External Review

Access and capacity of Riverside Medical Practice LLP & Associated Services – September 2022

River Esk, Musselburgh

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1. Executive Summary

The purpose of this independent and external review, commissioned by East Lothian Health and Social Care Partnership (ELHSCP) is:

- to understand patient concerns regarding access to health care services provided at Riverside Medical Practice (RMP), Musselburgh and associated services and
- to identify opportunities to address these concerns.

The catalyst for this review was the volume of concerns and complaints raised by the people of Musselburgh registered at RMP. Led by Dr Dorothy Armstrong, the Review Team comprised Fiona Duff, an experienced primary care and practice manager, Dr Scott Jamieson, a GP Partner and Quality and Safety Fellow and Dr David Shaw, a GP partner and Primary Care Associate Medical Director.

Throughout the process, the Review Team used a values-based approach where the principles of independence and transparency; dignity and respect; and care and compassion were paramount. The Review Team used a range of ways to gather information about the access and capacity of RMP and associated services provided by the ELHSCP. This included:

- reviewing anonymised complaint letters sent to local MSPs
- patient focus groups
- an online form
- meetings/interviews with various Riverside Medical Practice staff – GP partners, managers, call navigators
- observations of call handling
- meetings/interviews with other health and care staff
- reviewing and comparing data about Riverside Medical Practice in relation to other general practices across Scotland/UK, also called benchmarking.

Information and data gathered highlighted challenges in the following areas:

- accessing appointments with GPs in particular
- flexibility of the appointment system
- capability and capacity of the phone system
- operation and understanding of the triage system
- obtaining prescriptions/repeat prescriptions in a timely manner
- continuity of care provided
- communication and engagement with patients, the community and other health care professionals/teams
- management of feedback and complaints and their use in driving improvements
- public awareness of the "new" roles in primary care and the contribution of other health care professionals
- accountability and quality control systems in place regarding general practice

The Review Team have concluded that several improvements can be made to improve access to health care services provided at RMP. The Practice must take direct action to implement improvements. Other improvements require the support and involvement of ELHSCP and more widely, NHS Lothian.

Because the review team found no apparent gaps in staffing or financial resources, the obvious route to improving access and capacity is by improving the efficiency and effectiveness of the systems in place. This will best be achieved by RMP working alongside ELHSCP. The most pressing need for improvement relates to patients being able to access an appointment with a healthcare professional and in particular a GP.

Improvements can be best achieved by focussing on providing a positive experience at every stage of the patient's journey. Above all, a fundamental aspect of this improvement process is to restore trust, confidence and good relationships between RMP and the community it serves.

The Review Team have made seventeen recommendations which are outlined in greater detail in section 10. These recommendations require action from RMP, ELHSCP and NHS Lothian.

2. Introduction

This independent, external review commissioned by Alison MacDonald, Chief Officer of East Lothian Health and Social Care Partnership (ELHSCP), was in response to over 300 complaints to MSPs about access and capacity to Riverside Medical Practice LLP (RMP) and associated ELHSCP services.

The Scottish Public Services Ombudsman (SPSO) recognises

> *"Handled well, complaints provide a low cost and important source of feedback and learning for organisations to help drive improvement and restore a positive relationship with customers who feel let down by poor service. Handled badly, they erode public confidence and trust in public services."*

ELHSCP prepared a Scoping document which was agreed with all stakeholders (Appendix 1) and the Review Team was assembled (Appendix 2). We considered our task from three angles: the patient perspective, the practice perspective and the partnership (ELHSCP) perspective.

A key part of the review was listening to the patients of RMP. It was both humbling and poignant to hear, first hand, the accounts from patients about their experiences both positive and negative. We are immensely appreciative of the courtesy and commitment from those people who participated in the focus groups online, in person and the on-line survey (Appendix 3). Thank you.

We are also grateful for the professionalism demonstrated by the staff at RMP and associated services delivered by ELHSCP. We met with staff in person and online (Appendix 4) from RMP and ELHSCP providing services to the community including the Care When It Counts (CWIC) team who provide same-day care for patients at RMP and other practices in ELHSCP. We recognise the extraordinary impact of the Covid-19 pandemic and how clinicians and support staff were subject to significant challenges in delivering healthcare for the community.

Our findings are presented in this Report. In essence, our work indicates access to healthcare professionals needs to be improved. It is the opinion of the Review Team that the current systems are cumbersome, difficult to manoeuvre for patients and overly complex. Being able to access a healthcare professional both for an urgent, same-day or pre-bookable appointment should be person centred, compassionate and clinically informed. Complaints should be welcomed as an opportunity for improvement.

We are very encouraged by the progress RMP have already made in adopting some of our early suggestions and feedback. There is more work to be done and we trust this Report offers helpful insights, suggestions, and resources to enable change so the citizens of Musselburgh can experience improved access to healthcare services in the community.

Finally, I wish to thank the members of the Review Team: Fiona Duff, Dr Scott Jamieson and Dr David Shaw for their wisdom, integrity, and warmth. It has been a privilege to work alongside them.

Dr Dorothy Armstrong

Lead, Independent Review Team

3. Overview and Key Findings

"A strong and thriving general practice is critical to sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities." (Scottish Government & British Medical Association, 2018)

1. The key findings of our review are presented using the Starfield Four Cs model: Contact, Comprehensiveness, Continuity and Co-ordination (Starfield, 1992). The model uniquely speaks of how "GPs see people in their holistic lived experience." The Four Cs has featured in Scottish Government policy, is widely endorsed and importantly puts the patients at the heart of the services they receive.

2. This Report features excerpts from the Community Engagement Report (Appendix 3), which is peppered throughout with illustrative quotes. We hope this gives the reader a sense of the stories behind the Report and illustrates the many points people shared with us.

3. There have been challenges and issues in Musselburgh General Practices for some time in relation to access and capacity. A number of changes and initiatives have been tried by NHS Lothian, ELHSCP and RMP to address these issues. The Review acknowledges taking over Eskbridge Practice in January 2018 has contributed to the difficulties faced by the Practice. Covid-19 also had a significant impact on all health and social care services across Scotland including CWIC and other services provided by the ELHSCP and NHS Lothian.

4. ELHSCP provide several support services to the patients of RMP including the Care When it Counts (CWIC) services (formerly known as Collaborative Working for Immediate Care). RMP believe that the reduced availability and daily allocation of CWIC appointments for RMP patients compared to the numbers that were set out in the SLA agreed in January 2018 is a key factor to their access and capacity issues.

5. In our benchmarking Chapter, we noted that the RMP appointment system encourages all patients to telephone at 8am to access an appointment as all patient-initiated appointments are only available on the same day.

6. Continuity of care is eroded when all appointments are given on the same day as patients cannot always book in with the doctor leading on their care. Re-introducing pre-booked appointments is a key recommendation of this Report. The Review Team are confident this change will positively impact on patient satisfaction, access and capacity. However, they note that RMP state this would be difficult to do without an increase in the availability of CWIC appointments. The Review Team would like to see the reintroduction of pre-booked appointments irrespective of the position with CWIC.

7. Same day appointments are given to those patients who managed to get through first. It is for RMP (working with NHS Lothian and ELHSCP where appropriate) to review their systems to include improved telephony and a more personal approach for patients accessing appointments and other services. A number of recommendations are made throughout the Report to address these concerns.

8. The view of the Review Team is that the benchmarking data indicates there should be sufficient clinicians to assess and treat the patients at RMP who need care based on current levels of demand. However, the systems were found to have inefficiencies and could be more person-centred.

9. Patients find it difficult to provide feedback and complaints to RMP, hence why many people have gone to their MSP or other routes. The complaints process should be accessible and used as a vehicle for learning and improvement. However, we recognise being on the receiving end of criticism and complaints can be challenging. Staff require education, training and support to respond effectively and with compassion.

10. The public are generally unaware of the contractual mechanisms by which General Practices are run and managed. RMP is a group medical practice run by four GP partners who hold a 17C contract for general medical services with NHS Lothian. This is a standard means of running a General Practice in Scotland usually known as an 'independent contractor' model. The practice is not owned by an external healthcare provider. Further information in Appendix 1A

11. We found many patients were unaware of the many changes that have happened across Scotland in the way primary care (including general practice services) is delivered including the role of the multi-professional team. We consider the publication of this Report an opportunity to enlighten RMP patients and the wider community about the many services available. It is for Scottish Government, the Health Boards, HSCPs and General Practices themselves to publicise more widely the many options available locally to ensure the citizens of Scotland receive the Right Care at the Right Time in the Right Place.

12. Growing trust and confidence between RMP and their patients can be harnessed by wider interaction, collaboration and engagement with the people RMP serves. A refreshed model of community engagement using a values-based approach will enable changes and improvements made to be aligned to what is important for patients and the community.

4. Background – History of the Practice

General Practice in Scotland

Riverside Medical Practice LLP is a General Medical Practice in Musselburgh, East Lothian with 19,622 patients (Public Health Scotland, 2022).

At the time of writing there are 913 General Practices across Scotland contracted to provide General Medical Services (GMS) to their registered populations.

Under a GMS contract (17J and 17C), practices have to be available to their patients from 8am – 6pm Monday-Friday (with NHS24 and the Out of Hours service available out with these hours). The contract also specifies the practice area or practice boundaries that the practice will accept patients from.

In 2018, a new Scottish GMS contract came into effect and included provision for the delivery of new services provided by the Health Board and HSCPs including

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

How these services are delivered was to be decided at local level between the Health Board and the Health and Social Care partnerships (HSCPs) with advice from the GP Subcommittee of the Area Medical Committee. General Practices are represented by the Local Medical Committees.

NHS Lothian is one of 14 Regional Health Boards in Scotland. Each Regional Health Board is divided into a number of HSCPs. East Lothian is one of four HSCPs within NHS Lothian. All partnerships are responsible for adult social care, adult primary health care and unscheduled adult hospital care. Within each HSCP there are GP Clusters. These are groups of practices who focus on improving the local quality of care. East Lothian West GP Cluster is the GP cluster that RMP is part of.

Riverside Medical Practice LLP and East Lothian HSCP

Riverside Medical Practice LLP is a General Practice located in the Musselburgh Primary Care Centre in Musselburgh. This is a purpose-built health centre which was originally designed to house three general practices and other health board run services. The CWIC (Care When It Counts) service (formally known as Collaborative Working for Immediate Care) and CTAC (Community Treatment and Care Services) are now based in the building where Eskbridge Practice was previously based.

Musselburgh historically has been served by three General Practices, with patients having the choice of registering at Inveresk, Eskbridge or RMP. Only two of these practices - Inveresk and RMP - remain. The population served by Musselburgh based practices has increased steadily over the period from 2004 to date from a little over 25000 patients in 2004 to around 29300 patients in 2022, an increase of approximately 17%. Patients who move to Musselburgh can register with either RMP or Inveresk if they live within the practice area. There is a local arrangement between the two practices as to which practice will accept new patients when.

During the period of 2004-2017, all three Musselburgh practices showed an increase in patient numbers, with the largest share moving to RMP (see table 1 below). This placed significant pressures on all three practices. Health and Care Experience Survey (Public Health Scotland, 2022) reports from 2017 showed all three practices struggled with access – with 20% of patients in Inveresk reporting difficulties in contacting the practice the way in which they wanted, 49% reporting the same in Riverside, and 47% reporting the same in Eskbridge. This is discussed further in the Benchmarking section below.

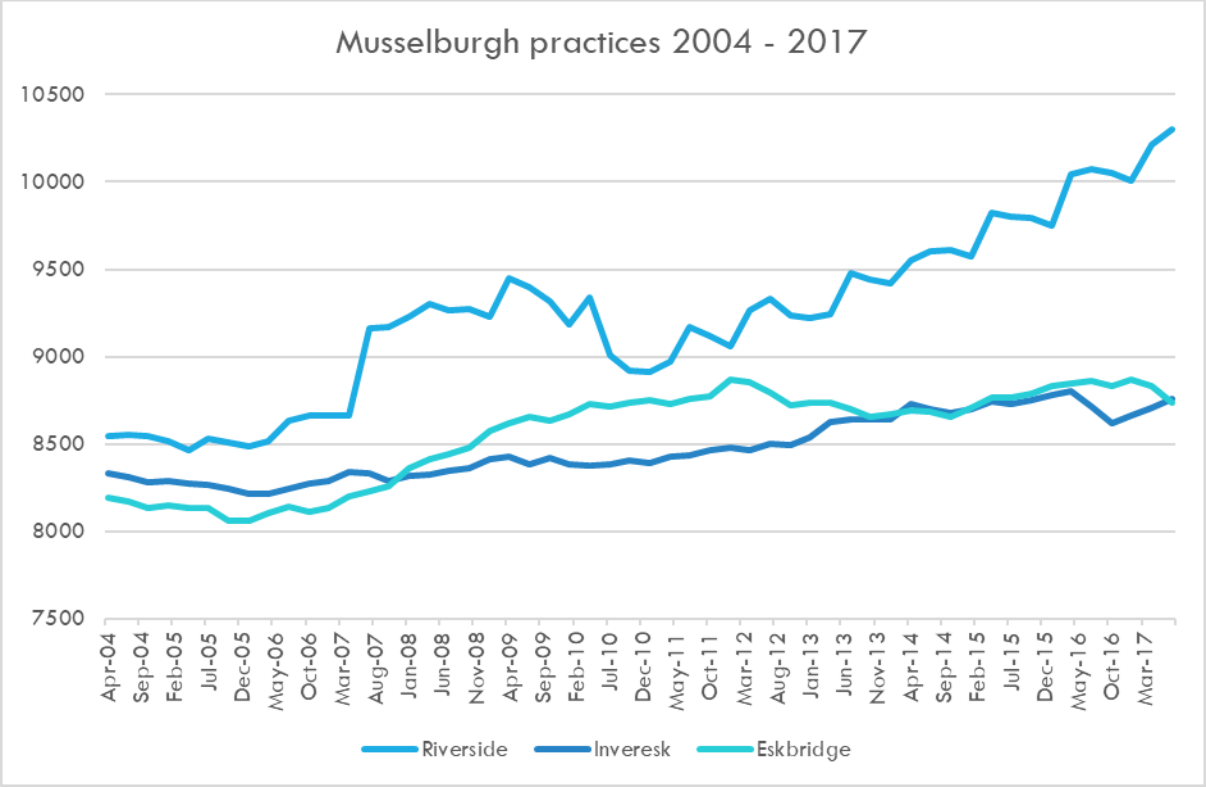

Table 1- Patients registered with Musselburgh Practices 2004-2017

There have been challenges in Musselburgh for some time in relation to access and capacity and several changes and initiatives have been tried by the Board, HSCP and RMP to address these issues. Below is a summary of the timeline of events and initiatives which have led to the current situation. This is a high-level summary of what has happened and is not an attempt to evaluate or review the different initiatives but help to give context and background to where we are today.

