the longer term.

6. The Final Principles

Following the work described above involving key stakeholders and the engagement with the public through the HIS Community Engagement Team, we have agreed the following four high level overarching main principles, and ten more detailed supplementary principles.

1. Access to General Practice is inclusive and equitable for people, based on the principles of Realistic Medicine and Value Based Health & Care, Care will be person-centred and based on what matters to the individual.

2. People should have a reasonable choice about how they access services.

3. Services should be approachable, sensitive, compassionate, and considerate to need.

4. General Practices should help people to get the right care from the best and most appropriate person or team to care for them (Right Care, Right Place, Right Time).

Supplementary Principles

a) People should be enabled and supported to maximise their own health and wellbeing through:
   - Self-management of their condition
   - Using online resources such as NHS Inform[27]
   - Accessing other primary care services where these are suitable such as their local Community Pharmacy, Optometry (Opticians) or Dentists

b) When capacity and appointment availability is limited General Practices' should ensure that those with the most urgent care needs are met.

c) Methods of access to General Practices teams should be clear, understandable, and transparent for people to access the right service for their needs.

d) The role of trained practice administrative staff (receptionists) to help people find the most appropriate service (both within and out with the practice) to meet the person's needs, is the norm (sometimes called Signposting or Care Navigation). More Information about Care Navigation is available from Care Navigation Toolkit – Care Navigation Toolkit (ihub.scot)[28]

e) Receiving care from the wider General Practice team (other than the GP) is the norm (sometime called the multi-disciplinary team (MDT)).

f) People should be able to understand and trust the different roles in General Practice and wider MDT team and that they won't always need to see a GP (doctor)

[27] NHS Inform website
[28] Care Navigation Toolkit

g) People who have complex health needs or who live with frailty should be supported to receive continuity of care through a known and trusted healthcare professional or team (more information on continuity of care is available from the Royal College of General Practitioners[29]).

h) General Practice should be delivering holistic healthcare (the treatment of the whole person), considering psychological and social determinants of health, rather than just the symptoms of illness.

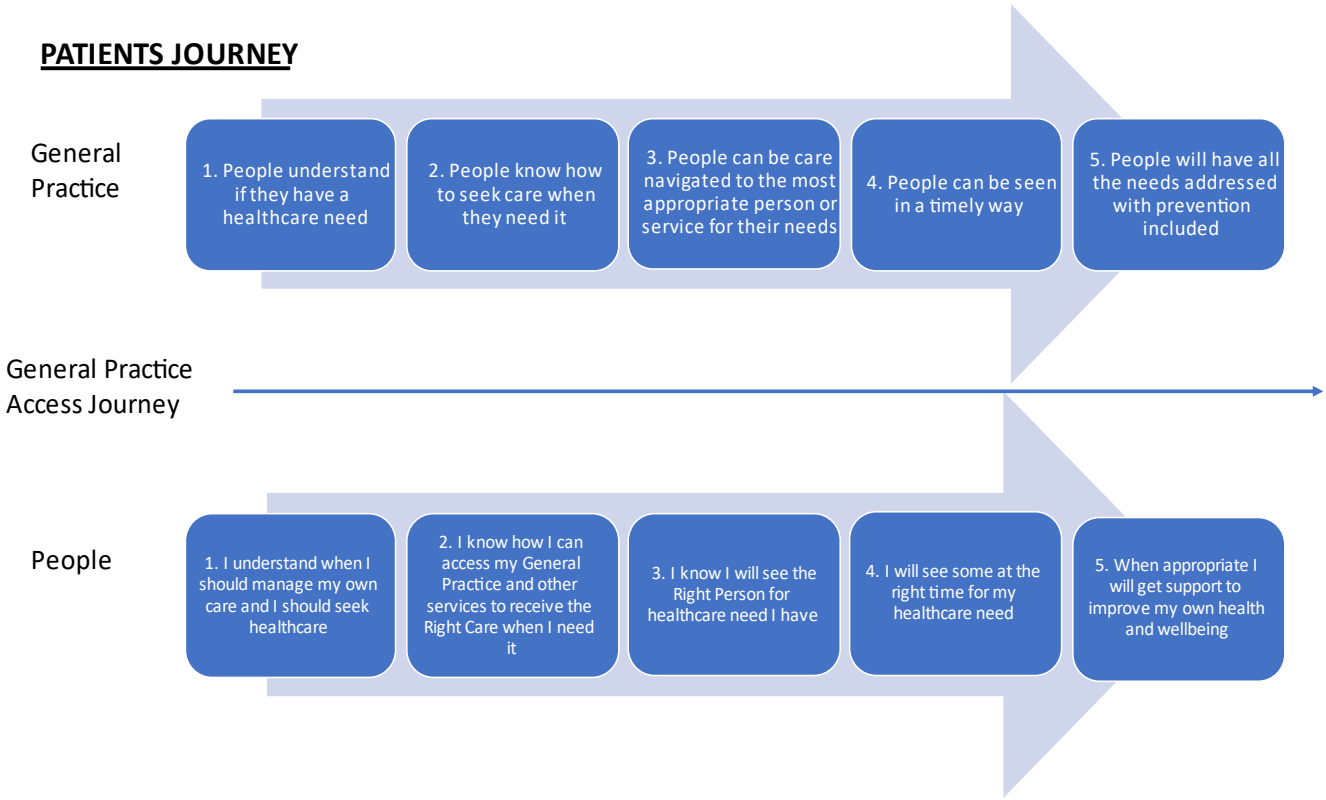
i) People should have a positive and trusting relationship with their General Practice team. Practices should actively seek, welcome, learn and act upon feedback (formal and informal) from people about their experience of accessing care.