Timeline

2015 – Eskbridge GP Practice hands back their contract to NHS Lothian and ELHSCP takes over the management of the practice as a 2C practice. Eskbridge had approximately 9,000 patients.

2016 – Discussions begin between ELHSCP and RMP regarding the future of services and practices in Musselburgh

November 2017 – ELHSCP, RMP and NHS 24 partner together to pilot a new approach with key aims of:

- Providing access to 'same-day' care while reducing the numbers requiring same-day/ face-to-face GP consultations
- Supporting primary care demand through bespoke care navigation

- Raising patient awareness of alternatives in care provision

The 'Musselburgh Model' is implemented in January 2018 to serve the registered patients of RMP, with care provided by RMP, supported by NHS 24 and ELHSCP CWIC service. The CWIC service provides same day care for a broad remit of patients and undertakes to provide the practice with a minimum of 350 same day appointments per week. As set out in the Service Level Agreement (SLA), there are a number of patients who should not be seen by the CWIC service including medical emergencies, pregnant women, minor injuries, mental health issues and patients with eye or dental issues. Children can be seen within the CWIC service by a GP or Advanced Nurse Practitioner. This initiative is funded by the Scottish Government funded.

January 2018 – Riverside takes over the Eskbridge practice which was previously run by NHS Lothian with ELHSCP. This doubles the number of patients registered with Riverside to around 19,500 patients.

A new contract is put in place between Riverside and NHS Lothian which includes an agreement about the services CWIC will provide and the nature of the working agreement between CWIC and the practice. Additional funding to support this development is provided to Riverside. This agreement and accompanying SLA states:

"*Same day demand for general medical services will be dealt with by East Lothian HSCP's CWIC Service*"

(See Appendix 1A for further information on the agreement / SLA).

April 2018 – The new General Medical Services Contract is introduced across Scotland including plans to deliver wider multi-disciplinary teams models developed over the next four years.

2019 – Riverside establishes a Patient Participation Group.

ELHSCP develops other services including the Care Home Team, CWIC Mental Health Service, Musculoskeletal (MSK) Service, Community Treatment and Care Service (CTAC) and Pharmacotherapy Service (medicines management). CWIC Mental Health and MSK services are initially part of the main CWIC service but are later divided into separate services. The SLA is not revised to reflect this change.

December 2019 – A new telephony system is installed in the Musselburgh Primary Care Centre by NHS Lothian.

January 2020 – ELHSCP makes plans to roll out the 'Musselburgh Model' to other GP practices in the locality as it is has evaluated well.

March 2020 – The Covid-19 pandemic brings significant changes to the way all services, including General Practice, work across Scotland. All patient contacts have to be by telephone first with clinical assessment carried out by healthcare staff. Other infection prevention control (IPC) measures also have an impact on services, including access for patients to health service buildings, increased use of protective clothing (PPE), cleaning requirements etc.

In Musselburgh, provision of the CWIC service is temporarily withdrawn by ELHSCP as CWIC is redirected to become a COVID assessment centre. Again, due to the pandemic, NHS24 support is withdrawn permanently. It is at this point that the current same-day appointment system at RMP is introduced. RMP makes immediate representation to ELHSCP and then NHS Lothian Director of Primary Care about the impact this will bring for RMP patients.

March – Sep 2020 – The practice has to deal with significant upheaval including staff absence and sickness levels. A significant number of support staff (call navigators) leave the practice at this time putting considerable pressure on the remaining team.

July 2020 – The CWIC service is reinstated (although not to the pre-pandemic level of appointments) alongside MSK and CWIC Mental Health services.

Sep 2020 – Demand on the practice increases as services are re-opened. The number of complaints to the practice begin to increase at this time. Discussions begin with ELHSCP about providing winter pressure support, as outlined in the practice's contract

Autumn 2020 – The practice begins to deliver Winter Flu vaccinations to over 65s (while ELHSCP's vaccination team administers flu vaccines to the under 65s). Riverside's system begins to struggle with the volume of calls to book vaccination appointments, putting additional pressure on the practice and resulting in an increase in complaints. ELHSCP establishes a phone line to take calls on behalf of the practice.

Jan 2021 - RMP develops the use of clinical assessment via telephony by the Clinical Triage team of Advanced Practitioners

June 2021 – The number of complaints continues to increase. RMP successfully recruits additional GPs to its team with a well-described pre-set workload and has a fully staffed administration and support team.

Feb 2022 – The ELHSCP Chief Officer writes to the practice to inform them of the review.

April 2022 – The review of Access and Capacity at RMP begins.

5. Benchmarking

"You can have the best care but if people are enraged about trying to get an appointment it doesn't matter – the access issue contaminates your view of the care you get in the practice." Focus Group participant

Introduction and Process

The Scope of the Review (Appendix 1) states: the external review will be driven by the patient concerns and limited to the following:

- **Patient feedback:** Comprehensive engagement with the practice population to gather insight and hear from the community
- **Reception processes in the practice**. This includes all methods available to patients to contact the practice and includes the capacity, organisation, and alignment of reception resources against variation of patient demand
- **Non-clinical and clinical triaging systems** within the practice to optimise good utilisation of clinical capacity
- **Clinical capacity** within the practice team, and from the HSCP resources provided as per the 17c contract and PCIP associated services

The following are outside the scope of this review

- The quality of patient care provided by Riverside Medical Practice
- Contractual arrangements of the practice

The Review Team was asked to give particular attention to:

- Contacting Riverside Medical Practice
- Patient satisfaction with contacting Riverside Medical Practice
- Non-clinical and Clinical Triaging process within Riverside Medical Practice
- Clinical Capacity within Riverside Medical Practice

This Chapter provides a summary of the factors the Review Team considered and how we compared RMP to other General Practices in Scotland. At present, in comparison to some other parts of the Scottish health and social care system and the rest of the UK, data relating to Scottish General Practice, particularly activity and capacity data, is limited.

Work is rapidly progressing nationally to address this issue led by the Primary Care Data and Intelligence Oversight Group, chaired by Sir Lewis Ritchie, however at the time of the review this data was not available. This presented the Review Team with significant challenges, but the Team has used the best data that is available as well as local data provided by RMP.

Benchmarking is challenging as there is not one specific marker or measurement for many of the areas reviewed and there can be many differences between General Practices in terms of size, services provided and geographical location for example. In addition, some information is not published which in turn makes comparison more complex.

The benchmarking for this review involved a staged process. We gathered information from RMP on the way their services are delivered. The Review Team used their expertise and judgement to decide what would require further exploration. Some processes were looked at in depth and others less so. Assessing access to a practice is a subjective process – the experience is unique to each individual patient over the course of their care and their perception.

'Access' is defined in many ways; it can be in terms of physical access, timely access and choice (Boyle, 2010). However, there are more complexities to subjective assessment of access both from a patient and healthcare provider perspective. Importantly, it can impact on health inequalities. To describe access definitions further is beyond the scope of the review, but it is important to outline that there is no one measure defining 'good access'. (see (Voorhees, 2020) for a full thesis on this complex matter).

> *"When I really needed an appointment with a doctor… I could not have had a quicker, more efficient & personal service from anyone"*
>
> *"What is the quality control? Most other companies and businesses, the better they are, the more money they make." Focus Group participant*

The Team considered several processes to assess access against other practices including:

- Health and Care Experience Survey
- Telephone system data
- Clinical capacity
- Practice policies and patient feedback, referenced in other chapters of this report.

Health and Care Experience Survey

The Health and Care Experience (HACE) Survey is a biannual national survey commissioned by Scottish Government of randomly selected patients from every General Practice in Scotland assessing care experience – including access – in the previous 12 months. The last survey was sent out in November 2021 surveying experiences over the previous 12 months and was published 10 May 2022 (Public Health Scotland, 2022).

We reviewed the HACE results regarding access of RMP against Scottish average.

Question	Percentage of positive responses	
	Riverside	Scottish average
Q03 How easy is for you to contact your GP practice in the way that you want?	7%	75%
Q04 If you ask to make an appointment with a doctor 3 or more working days in advance, does your GP practice allow you to?	5%	48%
Q05 The last time you needed to see or speak to a doctor or nurse from your GP practice quite urgently, how long did you wait?	65%	85%
Q09b Overall, how would you rate the arrangements to speak to speak to a Doctor at your practice?	13%	61%

Table 2 - HACE Results RMP and Scottish average

During the time period assessed, in all questions regarding access, RMP was notably below the Scottish average. These figures were explored further. We wanted to consider other factors that may have influenced the findings and examined the size of the practice in comparison to practices with similar numbers of patients. Appendix 6 illustrates the positivity of access for all NHS Lothian practices against list size.

List Size	Name	Practice Code	Board	Response Rate	Number of responses	Q03 Access positivity
	Practice List Sizes >15,000 in Scotland					
55163	Barclay Medical Practice	43576	GG&C			Not listed
25062	Inverurie Medical Group	32021	Grampian	34%	146	50%
24465	University Health Service	70592	Lothian			Not listed
23609	Forth Medical Group	26015	FV	19%	110	56%
22546	Peterhead Health Centre	31634	Grampian	26%	148	51%
22437	Maryhill Group Practice	32779	Grampian	31%	167	64%
21008	Waverley Medical Practice	61447	Lanarkshire	16%	139	82%
20832	Wellwyn Practice	61625	Lanarkshire	21%	182	19%
20393	Newburn Health Centre	30078	Grampian	13%	132	66%
19695	**Riverside Medical Practice LLP**	**76033**	**Lothian**	**30%**	**175**	**7%**
18706	Newbattle Medical Practice	77106	Lothian	23%	160	56%
18462	Lanarkshire Medical Group	63724	Lanarkshire	24%	162	31%
18316	Muirhouse Medical Group	70662	Lothian	16%	157	63%
18228	Oldmachar Medical Practice	30504	Grampian	25%	152	66%
18109	Inverkeithing Medical Group	20752	Fife	37%	173	78%
17815	Parade Group Practice	46061	GG&C			Not listed
17358	Marnock Medical Group	80378	A&A	23%	131	62%
15785	The Taymount Surgery	14037	Tayside	35%	143	72%

15765	Ellon Group Practice	31901	Grampian	35%	166	51%
15521	Linlithgow Group Medical Practice	78166	Lothian	38%	166	91%
15501	Nairn Healthcare Group	55041	Highland	34%	157	83%
15476	Portlethen Medical Centre	32411	Grampian	32%	149	90%
15371	Pipeland Medical Practice	21830	Fife	24%	178	83%
15096	Skene Medical Group	32209	Grampian	39%	179	82%
	Comparison Averages					
	Scotland			24%	130,352	75%
	NHS Lothian		Lothian	25%	17,124	76%
	East Lothian HSCP		Lothian	31%	2,156	68%
	East Lothian West Cluster		Lothian	28%	856	49%
	GP Cluster Practices					
9497	Inveresk Medical Practice	76141	Lothian	28%	144	80%
4108	Ormiston Medical Practice	76211	Lothian	30%	139	96%
9368	Prestonpans Group Practice	76122	Lothian	20%	115	92%
9786	The Harbours Medical Practice	76052	Lothian	32%	142	61%
14058	Tranent Medical Practice	76226	Lothian	25%	141	35%

Table 3 - HACE results RMP and practices over 15,000

It is clear, against Scottish, Health Board, HSCP, GP Cluster and practices of comparable size, that RMP does not compare favourably in the HACE survey. We also reviewed the trend in HACE Survey over time in the previously available returns. Averages for NHS Lothian, East Lothian HSCP and East Lothian West Cluster are distorted by RMP low score. Having started below the average in 2017/18, there has been a downwards trend in patient perspective on contact positivity.

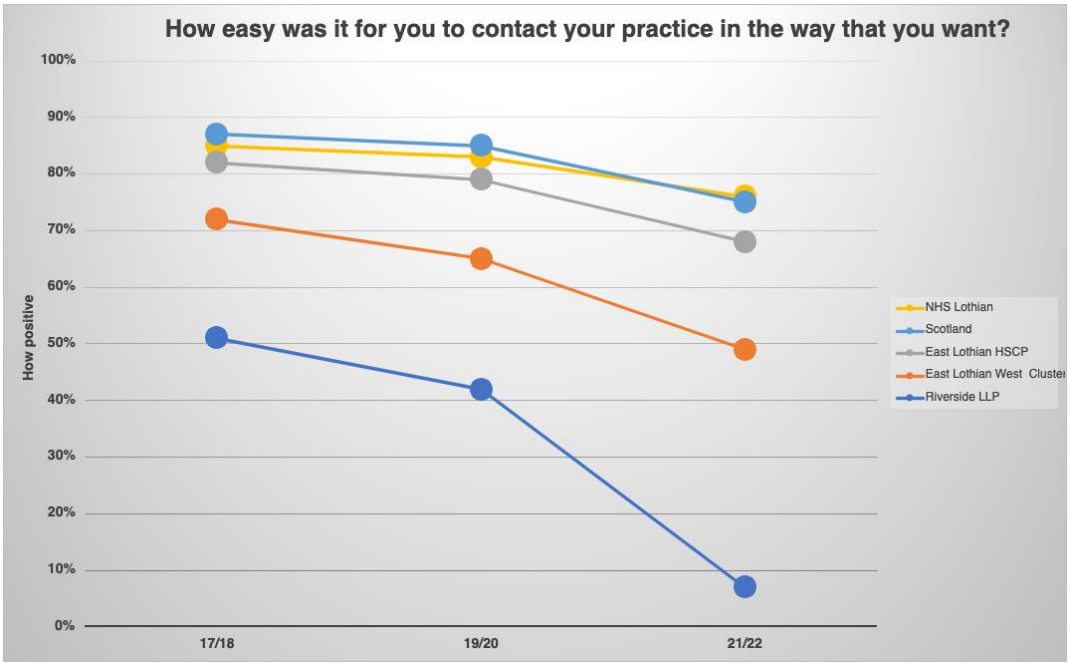

Table 4 - HACE Scores from 2017-2022

Telephone Access

The Team was asked:

"How does Riverside Medical Practice compare with other General Practices for telephone access?"

Most practices use their telephone system to access appointments (further details in the 'Contact' section below). There is a cap of a maximum of 30 calls waiting to avoid overload of the system. In the morning particularly, calls are frequently in excess of this due to the large population all trying to access the telephone system for care which can only be delivered on the day.

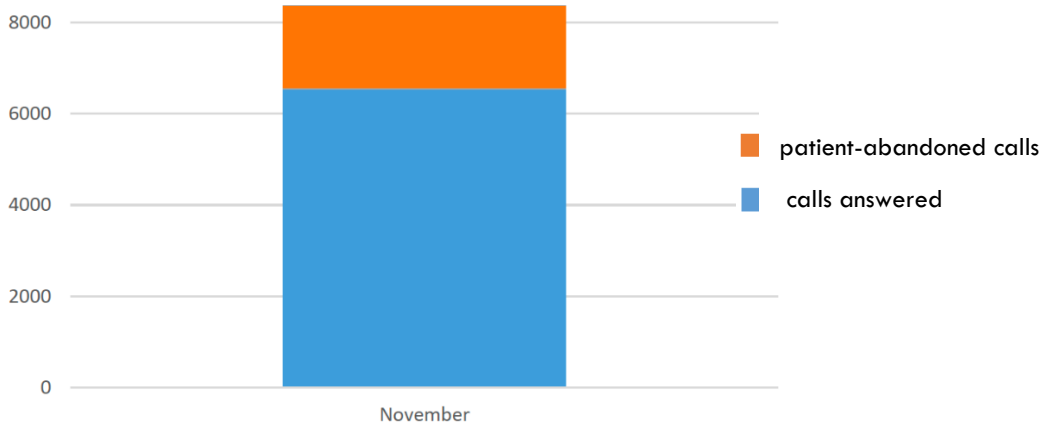

Table 5 – Patient-abandoned calls to answered calls to RMP November 2021

The Review was provided with this data by RMP – please note this does not include all call attempts to the practice 0300 number. The results are consistent with feedback received from the time which outlines the challenges patients faced in successfully getting through to the practice. The Review endeavoured to look at different methods of comparing this data with that from other practices. We risked selection bias as practices who require systems to measure unanswered calls may be those with challenges whilst those with no complaints regards telephone systems are less likely to make the

investment required for those systems. Moreover, each telephone system will measure 'answered' and 'unanswered' calls in different ways depending on when a call is regarded as answered.

RMP have recognised that the proportion of unanswered calls was higher than was desired and have taken steps to improve average answer time and maximum call waits. See page 26 for further data.

	1 Jan – 27 Mar 22	28 Mar – Jun 22
Average answer time (minutes)	**16.5**	**13.2**
Maximum answer time (minutes)	**65.5**	**48.2**

Access to a GP or Healthcare professional appointment

The Review Team were asked:

"How does Riverside Medical Practice compare with other General Practices clinical capacity?"

We were asked to consider the 17C contractual agreements and accompanying SLA between RMP and ELHSCP and in particular the services provided by the CWIC team.

The nationally agreed GMS Contract (which both 17C and 17J contracts are based) sets out that practices must provide services to their patients or temporary residents (visitors) who are:

a. ill, with conditions from which recovery is generally expected

b. terminally ill; or

c. suffering from chronic disease

General Practice has a 'duty of care' to their patients as set out in their GMS contract. In the 2018 Scottish GMS Contract and MOU, Urgent Care Services were one of the six areas identified where HSCPs should provide support to General Practice.

RMP have an SLA with ELHSCP which sets out services provided to support RMP patients. (Appendix 1A). This was agreed in January 2018 prior to the new GMS contract publication.

The 17C Contract for RMP states (Appendix 1A):

"Same day demand for general medical services will be dealt with by East Lothian HSCP's Collaborative Working for Immediate Care (CWIC)… Riverside Medical Practice will identify same day demand and direct this to the CWIC Service… The CWIC Service will respond to and manage same day demand… Patients needing further routine medical assessment will be directed back to Riverside Medical Practice."

Within the SLA, *"The CWIC service will see RMP patients who have been triaged to require same day appointments. A same day appointment is defined as a clinical requirement of face-to-face assessment within 36 hours after the initial RMP led triage processes.*

CWIC will initially provide a minimum of 350 appointment slots per week to RMP between the hours of 09:00 and 17:00, Monday to Friday, across a balance of specialist clinicians."

The definition of 'same day appointment' as defined in the SLA is similar to that of Urgent Care as understood by the Review Team. However, over time RMP and ELHSCPs shared understanding of 'same day care', urgent care and who ultimately has the duty of care for the patients varies. The

Service provided by CWIC has changed and the introduction of services such as MSK and mental health services have not been considered in relation to the SLA.

RMP currently operate all their care on the 'same day' with no ability for a patient to pre-book appointments with a general practitioner. Within the current SLA it advises 'same day care' is managed by ELHSCP. When the contract was negotiated, RMP offered both routine pre-booked appointments and same day care. Appointments have not been available to patients to book in advance since the start of the pandemic.

The capacity for CWIC to manage same day appointments has reduced in time due to staffing issues including recruitment, retention, absences etc. There has also been a widening use of CWIC to include other practices. A broader suite of services beyond CWIC also exists but does represent a drop from the expected 350 per week.

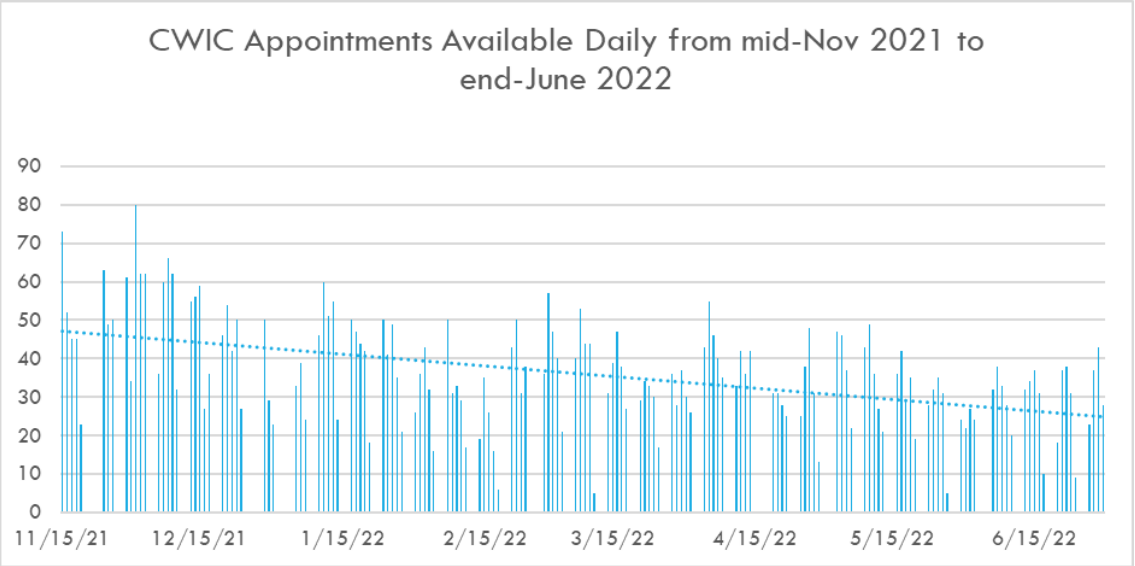

Table 6 - CWIC appointments daily from Mid- Nov 2021 to end June 2022 (data supplied by RMP)

Clinical Capacity

The Review Team were asked: -

"*How does Riverside Medical Practice compare with other General Practice service models for clinical capacity?"*

Patients are given an appointment with a GP or an Advanced Nurse Practitioner (ANP). Within RMP it is noted that ANPs have 27 appointments each day and GPs have 21. GPs will have a different case mix, and other responsibilities in care management, supporting the running of the practice and in training.

Clinical capacity within General Practice is notoriously challenging to compare due to the complexity of the GP role and variations across Scotland in how these data are collected and measured.

Face-to-face ANP and GP appointments at RMP are 15 minutes in duration. Guidance from RCGP (Royal College of General Practitioners, 2019) supports that GP appointments should be15 minutes long. There is variation in appointment length throughout Scotland depending on the appointment type and practice processes. In general, longer appointments are considered good practice as more problems are likely to be more fully managed with more opportunity to share decision making for the

increasingly complex problems of a frailer population (Royal College of General Practitioners, 2019). They have been introduced by many General Practices but will mean GPs will see less patients per day therefore impacting on capacity. Telephone appointments are generally shorter in duration.

The Review Team noted doctors at RMP had 21 patient appointments a day. The BMA and European Union of General Practitioners recommended a safe working limit of no more than 25 patient contacts per day (British Medical Association, 2018). Other authors advised it is safe to see 28 patients per day and notably highlights GPs in England are having on average 37 patient contacts per day (Policy Exchange, 2022). A higher average may represent a model utilising more telephone contacts. No report differentiated between whether these were by telephone, video or in person, nor appointment lengths. With this, RMP are seeing 16% fewer patient contacts per day than the safe limit.

RMP has good provision for breaks and administration time for its clinical staff. This allows dedicated time for reviewing blood results, letters, writing referrals or responding to queries/messages. This reflects the need to provide protected breaks as would be best practice and mandated for salaried GP staff within the standard BMA Salaried GP contract.

There was additional home visiting capacity in the form of a dedicated GP and paramedic who carry out all home visits. Care Home visits are done by the Care Home Team.

RMP advised that they provided 31,980 GP/ANP appointments between 1 Jan 2022 – 30 Jun 2022. Comparison practices reviewed which were adjusted for population offered 23,965 – 25,756 GP appointments including face-to-face and telephone over the same time period. This is notably less that the 31,980 appointments RMP advise they offered. This is likely to reflect differences in the data collection and reporting methods used by different practices. Continuity of care in smaller practices may also reduce the number of contacts though differences in counting methods likely played a more significant part.

We explored the number of hours (often referred to as sessions – one session is 5 hours) worked by the GPs. This was reported by RMP as a total 94.5 sessions per week (472.5 hours a week).

The numbers of patients registered with the practice per GP session offered by RMP was 208. The national average is 178 patients per GP session (British Medical Association, 2016). Benchmarking against other Scottish Practices is shown below. RMP was above both the sampled Scottish practices and UK average. This could suggest there are not enough GP sessions provided at RMP. However, this is mitigated by 190 hours per week of ANP time (38 additional sessions).

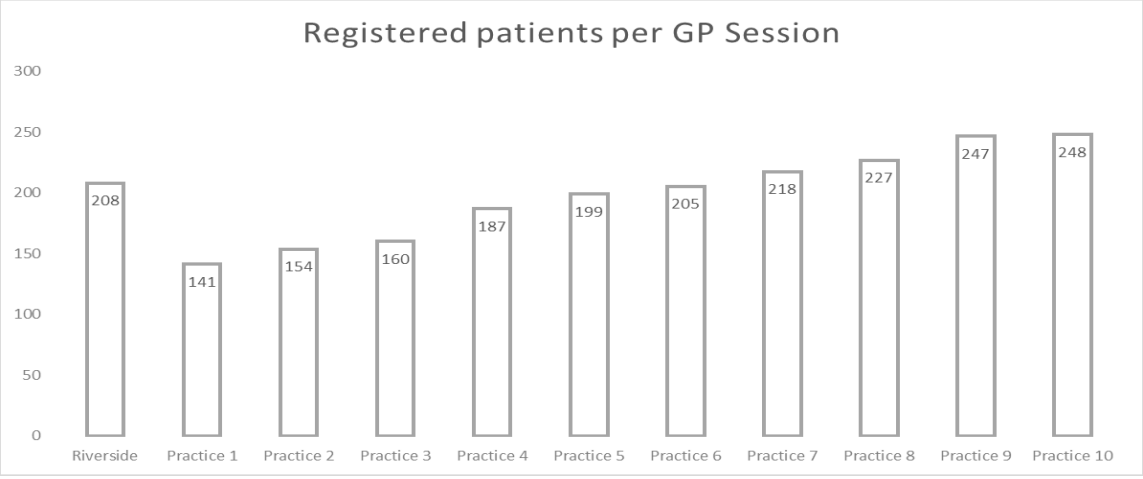

Table 7 - Registered patients per GP session provided

Over time, the practice has reduced use of GP locums and increased the number of GP sessions (partner and salaried GP) offered each month. This should improve the resilience of the practice, the availability of GP appointments and the potential for improved continuity of care.