j) General Practices will use digital resources (Information Technology), where appropriate and when people choose, to meet people's needs. The needs of people who struggle with digital technology will also be considered and addressed by General Practices.

[29] RCGP Blog – Continuity of Care

7. Ongoing work

Focussing on the 5 steps (section 4c) of a person's journey to access the care they need may help General Practices to consider what changes they could make that could have a significant positive impact on a person's access experience.



*Graphic demonstrates the journey for General Practice to delivering good access to Primary Care and for people. These are aligned to demonstrate the 2 perspectives for each consideration. People and patients both understand when they have a healthcare need and when to seek advice on this. There is awareness of how patients can access the care they need and be seen by the right person for this need; They will be assessed in a timescale that is appropriate for the healthcare need and their needs will be addressed and supported, including preventative measures (where appropriate)

A number of national initiatives to support and improve access in General Practice are already in progress or planned. Some programmes span more than one of the five steps and all have the aim of achieving 'better access' underpinned by the Access Principles. This work includes but is not limited to the following:

1. Continuation of Scotland's HIS Primary Care Access Programme (PCAP) which has been developed and rolled out since August 2022. Approx 100 practices to date have participated or are participating in this improvement work over a seven

week ‘sprint’ to improve access in their practice. Cohort 4 is now complete with Cohort 5 planned for the Autumn.

2. Sharing of case studies, good practice examples and other resources developed with practices who have participated in PCAP/associated relevant Access improvement programmes (HIS).

3. The Developing General Practice Managers and Administrative Staff roles group has worked collaboratively with NHS Education for Scotland (NES) to develop a Core Competency Framework for general practice staff[30]. The framework was published by NES in September 2023. Part of this work includes prioritising the development of a number of training programmes and modules for practice administrative staff by NES. This work will begin with Communication Skills and Care Navigation. The first of these resources will be available for practices in Autumn 2023.

4. With the switch from analogue to cloud-based telephony systems in 2025, Practice Telephony Guidance is being developed by Scottish Government to support general practices improve their communication systems, while at the same time ensure they are fit for the future and meet the needs of the public.

5. Continued rollout by Scottish Government and HSCPs of the Primary Care Improvement Programme (PCIP) to recruit and embed the MDT in primary care.