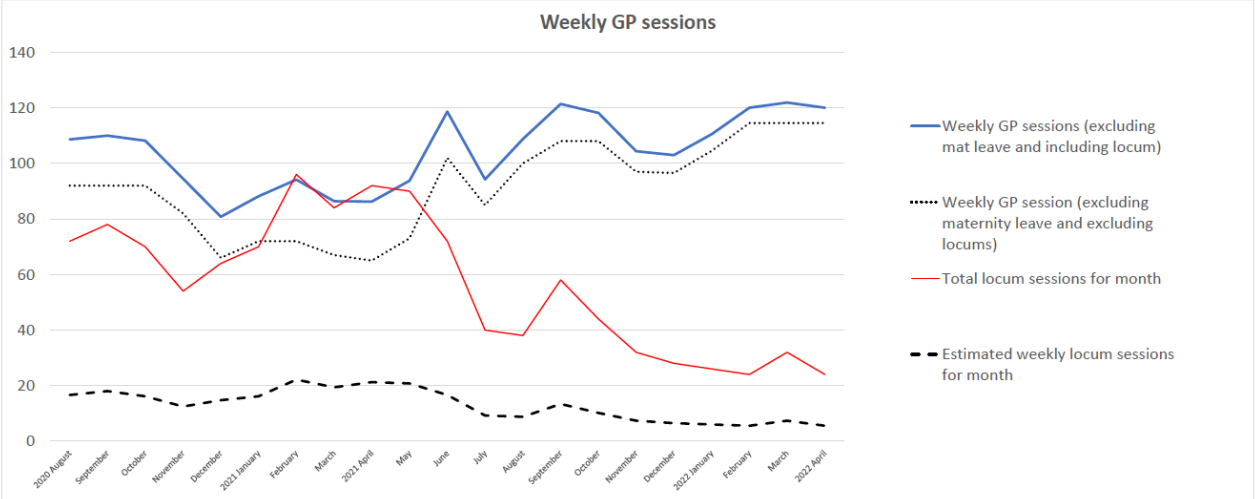

Table 8 - Weekly GP sessions over time

In summary, the number of GP sessions offered has improved over time, appointment length is longer than average and, mitigated by ANP hours, is likely comparable to the national averages.

Prescribing Process

The Review Team were asked: -

"How does Riverside Medical Practice Prescribing Process compare with other General Practices?"

In line with GP contractual changes in 2018, ELHSCP supports RMP's prescribing through the provision of a pharmacotherapy service. This service includes dedicated pharmacist and pharmacy technician time to support medicines reconciliation after hospital discharge, medication reviews, repeat prescribing issues and other issues regarding medicines management.

The Review Team met with members of this pharmacotherapy team who commented on the good relations between RMP and pharmacotherapy staff.

The practice website reports up to 5 working days needed for repeat medications and 10 working days if the repeat medication needs reauthorised or for a new request (acute medication). The actual time taken is often less and RMP reported to us repeat prescriptions are normally processed within two working days and new prescription requests on average 4.5 days (reported by RMP August 2022).

Local practices in Musselburgh reported on their websites 2 - 5 days for all medication requests.

There was no significant discrepancy in acute or repeat medication process versus other practices beyond the longer wait for medications reported on the RMP website.

Benchmarking Clinical Consequences

The Review Team explored the wider impact of the RMP service to ensure there was no negative correlation between use of other services such as Emergency Admissions and Readmission Rates after hospital discharge. This was reviewed via Primary Care Indicators platform for data from April 2021-March 2022.

Overall, Emergency Admission rates were well within expected levels as were outpatient referrals. Readmission rates both at 7 days and 28-day post admission were again benchmarked comparably across Scotland (Appendix 5).

Prescribing data was similarly assessed from National Therapeutic Indicators. There are evident 'jumps' in the data at the time of merging in March 2018. There are some areas where prescribing is broadly within expectations, particularly around analgesic use.

Antibiotic and protein pump inhibitor (drugs to treat stomach conditions) use is notably below average. For the later, affirming in Scottish Therapeutic Indicators could help identify any patients not getting gastric protection where it might be indicated. It may also reflect the very low NSAID use. NICE guidance here is also helpful. The low use of antibiotics may be exemplary and commendable, it could represent access to antibiotics via CWIC but could represent challenges in access given it coincided with the merger and was not a gradual reduction, though no firm conclusion on this can be made.

Improvement work in asthma prescribing utilising patient specific data in Scottish Therapeutic Indicators would likely help target patients with high inhaler use.

6. Contact

> *"The thought of waiting up to an hour on the phone to get through to someone and then need to wait for a call back just doesn't work when you have a job in town. I then can't make an appointment at short notice if I am at work and can't book ahead for a future date. My husband and I just don't bother making appointments for ourselves." Focus Group participant*

Introduction

The Review Team has consistently heard concerns about the telephone and appointment systems in RMP, and this has been the main concern identified in the review of complaints and in our work with the community in the Focus Groups and on-line form.

Concerns included the inability to get through on the telephone, long waits on the phone and then when patients did get through to the practice there were no appointments available, and patients were asked to call back again the next day. Patients reported having to do this for sometimes days and weeks before getting an appointment or in some cases giving up or going elsewhere such as A&E.

> *"I have been disciplined at work several times for trying to make a GP call - my employer does not believe that access to the GP has to take so long or be so persistent." Focus Group participant*

In the focus groups patients claimed that access to the practice including difficulties getting through on the telephone was a longstanding issue going back to before the pandemic and to the time of the merger with Eskbridge practice. However, we were told by ELHSCP and RMP that things were working well up until March 2020 with the support of NHS24 and CWIC service with plans to roll out the model to other practices in the area.

Physiotherapy and CWIC Mental Health services, which were originally part of the main CWIC service, are now separate services which patients can access directly. RMP and other practices cannot book patients directly into these services.

Telephone System

The practice telephone system is a BT Cloud Contact 0300 System and was installed in December 2019. ELHSCP told us the contract for the telephone service is held by NHS Lothian as it is part of the telephone system in the Musselburgh Primary Care Centre. ELHSCP indicated that RMP has the ability to change the configuration of the call management system and could explore using a different system, but this would not appear to be RMP's understanding. Call recording is one of the features of this system.

Currently the system is set up to have a maximum of 30 patients waiting in the queue at any one time. The practice introduced this to '*limit excessive waits on the phone, which can lead to higher bills and patients waiting for a long time*". If this limit is met patients will hear a message and are asked to call back. The message is: -

"We're sorry, we can't answer your call right now - our phone lines are very busy. Please try again shortly: call from 8am to book an appointment with a GP or the health board's CWIC service, and after 10am for everything else."

Only six calls per second can be transitioned into the system. Patients don't know where they are in the queue as there is no 'Call Waiting' and how long they may need to hang on for before their call is answered. Therefore, it is difficult for patients to decide as to whether to hang on or wait. The practice recognises this is an issue and have been advised by BT that NHS Lothian have to agree to a redesign of the phone messaging. Again, there appears to be a lack of clarity as to who is responsible for changes to the phone system

Patients then hear the following on hold messages:

***On hold message 1**: "You can call the health board's CWIC mental health team on 0300 790 6292 - weekdays 9 till 4. For joint, bone or muscle problems, call the health board's physio team on 0300 369 0680 – weekdays 9 till half 11.*

Call 111 if you have a minor injury or think you need to be seen at A&E.

For dressings and stitch removal call the health board's CTAC service on 0300 790 6292 - weekdays 8.30 till 12, and 1 till 4.30."

***On hold message 2:** "We know you're on hold. Our reception team will answer your call as soon as they can. We're working hard to reduce our call waiting times … it can take a while to get through first thing in the morning. Please stay on the line, or you'll lose your place in the queue.*

Thank you for your patience."

When patients first call, they are given the option of select 1 for '*same day need*' and 2 '*for other*' e.g., *nurse appointments etc.* Patients are asked to call from 8am to book a same day appointment with a GP or CWIC service and after 10am for all other appointments and other matters, although this option is available before 10am. However, what was observed by the Review Team is that at the practice end calls are not filtered and all 1 and 2 calls are merged together into the queue of patients to be dealt with by the practice staff in the Call Hub irrespective of the time of day. RMP advise that calls remain filtered with the two queues being weighted differently and prioritised at different times of the day, but this was not the practice staffs' understanding when asked by the Review Team. Further clarification is required to ensure the best system and experience for patients

There is a separate phone line for use by the community pharmacy team and also a separate mobile phone, which the CWIC team and other services can use to call the practice. However, the CTAC team believed that they weren't allowed to use this number and had to use the same number as the general public in order to access the practice team. On raising this with the practice they were not aware of this and were happy for the CTAC team to use this mobile phone number.

The practice has an 0300 number which they changed to in 2019 on the advice of NHSL. 0300 numbers are non-geographic numbers and are used by non-profit organisations, public support services and other charities such as helplines. Across all landline and mobile phones 0300 numbers should be charged at a standard local rate. Ofcom has stipulated that network providers cannot charge more to call 0300 number than a regular 01 or 02 number. If you are calling an 0300 number from a mobile phone, calls should be included within your inclusive minutes, however out with inclusive minutes callers could be charged as much as 30 pence per minute to call an 0300 number, it all depends on the tariff operated by the mobile phone provider. This may particularly impact those with pay as you go mobile phones who do not have free inclusive minutes in their contract. Further information on call charges is available at Call charges and phone numbers - GOV.UK (www.gov.uk)

The practice does not receive any financial benefit from people calling this number and there are number of benefits to the practice from using an 0300 number including better customer service, a resilient network, free online statistics and secure disaster recovery options.

"my phone bill was £30 plus one time, and the only calls were to Riverside" Focus Group participant

Patients are not able to book appointments with a GP or with the CWIC service at the practice reception desk. This can only be done by telephoning the practice. Many practices adopted this approach during the pandemic because of infection prevention control measures. This approach was used at RMP prior to the pandemic in line with the 'Musselburgh Model' service which was collaboratively designed by RMP and ELHSCP.

The practice has a call handling team based in their call hub within the practice area in the Musselburgh Primary Care Centre, which deals with all incoming calls. This team is made up of Call Navigators (in other practices they are known as receptionists, Patient Advisors or Care Navigators), Call Supervisors, the Practice Manager, the Clinical Triage team (Clinical Nurse Manager and Advanced Nurse Practitioners) and the Duty Doctor. In addition, the practice has a home visit team made up of a GP and an Advanced Paramedic, an ELHSCP prescribing team and practice admin staff. The practice also has GPs, General Practice Nurses, Phlebotomists and other administration and secretarial staff. Patients can contact the Mental Health CWIC team and the MSK team (musculoskeletal).

The call handling team monitors the telephone system and can see how many patients are in the queue waiting to be answered and how long patients have been waiting in the queue. The Call Supervisors manage the team of call navigators and will direct them to the most pressing piece of work (as well as answering the phone the call navigators also manage other administration processes such as management of documentation received into the practice e.g., blood results, hospital letters etc and any work that is required as a result of this).

We heard several accounts of people being in a three-way conversation, with the receptionist/call handler relaying questions and answers to and from the patient to a nurse. These people felt it would be more productive and efficient if they had been able to speak directly with the nurse.

"I managed to get through to the surgery to get some advice had the operator, asking me as she does, what was wrong. Explained what was wrong, very calmly. She then spoke to a practice nurse. And then started relaying in back questions from the practice nurse – now this is the operator. I asked to speak to the practice nurse, I was told no, they had to relay the questions back." Focus Group participant

Staff follow a script when answering the phone asking patients for information such as name, date of birth, address, contact mobile number and reason for their call today.

***1. Recommendation RMP** urgently review the telephone system to ensure it meets patient need. Areas to be considered include call-waiting, filtering of phone calls and content of messages to be more patient centred.*

Telephone Data

The practice states that they use the data from the telephone system to improve the service to patients and have provided the following data for the six-month period between January and the end of June 2022.

a) Number of calls answered a day: **303** (50-week average)

b) Number of unique and total abandoned calls each day:
382 unique calls a day (50-week average),
Abandoned call each day - 24 from Option 1 ("same-day") and 40 from Option 2 ("everything else")

c) Minimum and maximum call answer time for patients.

	1 Jan – 27 Mar 22	28 Mar – Jun 22
Average answer time (minutes)	**16.5**	**13.2**
Maximum answer time (minutes)	**65.5**	**48.2**

The Review Team were pleased to see telephone data being recorded and used for improvement, however there is further work that could be done with the telephony data available from the system for example looking at data on number of abandoned calls, length of wait of patients etc.

***2. Recommendation RMP** carry out further work to maximise the utilisation of the data from the telephone system to improve the patients experience of accessing care.*

Work done by the practice in Feb/ March 2021 showed that 10% of calls come in the first five minutes of service. On the busiest days that could be over 90 unique callers in the first five minutes of opening phone lines. As each call can take 3 to 5 minutes for a call handler to deal with then even with a large call handling team it would take some time to clear the backlog. However, patients feel that they have to call at 8am in order to have any chance of getting an appointment that day. This may exacerbate health inequalities, limiting access for those with most need.

> *"My husband needs to have a review of his heart medication just now, but he has M.E. / chronic fatigue and mental health problems and is not in a fit state to phone at 8am but if he calls later in the day, he is just told to ring at 8am. There is no flexibility in the system at all." Focus Group participant*

Appointment System

When patients call the practice in the morning from 8am onwards, and for those that get through the call is answered by a call navigator who will ask them a number of questions as outlined above.

Based on the reason for the call, the call navigator will then offer the patient the following:

a) A telephone call back from the CWIC service. Each morning the practice is notified of the number of appointments that are available from the CWIC service that day. As the CWIC service provides a same-day service patients are passed to that service (provided they meet the referral criteria first). Patients who don't meet the criteria for CWIC will be offered a GP appointment or a call back from the Clinical triage team as appropriate. Once the CWIC appointments are used up the practice will then manage all patients internally or sign post them to other services

> *"If you are in employment, the 'phone the same day for an appointment that day' is like Russian Roulette - you may get one, you may not. How can you hold down a job not knowing if you need to take time off later that day or not?" Focus Group participant*

The number of appointments available from CWIC appears to change daily depending on staffing levels and can also change during the day which means the practice is unsure of what capacity is available and how much capacity they need in order to meet demand.

The CWIC service is passed a list of patients from RMP and will then call those patients back and carry out their own review and triage. RMP cannot advise patients of when that call back will happen as they are not booking patients into appointment slots and it is up to the CWIC service to manage their list, prioritise call backs etc.

> *"We can be taking those phone calls anywhere and even have taken them in Tesco, have taken them in the vet." Focus Group participant*

Despite RMP working to the CWIC 'exclusion criteria there are occasions when patients are passed back to the practice by the CWIC team as it is felt that the patient is not suitable for the CWIC service because of nature of query, patient had previously been seen by CWIC etc. This is an ineffective and impersonal system for patients and for CWIC and RMP who need to make alternative arrangements for the patient.

***3. Recommendation ELHSCP** urgently review their contracting and working arrangements with RMP to develop a shared understanding of how the resources provided [in addition to GMS] such as the CWIC service, can be delivered and sustained.*

b) **An appointment with a GP that day** – When there are no appointments with the CWIC service left or patients are not appropriate for the CWIC service they will be offered an appointment with a GP in the practice. Patients will be offered a telephone or face-to-face consultation by the call navigator and given a time to attend the practice.

Patients cannot request a pre-bookable appointment from the practice, but where a GP sees a patient and wishes to follow them up the GP can arrange a future appointment for that patient. The practice also offers pre-bookable appointments for General Practice Nurse and healthcare assistant appointments.

"I feel bad because you've taken an appointment that day for something which is actually really quite routine." Focus Group participant

Introducing pre-bookable appointments would offer many benefits: reducing the number of patients who have to call back on other days and provide patients with continuity of care and choice by allowing them to arrange appointments with a GP of their choice. There may be longer waits for specific doctors.

***4. Recommendation RMP** should carry out quality improvement work to identify the nature of the requests they get from patients in relation to pre-bookable, same day or urgent care.*

c) **Triage Team** – the Review Team observed that when all the GP appointments are full patients are asked if their problem is urgent or can it wait. If they say it is urgent, then they are added to the list to get a call back from the Clinical triage team who will call them back and carry out a clinical review and triage. Triage is a clinical function and can only be carried out by clinical staff. The call navigators are unable to give patients a time for the call back. Some GP appointments are kept available for late afternoon in case the triage team speaks to someone who requires a face-to-face follow up from a GP that day. If these aren't utilised the call supervisor can open them up later in the day to be used for other same day appointments so they are used effectively.

"So, I've had a couple of phone consultations with GPs, which have been excellent. And they have really listened, they've allowed time to have proper conversations we've explored a number of options, and there's a real sense of it doesn't feel nearly as rushed as a recent appointment I had face-to-face" Focus Group participant

It was noted in the patient focus groups that many patients were not aware that the practice must make arrangements to provide care to patients with urgent clinical needs and after hearing the voicemail message informing them that there were not appointments left, many patients hung up rather than waiting for further instructions.

Future Access Models

Numerous suggestions were made by patients in the Focus Groups and on-line form submissions about what could be improved. The practice has also spent considerable time reviewing access arrangements available to General Practices in other areas and whether they would benefit the patients of RMP.

The Review Team is aware of many of these models and how they work in other areas. We think although some changes and improvements could and should be made, some of the suggestions, particularly those involving technology are unlikely to significantly improve access and could actually widen the divide between different demographic groups of patients such as patients from more deprived areas.

Telephone Access – the telephone remains the most common way for patients to access care across the country. In the Review Team's opinion where it works best is where the patients are given a number

of options of services they can access i.e. press 1 etc, voicemail messages are short, clear and regularly updated and services such as call-waiting are used. Sufficient number of call-handling and clinical staff are required to manage the system. It should also be noted that RMP make a significant number of outgoing calls to patients daily with information such as test results, arranging follow up review appointments etc.

The practice has invested in an excellent practice team of call navigators, call supervisors and practice management. We suggest further thought be given to the role, responsibilities and further training.

***5. Recommendation RMP** should continue to review the job title, role and working hours of the team to ensure that there is sufficient staff working with the appropriate skills at the right time i.e. 8am – 10 am to meet patient demand.*

Care Navigation/ Signposting – There are a range of other services that patients can access rather than going to their General Practice. This report has already touched on many of the services provided by the HSCP such as CWIC, MSK (Physiotherapy Services), Mental Health Services, Vaccination Services and Community Treatment and Care Services. In addition, we encourage RMP to continue to promote services such as NHS Inform (for self-management advice), Pharmacy First (Community Pharmacy), Optometry and Dental Services, Minor Injury and A&E Services. Patients often call the practice to access these services (particularly at flu/covid vaccination time which was traditionally provided by GP practices but is now provided by the HSCP), which again is blocking the phone unnecessarily.

***6. Recommendation ELHSCP & RMP** continue to promote and signpost patients to the range of alternative services that are available in the locality. This information should be easily accessible for patients in a range of venues and formats, such as on-line and in the community.*

The Review Team was very impressed by the work of the practice call-navigators, and the calm professional way they carried out their role.

"Some of the team that field calls are fantastically friendly and helpful."

"Good listener, professional - but I am not sure I am getting the best out of her abilities due to the way I have to access them." Focus Group participant

This was supported by patients in the patient focus groups who noted how helpful the call navigators were, and that they had a very difficult job to do. Many of the call navigators have only worked for the practice for 18 months or so and have had significant training in this time supported by the call supervisors.

***7. Recommendation RMP** continues to support its call navigators learning and development and considers further training in areas such as Care Navigation, Customer Care and Challenging Conversations and Complaints. The practice considers developing a Care Navigation protocol for the call navigators which could also be shared with patients.*

Telephone Triage – all General Practices across Scotland introduced telephone triage at the beginning of the pandemic as advised by Scottish Government. This meant that all patients were given a telephone call back from the appropriate clinician in their practice (GP, ANP etc) who then agreed with the patient what further action was required e.g., a face-to-face appointment. Some practices have continued with this way of working but many practices are returning to more traditional ways of working offering patient face-to-face appointments etc as they felt that telephone triage created additional work (double handling) as many patients would have a telephone consultation and a face-to-face consultation.

RMP worked this way through the pandemic, but in the past six months have introduced a much more mixed economy as described above. The Review Team observed that some patients will immediately be offered a face-to-face appointment with a GP and others will be offered a telephone call back from the CWIC service, GP or the practice Clinical Triage team. However, patients may be allocated an appointment according to what time they call the practice, rather than be allocated to a healthcare professional according to clinical need.

***8. Recommendation ELHSCP & RMP** continue to review their triage and telephone consultation processes and consider providing more personalised call back or a booked telephone consultation time. RMP should review its list of issues which should be managed in a face-to-face appointment to prevent patients having to have both a telephone and face-to-face consultation.*

MSK (Musculoskeletal) and Mental Health Patients -

Patients with MSK (musculoskeletal/ joint issues) or mental health issues are assessed by the Clinical Triage Team before being passed to the appropriate service. This appeared counter intuitive to the Review Team when the purpose of these services is to take work away from general practice, so that patients get the right care at the right time. RMP informed the Review Team that their medical defence union was not prepared to underwrite the risk of non-clinical call navigators directing patients to these new services because non-attendance is not apparent. However, the Review Team note this is supported specifically by Healthcare Improvement Scotland here and the role of directing is specifically referenced in their job title.

The Practice also told us it was important to review these patients before passing them on in case there was anything urgent that needs to be addressed as they were not confident that these services would/ could provide a responsive same day service. ELHSCP told us patients can be signposted directly to MSK and CWIC Mental Health without review by the Practice. This happens in other Practices in East Lothian.

***9. Recommendation RMP** in collaboration with ELHSCP, review the process for signposting to ELHSCP services to reduce double handling or duplication.*

On-line appointment booking – At the beginning of the pandemic the Scottish Government agreed that all GP practices should suspend online appointment booking, as it didn't allow for telephone triage and the screening required for Covid19 and other respiratory infections. Some practices are now slowly reintroducing them, but they tend to be for more routine appointments with General Practice Nurses and healthcare assistants. Online appointments are less suitable for urgent on the day appointments where some screening/triage is still required to ensure that the patient speaks to/sees the most appropriate member of the team. Online booking also does not allow for care navigation to other services where appropriate.

***10. Recommendation RMP** consider introducing on-line appointments for more routine appointments with the practice nurse and other members of the team.*

On-line (Digital Triage) (also known as Digital Asynchronous Consulting DACs) - a small number of practices across Scotland have introduced digital triage systems such as eConsult®. These systems allow patients to complete an on-line form setting out what their issue is and other questions and is submitted to the practice for review by clinical and admin staff. The practice will then respond to patient within a specified timescale (this varies from practice to practice) with what action should be taken e.g., self-care, pharmacy, prescription, telephone or face-to-face appointment.

The experience of practices using DACs systems is very mixed with some practices very enthusiastic and reporting that it has greatly improved their patient pathways whilst others found it increased the requests for care to unmanageable levels and that staff found it very difficult to cope. Scottish Government is currently looking at DACs from a national perspective and what support should be available to practices that wish to use it. Anecdotally it has been noted that it is not a solution to practices with sustainability or access and capacity issues. Therefore, the Review Team will not be recommending that RMP introduce a digital triage system at this time. Once access is no longer posing such a notable challenge, it could be a useful option to consider trialling.

Front Desk – like the majority of GP practices Riverside should continue to promote its telephone first approach (with the suggestions above), but for a small minority of patients using the telephone is difficult for a number of reasons.

> *"We should be able to book appointments at reception. The reason I say this is that my mother is very deaf. Despite being independent in other aspects of life she is unable to deal with her own medical needs because she cannot hear on the telephone. …….. whereby she was to be given a face-to-face appointment but still that does not happen. It is nothing short of discriminatory that because of her disability she is being prevented access to a doctor. On occasion after calling for her she has been offered a telephone consultation which is frankly outrageous. It is quite clear on her medical records that this is not suitable due to her deafness, yet we have had to accept as there was no alternative. Meaning calls are made to me and I have to discuss personal and*

at times embarrassing details on her behalf. She should be able to have a face-to-face appointment where she can manage much better and can lip read the doctor." Respondent feedback via On-line Form

RMP has some provision in place for patients who have difficulties over the telephone e.g., people with hearing issues can email, but the Review Team consider that some provision should be made for patients to be able to access care when needed, most easily at the front desk.

***11. Recommendations RMP** review its access arrangements for patients who find it difficult to access care over the telephone or online.*

7. Comprehensiveness

I have found the doctors and nurses to be kind and professional but getting to speak to one is nigh on impossible, which is very disheartening and causes me to worry that should the need arise, I would not have access to a GP or nurse when needed. Focus Group participant

Introduction

GPs and their teams manage a comprehensive range of conditions "from cradle to grave" delivered using a person centred and relationship-based philosophy (General Medical Services contract 2018).

The Four C model describes comprehensiveness as the "holistic care of people" and is a fundamental value for all healthcare professionals.

Yet, we found many patients found the challenges of accessing care to be impersonal, concerning and frustrating. This chapter describes their experiences and how the current process makes it very difficult for people to voice their concerns and complaints.

The Patient Rights (Scotland) Act 2011 introduced the right for patients (and others) to give Feedback, make Comments, raise Concerns and make Complaints about NHS services. Importantly, it also places a duty on the NHS including all independent contractors such as General Practices, to encourage, monitor, take action and share learning from the views received.

The NHS Model Complaints Handling Procedure (revised 2017) supports a more consistent person-centred approach to complaints handling across NHS Scotland. The policy reflects the broader ambition for our NHS to be an open, learning organisation that listens and learns from mistakes and values feedback as an opportunity for improvement. The procedure is complimented by the Duty of Candour which is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death, to apologise and to meaningfully involve them in a review of what happened. The Apologies (Scotland) Act 2016 is intended to encourage the use of an effective, sincere apology, without fear of liability.

Complaints

Prior to the Review commencing, the Review Team received over 300 complaints gathered from April 2018 – March 2022 from the offices of Colin Beattie MSP and Sarah Boyack MSP. The most recent 100 complaints were analysed. The complaints were about accessing healthcare services at RMP and their associated services. We also examined the complaints process at RMP and read any relevant information available.

The themes of the complaints echo our findings from the Focus Groups and via the submitted online forms. We used the Scottish Public Services Ombudsman categories of

1. Access to services / appointments
2. Clinical Treatment / diagnosis
3. Communication / staff attitude / dignity / confidentiality
4. Record keeping
5. Subject unknown

Three additional categories were included as sub-categories

6. Complaints handling
7. Prescriptions

8. Transfer to other Practice

The main finding was access to the service, including making an appointment to see a GP, which generated the highest volumes of complaints. Of the 101 cases examined, 77 people (76%) expressed dissatisfaction (either in the main issue they raised or in a secondary issue raised) about the system for making an appointment and/or trying to get access to their GP.

Twenty-six people (26%) also expressed dissatisfaction in regard to their clinical treatment/diagnosis. In some instances, these concerns were in addition to other expressions of dissatisfaction with the Practice. These (clinical treatment/diagnosis) concerns were often raised as a consequence of not gaining access to services, including getting an appointment to see a GP.

Of the 101 cases examined, 49 cases included two or more issues of complaint. 52 Cases related to 1 complaint. Where '*Clinical treatment/diagnosis*' featured as part of the complaint (whether or not it was the main issue raise), given the (potential) seriousness of such complaints and the possible impacts of delayed treatment, these were always recorded as the main complaint. Table 9 below documents the main findings:

Main complaint category	No	% of reviewed complaints
Appointments / Access to services	37	37%
Clinical treatment / diagnosis	38	38%
Communication / staff attitude / dignity / confidentiality	10	10%
Prescription	14	14%
Subject unknown	1	1%
Transfer to other Practice	1	1%
Total	101	

Table 9 - Breakdown of complaints

In addition to the two main areas of concern (access to service and clinical care and diagnosis) people also raised significant concerns around prescription issues (12%) and Communication issues (13%), including some comments about staff attitude.