6. Funding has recently been made available to HSCPs to support the reintroduction of protected learning time (PLT)[31] to support team training and development in General Practice. Improving Access is one area which General Practices could consider during their PLT.

7. NES and Scottish Public Services Ombudsman (SPSO) are working together to improve processes for learning from peoples’ feedback and the management of complaints in General Practice.

8. Remote solutions for monitoring of long-term condition such as high blood pressure as well as the ongoing work for NearMe (video consultations) for remote consultations continues to be spread across Scotland.

9. Supporting the introduction of group consultations in primary and secondary care settings.

10. Further development of GP.scot to improve communication between General Practices and the public through General Practice websites.

11. Support to maximise the use of digital technology including online appointment booking, prescriptions ordering, online reviews where appropriate and Digital Asynchronous Consulting (DACs).

[30] Scotlands Health on the Web publication regarding competencies.
[31] Scotlands Health on the Web circular regarding Protected Learning Time in General Practice.

12. Other national initiatives include the Scottish Government's 'Inclusion Health Action in General Practice' project which is providing funding and resources to General Practices in NHS Greater Glasgow & Clyde to help them address barriers to accessing and engaging with primary care that are associated with health inequalities. Learning from evaluation will be shared by the Scottish Government to help develop and enhance services in other areas.

13. Primary Care – In-hours General Practice Activity Visualisation[32] is now published by PHS to evidence the volume of overall work done across General Practices in Scotland. A Practice based activity dashboard is currently being rolled out by Public Health Scotland (PHS) to practices across Scotland to give them real-time activity data.

14. On-going public messaging to support people's understanding of how the healthcare system works, including General Practice and the expansion of the MDT. Further promotion of NHS Inform[33], Pharmacy First[34] and other services as the first port of call for healthcare advice before contacting General Practice.

[32] Primary Care, in hours activity
[33] NHS Inform website
[34] NHS Inform – Pharmacy First information

8. Conclusion

Many General Practices across Scotland already provide a high quality of care with access delivered in line with the principles above. However, this is not every person's experience of accessing care, and the stress, worry and anxiety that this can cause to people, families and carers can be considerable.

The Access Principles will only improve access to care for people if they are applied by General Practices, Health Boards and the Scottish Government across Scotland in a sensible and pragmatic way, ideally but not limited to, using quality improvement methodology and supported by a range of resources to make them achievable.

That said, we understand that many General Practices are under significant pressure at this time and feel that they do not have the capacity, both operationally and clinically, to significantly change the way they work. We certainly would not expect practices to do more, in the sense of providing more appointments or time with clinicians, as the welfare and wellbeing of the General Practice team is also a high priority. However, it may be helpful for practices to take cognisance of the feedback they receive from the public and make small changes to improve access, wherever that is possible within existing resources.

We would also like to reiterate again that General Practice will not be monitored or measured against the Access Principles by Health Boards as they are not quality standards. We hope that General Practices will recognise these principles in what they already do on a day-to-day basis to meet the needs of their patients. General Practices and GP Clusters should consider the principles collaboratively and learn from each other and share examples of how they have applied the principles in their practices.

We are also not suggesting that it is the responsibility of General Practice alone to apply these Access Principles to improve people's experience of accessing care. General Practices, GP Clusters, HSCPs, Health Boards and other parts of the system can use the principles as a benchmark of what good access to all health care services should look like.

General Practices should also continue to actively seek, welcome, learn and act upon feedback (formal and informal) from people about their experience of accessing care.

We have been encouraged by the significant number of practices who, even in difficult times, have signed up to the HIS PCAP. Primary Care Access Programme - Primary Care Access Programme (ihub.scot)[35] The experience from these practices has shown the power that small changes can make to a system or process. The support provided by the HIS Quality Improvement advisors has proven invaluable to practices to think differently about how they do things, even in challenging times. We highly recommend this programme to any General Practice which is considering making changes to their access arrangements.