There were many complaints which expressed emotive comments about the situation they found themselves in. It is important to remember that there is a person behind the numbers. When a theme or pattern emerges, such comments can become very powerful in demonstrating the human impacts of a service.

"I am at my wits end with the level of care being provided by the surgery as someone who has two young children. I feel worried about the challenges of getting through on the phone and whether I will be able to speak with someone about the care I need for them".

"I am writing to you this evening because I have concerns over the welfare of my grandparents. Their doctor's surgery in Musselburgh is, quite frankly, unreachable. We have been unable to make an appointment in months (no

exaggeration). Both of my grandparents are high risk: Grandad has cancer and my Gran is recovering from cancer". Complaint letters to MSP

RMP Complaints Procedure

We found aspects of the complaints process and procedure at RMP to be incorrect and incomplete and required addressing urgently. There were some inaccuracies about the complaints process and key information such as the RMP Complaints Procedure was not easily available to patients.

Patients told us the only way to complain was in writing. We informed RMP that complaints can be made in writing, by 'phone or face-to-face.

"When I've complained about things in the past, I have to say that the response that you get from the management there has not really been very satisfactory". Focus Group participant

The Review Team are encouraged to note these urgent issues have been rectified: The RMP website has been updated with the model complaints handling procedure evident. Patients can now complain in writing, by 'phone or in person.

We found it difficult to find evidence of learning from the complaints received as the information we received from RMP was limited. We would encourage the Practice to share how complaints are used for learning and improvements. Complaint performance data should be presented in a standardised way including reference to the key performance indicators and we would encourage RMP to ensure this information is included in their next complaints return.

People have the right to complain. RMP must ensure patients can make a complaint with ease. Complaints must be responded to, monitored, actions taken when needed and used as an opportunity to learn and improve.

We heard from patients they had lost faith in using the complaints process and that is possibly why the large number of complaints were taken to the MSPs or reported on social media. We encouraged people to complain to RMP as there are options for appeal (via the Scottish Public Services Ombudsman).

NHS Lothian and the ELHSCP also have a responsibility to ensure RMP meets its legislative and contractual requirements for the recording, monitoring and reporting of complaints. We would encourage the staff at RMP to use the many resources available for further learning such as Support and Guidance website of the Scottish Public Services Ombudsman and the numerous modules available freely via TURAS eLearning resource at NHS Education for Scotland.

We also found there were examples of uncompromising language relating to those patients who may demonstrate difficult behaviours. We have asked RMP to review this language being mindful that often people may be vulnerable or distressed and act out of character. We also acknowledged the challenges faced by support staff when on the receiving end of concerns and complaints.

The Review Team would like to acknowledge how receptive the management team at RMP have been to hear our feedback and recognise that a number of improvements have already been addressed or progress is being made. We would like to see this important work continue.

12. Recommendations RMP *adopt the NHS Model Complaints Handling Procedure to ensure patients can make complaints in an accessible and person-centred manner.*

a) Survey those patients who have complained to monitor the process and subsequent satisfaction.

b) Measure and Monitor the Key Performance Indicators for Complaints and report these on the RMP website.

c) Review the policy and associated materials about unacceptable actions

d) Ensure staff continue to be supported about how best to respond, resolve and learn from complaints.

13. Recommendation NHSL & ELHSCP *supports the contractual and legislative requirements for the monitoring and reporting of complaints. Consideration should be given to further learning and training opportunities for staff.*

8. Continuity

"I had over two months of intense cystitis but because there's no way to see the same doctor, I got no consistency of care. This all happened after my dad died three days into the first lockdown, on the same day my mum was put into a ventilator. So, I was going through the most stressful time of my life. Not seeing the same doctor meant I did not get antibiotics for months. I had the added stress of explaining what was going on to at least 5 different GPs." Focus Group participant

Introduction

Whilst the public recognises there have been significant changes to how General Practice services are delivered in the twenty first century, there remains frustration and concerns from patients who see care as fragmented, impersonal and difficult to manoeuvre.

Starfield describes continuity as enabling a long term and effective therapeutic relationship. Continuity is the delivery of care with the same clinician over time. Evidence would currently indicate the quality of care is enhanced when care is coordinated by a multi-disciplinary healthcare team led by a GP as the Expert Medical Generalist who know the patient and their family (Pereira Gray DJ, 2018).

People told us that they understand that they cannot expect to see the same doctor or nurse every time they visit the surgery, however, this is something that they really miss. We heard that being unable to see the same doctor often means that they have to repeat their story/symptoms. They also told us that GP locums can be variable in quality and also have a negative impact on continuity of care.

"I was struggling to cope with my husband's diagnosis of cancer. I saw a doctor who was very helpful and asked that I come back in a fortnight. No appointment was given then and had to wait for a phone call from the surgery. Then I saw another doctor and had to start again as to why I was there." Patient complaint.

During the COVID-19 pandemic, managing all care on the same day was a more common appointment structure in many General Practices in Scotland. However, with a limited daily number of appointments, it affords little opportunity for continuity of care. Being able to pre-book an appointment, even if that means a longer wait for a GP, is likely to improve the patient experience by making the appointment process easier and improving continuity of care. It would also reduce the need for patients to call back repeatedly before they get an appointment. Some patients are saying their issue is urgent when it is not in order to get through the system.

Contrary to some perceptions, patients tend to value continuity over speed of access and are willing to accept a longer wait for a clinician they know over rapid on the day access (Karen Gerard, 2008).

The greatest improvement that would impact to improved continuity of care would be the re-introduction of some pre-booked appointments. In addition, this would enable patient choice and may reduce the pressure on the 'phones in the mornings. Importantly, improved continuity would also allow GPs to focus on patients with more complex needs or increased need.

14. Recommendation RMP *resume pre booked appointments, particularly for patients with more complex conditions or increased need.*

9. Co-ordination

> *"GPs will no longer be the default health care professionals to see patients for urgent care, but they must continue to be an essential part of multidisciplinary urgent care teams, providing clinical leadership and expertise, particularly for complex cases." (Scottish Government, 2015)*

Co-ordination of Healthcare

The coordination of healthcare in the community lies with General Practices and GPs are often seen as the "gateway" to care and treatment. The public may be unaware of the increasing range and roles of healthcare professionals, sometimes known as the multi-disciplinary team working collaboratively with GPs within General Practice. Traditionally, nursing and allied health care professionals work as part of the multi-disciplinary teams in roles such as practice nurses, physiotherapy, in disease management roles such as asthma and providing care for patients in the community via community nursing and health visitors.

However, the introduction of the new GMS contract in 2018 and the arrival of new healthcare roles such as Physician Associates, Paramedics, Pharmacists and Advanced Nurse Practitioners has resulted in some members of the public being confused and concerned about who delivers what type of healthcare.

> *"I didn't know that pharmacists can actually prescribe antibiotics."*
>
> *"There's also an education piece for staff as a friend was told by reception, she had to go to minor injuries for antibiotics but she contacted her pharmacist who confirmed they could do it"*
>
> *"(there has been a) failure to communicate with the public about the dramatic changes which have been implemented as a result of the new GP contract. The one group who were not consulted as part of this process were the public".*
>
> *(Focus Group participants)*

People told us they were unsure about the different support available from the wider clinical teams and said they would appreciate this information being more widely shared. They said, if this information was available this could reduce pressure on the systems and capacity for GP surgeries.

Leadership

RMP is led by four GP Partners. They are assisted in this by leads within the nursing, administration and managerial teams. The review team noted that there was a very strong loyalty to RMP and the staff working there. Those who have remained with the practice have invested a significant amount of their personal values into trying to provide the best practice they can for the patients they serve.

The team has lived through very difficult times. It is clear that those who work at Riverside have been deeply hurt by criticism of the practice and they are worried that a situation that they have worked hard to stabilize becomes unstable.

RMP had a period of staffing crisis during the pandemic and have worked hard to recruit and retain staff including GPs. The working conditions appear to be favourable and includes well planned surgeries with appropriate spacing of patients, time for admin and access to resources and services offered by ELHSCP.

The practice has worked well with the pharmacy team to continue to improve access to medication. They have identified additional GP time to help resolve issues around medication review and prescription generation and also have good relationships with the frailty, mental health and physiotherapy teams.

However, the working relationship between RMP and the CWIC team was less collegiate. Blurring of roles and uncertainty about contract agreements, roles and responsibilities can be challenging. The Review Team would like to see the Practice and CWIC review their working arrangements to ensure Same Day care is managed effectively and has the patient at the center. To succeed, we believe ELHSCP and RMP must have a shared understanding of their agreements and agree a realistic, sustainable and deliverable model of care.

Relationships within the Community

Many of the people we spoke to were unsure of how RMP was managed and were concerned about RMPs ability to deal with the number of patients registered. We heard that people felt that the difficulty in accessing health care at RMP was due to lack of full time GPs, inadequate GP to patient ratio or insufficient administration staff to deal with calls. People told us they were worried about how RMP and general practice in Musselburgh will cope with the increase in population numbers in the area due to new building developments. People felt that RMP were not coping with the demand from the existing population.

Over the course of the Review, it became evident many of the RMP patients had lost confidence in the Practice. There were a number of potential reasons for this in addition to the poor access experience.

During the pandemic, communications were impacted and many of the more traditional ways to build relationships were paused. However, within the community in Musselburgh, the press and social media often portrayed a narrative that was damaging to individuals and negatively impacted on the staff recruitment, retention and well-being of staff at RMP.

We also heard from many different sources there had been an on-going issue with access and capacity at RMP for some time and even before taking on the Eskbridge Practice. These years of instability have been challenging for patients and staff, but a period of planned improvement should provide stability and sustainability.

RMP is fortunate to have a strong and committed Patient Partnership Group (PPG) and this could be capitalised much more. The PPG provide a unique perspective and for example, could provide valuable feedback about the way services are provided and improvements measured.

People who attended the Focus Groups and completed the on-line forms offered many suggestions which could improve the relationship between RMP and the community e.g. introducing a range of feedback tools on line and paper based, surveys, digital kiosks, open days, community events and use of independent feedback such as Care Opinion.

In order to create a local environment which is conducive to building more trusting and respectful relationships for all, we suggest RMP along with the appropriate colleagues, co-design a Vision and Values Blueprint which sets out their Improvement Plan.

***15. Recommendation RMP** working with PPG and other stakeholders produce a Vision and Values Blueprint as a basis for building relationships.*

Communications & Patient Engagement

Many patients felt communication from RMP could be improved. People told us that they want to see more information about RMP. For example, how many GPs are there, how many appointments are available in a week, how many calls are received, how many people did not attend appointments.

People told us that they would like more openness, honesty and transparency in communication and information.

During the Covid-19 pandemic and because of hostile and personal derogatory remarks about staff, RMP staff disengaged with the patients' local community social media groups such as Facebook. Some patients were upset about the way open communication had been removed and described this measure as *"all patients being tarred with the same brush."*

We also found some language on the RMP website to be uncompromising and defensive. Modelling words on the website and in documents which demonstrate care and compassion and take into account vulnerability or disability would be a welcome change. We are encouraged to see real improvements already on the website.

People told us they are curious and confused about who RMP are responsible to and whether they are part of the NHS or a private organisation. There was a lack of understanding about how GP Practices are managed and who they are accountable to. For that reason, we have included information in Chapter 2 and in Appendix 1A about the contracting process.

People asked whether there were national standards which GPs had to meet in terms of access to as well as delivery of healthcare. Given the complexity of defining good access, such standards do not exist. National aims set in other countries on access have failed to capture the complexities of access. (Voorhees, 2020).

"And I would also like to be clear exactly who the practice is accountable to for the delivery of the service. So, I think all of us will probably remember times over the past few years where we've tried to establish an answer to that question. And we've had NHSL saying they are private contractors, and they are nothing to do with us. I've spoken to EL Health and Social Care Partnership and not really had an answer to that to that question. So, I think that there needs to be clear, you know, in the public interest that needs to be clearer lines of reporting as to how effective or otherwise a given practice is."

"What is the quality control? Most other companies and businesses, the better they are, the more money they make."

"Should there be a standard as to the maximum amount of time people should have to a) wait on a call being answered b) wait for an appointment?"

Focus Group participants.

We suggest RMP take the opportunity, as part of their community engagement to inform patients about their services and how the Practice is managed.

We are encouraged RMP are planning to renew their engagement strategy including the use of various formats to increase the engagement with patients continuing to use newsletters, text messages, feedback and surveys as well as considering patient booklets, materials in the waiting room and the use of local media. We consider this a very positive step for the Practice.

We would also suggest adopting the good principles in National Standards for Community Engagement and the VOiCE tool to support the design and delivery of effective community engagement.

***16. Recommendation ELHSCP & RMP** to renew the patient engagement strategy to include the principles in the National Standards for Community Engagement and the VOiCE tool.*

Prescriptions and Medicines

Managing repeat prescriptions and collecting medicines was a very contentious issue for patients and featured in many of the complaints we received.

> *"I need a lot of medications for a serious heart condition and never a month goes by that I have to spend hours trying to contact them at high cost on a 0300 number from a mobile phone, as medicines are missing from the order I submit through my pharmacist, or I get a limited supply. I'm absolutely exhausted trying to contact them again and again". Complaint*

Some people told us that they have experienced problems getting prescriptions or repeat prescriptions. We heard that the turnaround time for prescription requests was previously 4 days but this took longer and was advertised as up to 10 days on the practice website. Some people told us that they try to order repeat prescriptions well in advance but sometimes this doesn't help, and they have to get help from their pharmacist/chemist. We heard that local pharmacies give medication supplies to patients until their prescriptions are authorized or arrive. People also told us about inaccuracies and delays in prescriptions being dispensed and their frustration at being on the receiving end of this.