[35] Primary Care Access Improvement Programme

Whilst acutely aware of the very significant challenges that General Practice is under at the current time, we would like to encourage all General Practices across Scotland to take this opportunity to reflect on how their patients currently access care and how they could use the principles set out in this document as best practice that we should all aspire to. Small changes can make a big difference and one of the huge strengths of general practice is its ability to adapt and change quickly and flexibly.

We would like to thank all those who kindly helped contribute to this report and we will ensure that this issue remains 'live' to support continuous improvement in this key area of people's care, using the principles and structure set out in this report to underpin the future ongoing approach.

Dr Scott Jamieson
General Practitioner
Kirriemuir Medical Practice
NHS Tayside

Fiona Duff
Senior Advisor
Primary Care Directorate, Scottish Government

9. Appendix 1

Short Life Working Group Terms of Reference and membership

Aims

Understand the challenges and issues affecting access to General Practice and where required improve access to General Practice to support and enhance the people experience of accessing the '**Right Care, Right Place and Right Time.'**

9.1 Outcomes and Deliverables

1. Identify all the programmes of work currently in progress across the system that impact on access in General Practice (both positive and negative).

2. Develop Good Access principles for General Practice and people based upon best evidence and data where available.

3. Share agreed Access principles with the wider system including across Scottish Government and external stakeholders to develop a greater understanding of access to General Practice and a consistency of approach by programmes and initiatives.

4. Endorse and disseminate resources to stakeholders to support improvements in Access in General Practice such as the Primary Care Access Programme (HIS) and the Developing roles for Practice Managers and Administrative staff (NES) work and support the development of new access resources as identified by the group.

5. Identify any gaps and support required to improve access for people with particular consideration to priority Scottish Government areas such as Health Inequalities, Carers, Women's Health, Dementia, Veterans, Rural etc in line with SG strategies including Realistic Medicine, GIRFE, PPC etc.

6. Identify the links between Access and other issues/ workstreams such as Sustainability, Digital, Winter Pressures, Urgent and Unscheduled Care, Public messaging to ensure a greater understanding and consistency of approach.

7. Consider how primary care activity data can be used to understand and support access arrangements and improve people's experience.

8. Consider how this groups can work with and influence the wider system re the role of General Practice and the impact of work being passed from the wider system inappropriately to General Practice

9. Review the impact of the above and consider next steps.

9.2 Scope

Peoples access to all General Practices in Scotland is within the scope of the group.

Out with the scope of the group is issues affecting capacity in general practice such as workforce issues, issues affecting general practice sustainability, Protected Learning Time and work focussed on individual workstreams/ strategies.

9.3 Membership

Chair – Fiona Duff, Senior Advisor, Scottish Government
Dr Scott Jamieson, General Practitioner (Co-chair)

Royal College of General Practitioners -
Dr Mary Ann Burrows, GP
Dr David Shackles, Joint Chair RCGP Scotland
Dr Chris Williams, Joint Chair RCGP Scotland

Scottish General Practitioners Committee (BMA) -
Dr Andrew Cowie, Deputy Chair
Dr Patricia Moultrie, Deputy Chair

Health & Social Care Partnerships (HSCPs) –
Lorna Kelly, National Strategic Lead for Primary Care

Primary Care Leads - Clinical –
Dr Helen Hellewell (NHS Fife)
Dr Scott Williams (NHS Forth Valley)

Primary Care Management Leads –
Louise McCallum (NHS Forth Valley),
Michelle Taylor (NHS Western Isles),

Patient Representative – Chris Corkish, RCGP Patient Forum

NHS Education for Scotland (Practice Managers Network) –
Tracey Crickett, National Lead
Jan McCulloch, Practice Manager, Barns Practice, Ayr

Healthcare Improvement Scotland (HIS) –
Primary Care - April Masson & Belinda Robertson
Community Engagement Team - Christine Johnstone, Gary McGrow, Tony McGowan

Scottish Government, Primary Care Directorate –
GP Contract team – Andrew Chapman/ Michael Taylor / Nikki Rae
Sustainability – Nick Smith
Data & Digital – Sarah Lowry
Urgent and Unscheduled Care – Dr John Freestone and Dahrlene Tough, Scottish Ambulance Service
Professional Advisors - Kathy Kenmuir, Senior Nurse Advisor, Primary Care Directorate

10. Appendix 2 - Output from the workshop

i. What does good approachable access to care look like? How do I perceive approachable access to care?

- Convenient/ Easy
- Maximising the use of technology, digital, virtual, social media, text, Near Me (while aware of digital exclusion)
- Information easily available e.g., practice websites (health literacy)
- Patient choice e.g., digital v traditional (multiple methods)
- Patients have knowledge/ information of options and how to access them
- Approachable
- Improved perception, improved relationships, increased trust, improved communication, increased confidence
- Meet unmet need (want v need)
- Manage demand and capacity
- Sensitive
- Care Navigation
- Timely/ responsive
- Appropriate/ correct care
- Manage patients expectations/ increase patient satisfaction
- Self-Management
- Fair for all/ Equitable
- Reduce variation
- 24/7
- Practice culture of saying yes not no
- Clear principles and standards for good access
- Value team, including the role of the receptionist

ii. What does acceptable access look like? How do I seek & access the care I need?

- I can get through on the telephone
- Multi-channel access
- Care Navigation
- Consistent offer/ choice
- Flexible
- Alternatives available
- MDT (understanding of, does not always need to be a GP)
- Equitable
- NHS Inform (content still very GP focussed)
- Satisfied with service
- Understandable
- Trust in the service
- Expectations
- Whole system
- Ease of registering with a practice

iii. **What does availability of access to care look like?**
How do I successfully reach the care I need?

- Wellbeing of staff
- Care Navigation
- Less complaints
- Meeting need
- Appropriate care
- Continuity of Care
- LTC management
- Urgent/ routine care
- Role of reception staff
- Expectations
- Preventative and initiative-taking
- General Practice is open
- Role and understanding of MDT
- Clear Pathways
- Services local/ close to home
- Timely

iv. **What does realistically deliverable care look like?**
What personal 'cost' can there be for me to access care?

- Education/ Knowledge/ information
- Some variation OK
- Effective
- Minimal harm
- Understand demand v need
- Honest
- One medical record
- Perceptions
- Professionalism and integrity
- Timely
- Receptionist role
- Transparent
- Digital
- Initiative-taking and Preventative
- Trusted
- Demographics
- Emotional cost, anxious
- Financial cost, telephone, travel, work

v. **What does inappropriate access to care look like?**
How do I put the right support around me to better my health and utilisation in accessing the appropriate care?

- Knowing what patients want

- Wrong part of system
- Gaming the system
- OOHs / NHS24
- Shouting the loudest
- Lack of access to other services
- Service not convenient e.g., phoning at inconvenient time
- Mandating they must use a service e.g., DACs
- Multiple channels – confusing
- Preventative
- Social factors
- Responsibility for own health

11. Appendix 3 – HealthCare Improvement Scotland: Gathering Views and Citizens' Panel for health and social care

The Healthcare Improvement Scotland report can be found online.

12. Appendix 4 References from footnotes.

1. Link to report completed by HIS investigating public perception of General Practice Access proposed principles.
2. Care navigation toolkit
3. Workflow optimisation toolkit
4. Details of PCAP programme
5. Lancet publication on Inverse Care Law
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7. OED definition of “Triage”
8. Scottish Health and Care Experience Survey (HACE)
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11. General Practice List size and Demographics
12. General Medical Services Contract (2018)
13. The National Health Services (General Medical Services Contracts and Primary Medical Services Contract 17C Agreements) legislation
14. Patient Right’s (Scotland) Act 2011 legislation
15. Scottish Public Services Ombudsman Complaints Handling Procedure
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17. Registration Guidance to General Practice
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21. General Medical Services Contract (2018)
22. Scottish Daily Express article regarding General Practice Access
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25. Wikipedia explanation of TRIZ theory
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33. NHS Inform website
34. NHS Inform – Pharmacy First information
35. Primary Care Access Improvement Programme

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