People told us that because of previous issues, they are not confident when they submit a prescription request. The only way to check if a prescription is being progressed is to telephone the surgery but that getting through is problematic.

> *"If you're on repeat medications, and they send a note to the pharmacists saying we won't renew this until you've had a review, and then you can't get a review, so you're then left for weeks months without medication that you need to maintain your health." Focus Group participant*

People told us that they understand and agree with the need for medication to be reviewed. We heard that people are asked by the surgery to make appointments for medication review, which might

include regular blood testing. However, because of the difficulties in making appointments, it is not possible to do this in a timely way and consequently important medication supplies are interrupted. Improving telephone access generally may impact positively on prescriptions and medicines reviews.

In line with GP contractual changes in 2018, ELHSCP supports RMPs prescribing through the provision of a pharmacotherapy service. This service includes dedicated pharmacist and pharmacy technician time to support medicines reconciliation after hospital discharge, medication reviews, repeat prescribing issues and other issues with regard to medicines management.

The review team met with members of this pharmacotherapy team who commented on the good relations between RMP and pharmacotherapy staff.

When we reviewed the prescribing process, we agreed there were several opportunities for improving processes for patients. Improvement in this should be driven by better understanding the experience of users of their systems, to help inform change ideas. This will be helped by clear prescribing principles agreed by all staff, continued work to move towards serial prescribing – as set out here – and having allowable repeat issuing by administration staff.

Medications are usually subject to a periodic review and reauthorisation to ensure changes to health or impact of recent tests for example is taken into account for safe ongoing prescribing. The practice should consider the pros and cons of reauthorisation of medication on serial prescribing being done by the pharmacy team. It is important to have a visible clinical input to this process beyond the issues currently considered by pharmacy staff. Education sessions with pharmacy staff and joint working may help to address this.

During our Review, we recognised the efforts required to provide pharmacy services and spoke to the Lead Pharmacist in ELHSCP. The support RMP received for pharmacy services delivered as part of improvements to support all practices across Scotland was comparable and aligned to that expected (Scottish Government, 2019).

***17. Recommendation RMP** in collaboration with ELHSCP to review prescribing processes alongside pharmacy team, informed by patient experience to improve quality and efficiency of access to acute and repeat medication.*

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10. Recommendations

The Review Team invited RMP to make their own suggestions about how improvements could be made. Many of these suggestions are included here and we are encouraged by the progress made by RMP since the Review began. The list of recommendations is included below and includes which organisation is responsible. The Review has been instructed to review progress at three, six and twelve months.

Number & Theme	Lead organisation	Recommendation
1. Contact	RMP	Urgently review the telephone system to ensure it meets patient need. Areas to be considered include call-waiting, filtering of phone calls and content of messages to be more patient centred.
2. Contact	RMP	Carry out further work to maximise the utilisation of the data from the telephone system to improve the patients experience of accessing care.
3. Contact	ELHSCP	Urgently review their contracting and working arrangements with RMP to develop a shared understanding of how the resources provided [in addition to GMS] such as the CWIC service can be delivered and sustained.
4. Contact	RMP	Should carry out Quality Improvement work to identify the nature of the requests they get from patients in relation to pre-bookable, same day or urgent care.
5. Contact	RMP	Should continue to review the job title, role and working hours of the team to ensure that there is sufficient staff working with the appropriate skills at the right time i.e., 8am – 10 am to meet patient demand.
6. Contact	ELHSCP & RMP	Continue to promote and signpost patients to the range of alternative services that are available in the locality. This information should be easily accessible for patients in a range of venues and formats, such as on-line and in the community.
7. Contact	RMP	Continue to support its call navigators' learning and development and consider further training in areas such as Care Navigation, Customer Care and Challenging Conversations and Complaints. The practice considers developing a Care Navigation protocol for the call navigators which could also be shared with patients.
8. Contact	ELHSCP & RMP	Continue to review their triage and telephone consultation processes and consider providing more personalised call back or a booked telephone consultation time. RMP should review its list of issues which should be managed in a face-to-face appointment to prevent patients having to have both a telephone and face-to-face consultation.

9. Contact	RMP	In collaboration with ELHSCP, review the process for signposting to ELHSCP services to reduce double handling or duplication.
10. Contact	RMP	Consider introducing on-line appointments for more routine appointments with the practice nurse and other members of the team.
11. Contact	RMP	Review its access arrangements for patients who find it difficult to access care over the telephone or online.
12. Comprehensiveness	RMP	Adopt the NHS Model Complaints Handling Procedure to ensure patients can make complaints in an accessible and person-centred manner. *a) Survey those patients who have complained to monitor the process and subsequent satisfaction.* *b) Measure and Monitor the Key Performance Indicators for Complaints and report these on the RMP website.* *c) Review the policy and associated materials about unacceptable actions* *d) Ensure staff continue to be supported about how best to respond, resolve and learn from complaints.*
13. Comprehensiveness	NHSL & ELHSCP	Support the contractual and legislative requirements for the monitoring and reporting of complaints. Consideration should be given to further learning and training opportunities for staff.
14. Continuity	RMP	Resume pre booked appointments, particularly for patients with more complex conditions or increased need.
15. Co-ordination	RMP	Working with PPG and other stakeholders produce a Vision and Values Blueprint as a basis for building relationships.
16. Co-ordination	ELHSCP & RMP	To renew the patient engagement strategy to include the principles in the National Standards for Community Engagement and the VOiCE tool.
17. Co-ordination	RMP	To review prescribing processes alongside pharmacy team, informed by patient experience to improve quality and efficiency of access to acute and repeat medication.

Table 10 - Table of Recommendations

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Appendix–1 - Scope

External review into the access and capacity of Riverside Medical Practice LLP.

v5 12.04.22

A. Purpose

An external review will be commissioned by the East Lothian Health and Social Care Partnership to assess patient concerns regarding access to primary care services provided under the 17C GMS contract held by Riverside Medical Practice LLP. This is to understand the views of patients of the practice, consider the practice model for providing access, triaging of patient need and clinical capacity within the practice and from the HSCP resources as provided for under the section 17c contract. The purpose of the review is to understand the key drivers for patient concern and identify opportunities to address these.

B. Scope

The external review will be driven by the patient concerns and limited to the following:

- **Patient feedback:** Comprehensive engagement with the practice population to gather insight and hear from the community
- **Reception processes in the practice**. This includes all methods available to patients to contact the practice and includes the capacity, organisation, and alignment of reception resources against variation of patient demand.
- **Non-clinical and clinical triaging systems** within the practice to optimise good utilisation of clinical capacity.
- **Clinical capacity** within the practice team, and from the HSCP resources provided as per the 17c contract and PCIP associated services

The following are outside the scope of this review

- The quality of patient care provided by Riverside Medical Practice.
- Contractual arrangements of the practice

C. Review Objectives

In reviewing access and capacity of primary care services provided for patients registered to Riverside Medical Practice, the external reviewers will give particular attention to the following focus areas:

Patient Satisfaction with contacting Riverside Medical Practice

The primary driver of this review is the concern raised collectively and consistently by the patient population with regards to access. It is vital that the review is able to assess the themes of these complaints and offer views on the proportion caused by system issues and the proportion driven by public consensus.

Contacting Riverside Medical Practice

Determine whether the external panel can provide assurance to East Lothian HSCP that Riverside Medical Practice benchmarks favourably with other General Practice service models for access to General Medical Services.

Non-Clinical and Clinical Triaging process within Riverside Medical Practice

Determine whether the external panel can provide assurance to East Lothian HSCP that Riverside Medical Practice benchmarks favourably with other General Practice service models for non-clinical and clinical triaging process within the practice.

Clinical Capacity within Riverside Medical Practice

Determine whether the external panel can provide assurance to East Lothian HSCP that Riverside Medical Practice benchmarks favourably with other General Practice service models for clinical capacity to General Medical Services taking into account the section 17c Contract arrangements

If the panel cannot provide assurance to all or any of the above, then to make recommendations for improvement.

D. Governance

The Review Panel will report to Alison Macdonald, Chief Officer East Lothian Health and Social Care Partnership. The Review Panel will investigate and make recommendations on any of functions within the scope of the external review.

E. Outputs

The Review Panel will report to the HSCP on tbc with an evaluation of its findings and recommendations for Riverside Medical Practice, NHS Lothian (NHSL) and East Lothian HSCP. There will be a review of the progress to implement recommendations after 3 months and a further review of progress after 6 months.

Appendix 1A – 17C Contract

General Practice in Scotland

GP Practices in Scotland fall into three contractual types:

17J practice: A 'Section 17J' or 'GMS' (General Medical Services) practice is one that has a standard, nationally negotiated contract. Within this, there is some local flexibility for GPs to opt out of certain services (such as additional services) or opt into the provision of other services (such as enhanced services).

2C practice: In general terms, this is most likely to mean that the practice is run by the NHS Board (as opposed to being run by GPs and/or other partners, as is the case for practices with 17C or 17J contract types).

17C practice: A 'Section 17C' practice is one that is based on the GMS nationally negotiated contracted (as per 17J) but also has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances.

GP Practices with a 17J or 17C contract are known as 'independent contractors' and are normally GP partnerships. They will have a partnership agreement which sets out the partnership arrangements including workload commitments, profit share etc. A small number of practices in Scotland have a non-GP partner such as a manager or nurse. The GP partnership has a GMS (General Medical Services) contract for NHS services with their NHS board.

The main funding to run the practice is known as the 'global sum' and is based on the number and demographics (age, sex etc) of their registered patient list. Practices can also receive additional funding for providing other services such as 'enhanced services' etc. Details around the funding to general practice is available in the Statement of Financial Entitlement (SFE)

During the patient focus groups several patients stated that they understood Riverside to be a private practice. Riverside is an independent contractor which has a 17C contract with NHS Lothian for the delivery of NHS services.

Practices as independent contractors employ their own staff (practice managers, receptionists, admin staff and general practice nurses) and decide what staffing levels they require, what salary and other terms and conditions they will offer etc. Profit that is left after payment of all expenses (including staff and salaried GP costs) are then available for the GP partners to take as drawings. Therefore, the level of income available to GP partners is dependent on the level of expenses. The more expenses a practice has to pay out the less income for partners.

As part of their 17C or 17J GP contract practices have to be available to their patients from 8am – 6pm Monday-Friday (NHS24 and the Out of Hours service will be available out with these hours). There GMS contract will also specify the practice area or practice boundaries which sets out which catchment area the practice will accept patients from. Practices can refuse applications from patients to join the practice if they live out with their practice boundary. Any applications to change practice boundaries (either increase or decrease) have to be agreed with their health board.

The GMS Contract (which both 17C and 17J contracts are based) sets out that practices must provide services (duty of care) to their patients or temporary residents (visitors) who are:

a. ill, with conditions from which recovery is generally expected;

b. terminally ill; or

c. suffering from chronic disease

The GMS Contract also sets out other contractual requirements such as compliance with the Patients' Rights Act, Health and Safety at work act etc. There are also separate regulations which set out the legal requirements for General Practitioners before they can work in Scotland.

Riverside Medical Practice has a 17C contract with NHS Lothian which includes a Service Level Agreement with East Lothian HSCP which sets out services which will be provided by the HSCP to support RMP provide care to their patients.

This section 17c contract states that:

"Same day demand for general medical services will be dealt with by East Lothian HSCP's Collaborative Working for Immediate Care (CWIC) Service. Operational procedures for this are set out in a Service Level Agreement which states: ELHSCP agrees to provide support from the Collaborative Working for Immediate Care (CWIC) Service to Riverside Medical Practice LLP (RMP) to manage same day appointment demand under the terms below.

The CWIC service will see RMP Patients who have been triaged to require same day appointments. A same day appointment is defined as a clinical requirement of face-to-face assessment within 36 hours after the initial RMP triage led processes.

CWIC will initially provide a minimum of 350 appointment slots per week to RMP between the hours of 09:00 to 17:00 Monday to Friday, across a balance of specialist clinicians. The CWIC team will additionally have seasonal support from HSCP funded GPs to support winter pressures and manage initial gaps in skills-sets or service in the CWIC team.

The annual review of the 17c contract by the Primary Care Contracts Organisation and ELHSCP will include consideration of CWIC service provisions to RMP.

RMP and CWIC will routinely gather appropriate activity and outcome data concerning practice activity, CWIC activity, clinical outcomes, referral and other activity data and utilisation of the CWIC service. This information will be used as part of the monthly CWIC/RMP meetings, the annual review process and any reporting/governance requirements.

RMP and CWIC will work together with each other in the preparation of any reports requested appropriately by the HSCP Management Team, East Lothian Integration Joint Board, the Scottish Government, other funders or partners. Any publication/report/publicity to any aspect of the joint service model between RMP and CWIC requires permission of all stakeholders and recognition of all contributions. "

Appendix 2 Review Team

Dr Dorothy Armstrong (lead) I am a registered nurse, director and lead professional adviser with the Scottish Public Services Ombudsman. My passion is to ensure people are at the heart of their healthcare experience, in an environment where those both giving and receiving care are valued and appreciated. I regularly present seminars on the Power of Apology and Listening and Learning from feedback. I am an Honorary Fellow at the University of Edinburgh and was awarded a Doctor of Science degree in 2010 for services to patients. I am a Fellow of the Royal College of Physicians of Edinburgh. During the height of the pandemic, I worked as a vaccinator. It is also a privilege to be the Chair of Seagrove, a day facility for people living with dementia.

Fiona Duff I am an experienced practice and primary care manager having worked as a Practice Manager, a Fundholding Manager and Primary Care Manager. In this role I ran Board run "2c" practices as well as leading on General Medical Services General Practice contractual and quality issues across Highland. I am currently seconded as a Senior Management Advisor to the Primary Care Directorate at Scottish Government. I have a particular interest in remote and rural issues, quality improvement in primary care, the sustainability of general practice and the development of the primary care team, especially the role of Practice Managers and administrative staff. In my government role I have developed the Practice Admin Staff Collaborative with Healthcare Improvement Scotland, work closely with the National Practice Managers Network at NHS Education Scotland, and was part of the team that negotiated the 2018 General Medical Services General Practice contract. Recently I have been leading the public messaging work in the directorate and developing support for practices as we come out of the pandemic with a particular focus on access and infection and prevention control.

Dr Scott Jamieson I am a GP at Kirriemuir Medical Practice in Angus, an Out of Hours (OOH) GP, a GP trainer, and Primary Care Strategic Lead in Tayside. I was previously the Royal College of General Practitioners (RCGP) Scotland Executive Officer Quality Improvement and am currently a Scottish Quality and Safety Fellow. I have an interest in quality improvement methodology to aid and coordinate service improvement. I am currently the RCGP UK GP member of the Year and part of the RCGP Primary Care Team of the Year in Tayside's Primary Care Coordination and Command Team. I have an interest in therapeutics working in local and national boards including Area Drug and Therapeutics Committee and development of the polypharmacy risk tool. I present the National Primary Care Resilience Webinars and am the GP on the national Pharmacy First Advisory Board.

Dr David Shaw I am a GP, working 3 days a week as a partner at the Erskine practice in Dundee. I joined the practice in 1997, and since 1999 have held a variety of positions within Dundee Local Health Care Cooperative, Dundee Community Health Partnership and NHS Tayside. Since 2015 I have been the Associate Medical Director for Dundee Health and Social Care Partnership, and since 2020, I have also been the Interim Associate Medical Director for Primary Care in NHS Tayside. I also work as an GP and have been an OOH clinical lead for NHS Tayside since 2015. I have an interest in improvement work and helped lead several award-winning initiatives designed at improving healthcare resiliency and health services. These include the RCGP Bright Ideas Award for the development of the Tayside Career Start programme; the Quality in Care Award for developing diagnostic and referral pathways to support hepatitis C care; and the RCGP Primary Care Team of the Year Award as part of Tayside's Primary Care Coordination and Command Team.

Appendix 3 Community Engagement Report

Community engagement

A key part of the review was engaging with the patients registered at Riverside, so we could understand their experiences of accessing care. We were interested to find out what worked well, what concerns they had and any suggestions for improvement. This Report outlines the process used, the themes and a selection of direct quotes from the meetings and interviews and suggestions for improvement.

We would like to take this opportunity to thank all those people who participated for taking the time to share their experiences with us in an open and transparent way. Thanks also to Gina Alexander who facilitated the Focus Groups and provided the Review Team with her expertise in community engagement.

Community engagement methodology

The National Standards for Community Engagement were reviewed and taken into consideration. The VOiCE tool was used to support the design and delivery of activity.

Planning and delivery of the community engagement activity was carried out by the independent, external Review Team in liaison with:

- the office of Colin Beattie, MSP
- the office of Sarah Boyak, MSP
- RMP management team
- East Lothian Health and Social Care Partnership
- Volunteer East Lothian
- RMP Patient Participation Group
- Riverside Medical Practice Experiences Group representatives

Focus groups were held during June and July 2022. Focus groups were a mix of online and in person options.

Potential participants were provided with a briefing note explaining the purpose of focus groups and the registration process.

ELSHCP and Volunteer East Lothian supported communication across community and voluntary sector organisations.

The focus groups considered three areas:

- Peoples' experiences of accessing healthcare at RMP & associated services such as CWIC
- What was good or working well
- Ideas and suggestions for improvement

We have included the many suggestions given by participants. Some of these have been included in the main report.

The table below gives details of each planned focus group

Date	Target Group	Registered	Attended
20 June	People who had been in contact with MSP	31	11
22 June	People who had been in contact with MSP	26	12
5 July	Facebook group	9	9
11 July	Patient Participation group	10	9
14 July	Patients recently accessing care – invitations via RMP	4	3
18 July	Patients recently accessing care – invitations via RMP	2	Cancelled, participants moved to alternative date
19 July	In person – community contacts	n/a	10
19 July	In person – community contacts	6	3
20 July	Online – community contacts	7	3
21 July	In person – community contacts	0	Cancelled due to lack of registration
21 July	In person – community contacts	0	Cancelled due to lack of registration
		Total	**60**

Table 11 - Planned Focus Groups

An online form was created to enable the participation of people who were unable to attend focus groups or who wanted to share further details.

The form invited people to consider the three areas noted above.

The table below shows the number of online forms completed.

Target group	Online forms completed to date
Individuals	160
Community groups/organisations	7
Pharmacies	2
Total	**169**

Table 12 - Completed online forms

Online forms were completed anonymously. The age profile of people who completed the form is shown in the chart below.

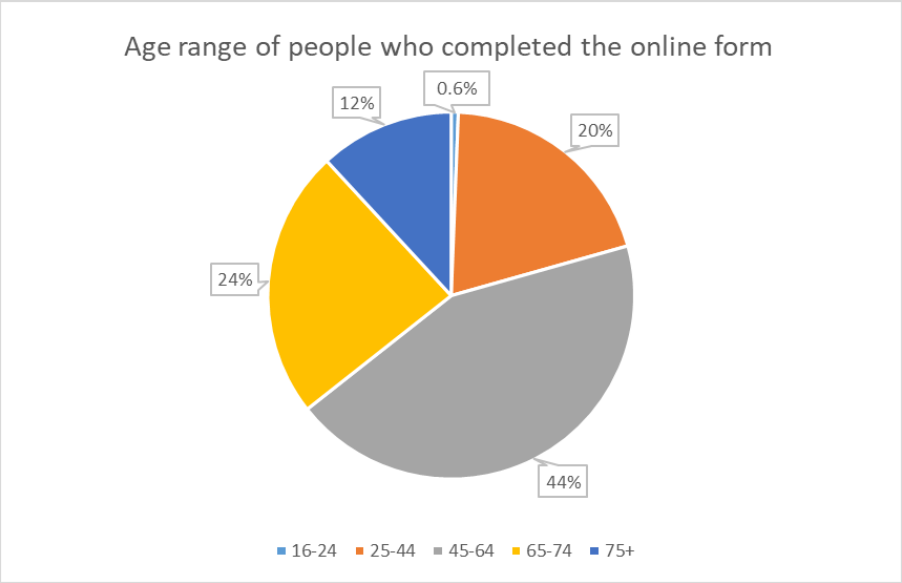


Table 13 - Age profile of completed forms

Most people (44%) who responded were in the 45-65 age group. 37% of those who completed the form were aged 65 and over. There was only one response in the 16-24 age bracket.

Things which work well

Almost everyone who told us about things which worked well said the care from healthcare staff at RMP was good using the following descriptions: professional, thorough, brilliant, excellent, helpful, understanding, friendly.

> *"Some of the team that field calls are fantastically friendly and helpful"*
>
> *"I have found the doctors and nurses to be kind and professional"*
>
> *"When I really needed an appointment with a doctor… I could not have had a quicker, more efficient & personal service from everyone"*

People also told us that they appreciate:

- That nurses can make advance appointments
- CWIC service
- Ordering prescriptions online
- Being able to get advice and support by phone
- Being able to write to or email health care staff
- The organization of the COVID vaccine

Challenges and suggestions for improvement

People were asked to share their experiences of accessing healthcare at Riverside Medical Practice. People also told us that the difficulties in accessing healthcare had a negative impact on their health.

> *"I have an ongoing need for regular ear wax removal. This may seem trivial but if I can't hear, I can't work and I can't communicate with family and friends - it can be several weeks before I can get an appointment. It's also not easy to make an appointment over the phone if you can't hear!"*
>
> *"I had skin cancer, all worked well but now have patches on body and neck. I should really get them checked but have so much else to deal with (getting my son and brother seen) I don't have the time and can't be bothered with the effort of trying to get an appointment".*
>
> *"I delayed for so long my condition deteriorated and when I finally had to get medical attention I was sent to A&E."*

We've organized what people told us by themes and included the ideas and suggestions for improvement people had. It's important to note that people felt that these improvements may need to be made by a range of organisations:

- Riverside Medical Practice
- East Lothian Health and Social Care Partnership
- Scottish Government

Phone system

Most people told us that the phone system which is the only way of accessing the practice causes frustration, in some cases leaving people feeling angry, upset, in tears, exhausted and stressed.

Some people told us that they start phoning at 8am, having to redial many times (up to 128 times), being cut off without explanation, on hold for long periods of time (up to 60 minutes), using multiple phones in an attempt to get into the queue often to be told that there are no appointments left for that day if they want to see a GP and are advised to call at 8am the following day.

Some people told us that due to work or family commitments they were unable to access the surgery via this route.

Some people told us that they have tried for days and weeks to get through to the surgery on the phone.

Some people told us that the effort of trying to get through on the phone puts them off calling the surgery and that sometimes they resort to different sources of support e.g., NHS24/111, Accident & Emergency, the internet, buying medication online. Some people expressed concern about the repercussions on their health of delaying or avoiding making an appointment with the surgery. Some people are worried that some groups of people e.g., elderly, vulnerable are unable to navigate or use the phone system.

Some people expressed concern that the phone number used by the surgery is a premium rate number and is costly for people who have to pay for calls.

"The thought of waiting up to an hour on the phone to get through to someone and then need to wait for a call back just doesn't work when you have a job in town. I then can't make an appointment at short notice if I am at work and can't book ahead for a future date. My husband and I just don't bother making appointments for ourselves."

"I have been disciplined at work several times for trying to make a GP call- my employer does not believe that access to the GP has to take so long or be so persistent."

"In the last year when we have had illnesses we have actually resorted to the internet and speaking to people. We have actually excluded the practice as a means of support"

"I work with vulnerable young people in the local area and the pandemic has had a massive impact on their general health (they are less active, more isolated and have high anxiety levels with increasing levels of self-harm and suicidal ideation). These young people and their parents are not accessing health services."

"My husband needs to have a review of his heart medication just now, but he has M.E. / chronic fatigue and mental health problems and is not in a fit state to phone at 8am but if he calls later in the day, he is just told to ring at 8am. There is no flexibility in the system at all."

"(my) phone bill was £30 plus one time, and the only calls were to Riverside"

What people suggested:

- Increase number of lines and operators first thing or at peak busy times e.g. Monday mornings
- Improve the user friendliness of the phone system, i.e.
    - Review content and tone of automated messaging
    - Advise callers on their position in the queue
- Increase the number of options available to direct calls e.g. 1 for on the day appointments, 2 for advance appointments, 3 for prescriptions, 4 for medicine review, 5 for fit notes 6 for advice etc.
- Create a separate prescription line to divert call and reduce bottleneck
- Offer a ring back service
- Change to a local phone number from premium rate number
- Enable callers to be diverted to the other services mentioned on the phone line e.g. mental health services
- Enable "silent hold" with no background music/voice overs

Booking Appointments

People told us about their frustration with the current system: where the only option is to phone RMP from 8am for a same day appointment. Some people told us that they have had repeat or regular appointments made by nurses, but others believe that booking appointments in advance is not possible.

We heard that people say that they do need an emergency appointment, even if they don't, otherwise they feel they won't be able to see a doctor at all. Some people told us that they are put off making appointments because they know they can't attend on the day appointments as they have other commitments or restrictions e.g. children, work, lack of transport.

People told us that the current "call back" system is incompatible with their daily lives. We heard that people miss calls or are unable to take them when they are working or dealing with other commitments.

"I feel bad because you've taken an appointment that day from something which is actually really quite routine."

"If you are in employment, the 'phone the same day for an appointment that day' is like Russian Roulette - you may get one, you may not. How can you hold down a job not knowing if you need to take time off later that day or not?"

"We should be able to book appointments at reception. The reason I say this is that my mother is very deaf. Despite being independent in other aspects of life she is unable to deal with her own medical needs because she cannot hear on the telephone. It is nothing short of discriminatory that because of her disability she is being prevented access to a doctor. On occasion after calling for her she has been offered a telephone consultation which is frankly outrageous. It is quite clear on her medical records that this is not suitable due to her deafness, yet we have had to accept as there was no alternative. Meaning calls are made to me and I have to discuss personal and at times embarrassing details on her behalf. She should be able to have a face-to-face appointment where she can manage much better and can lip read the doctor."

"We can be taking those phone calls anywhere and even have taken them in Tesco, have taken them in the vet."

What people suggested:

- Allow booking ahead for routine, not emergency, matters e.g., medication reviews
- Reallocate cancelled appointments
- Allow all health staff to make follow up bookings if they think it's necessary
- Allow health staff to book regular appointments e.g., for regular blood tests
- Enable any time booking to avoid the 8am bottleneck
- Enable booking at the reception desk for those who prefer this approach – not everyone is happy with online booking or using the phone
- Enable a call back window, i.e., someone will call you back between x and x

Using technology

People told us they felt that greater use could be make of technology to alleviate pressures on the phone and appointment system and RMP staff. We also heard that people believed that enabling greater use of technology would help RMP to accommodate people who need or prefer face-to-face appointments.

"The phone line is being taken up by things that could be dealt with in a different way"

"So I've had a couple of phone consultations with GPs, which have been excellent. And they have really listened, they've allowed time to have proper conversations we've explored a number of options, and there's a real sense of it doesn't feel nearly as rushed as a recent appointment I had face-to-face"

"I feel disempowered that you have all this info about me and I don't. I can't remember the order of events sometimes when I am wondering if I should get something checked. When was the last blood test? Having my own records would help."

What people suggested:

- Greater use of NHS video or virtual appointments system known as NHS Near Me
- Enable email correspondence from patients with simple queries or follow up questions
- Improved practice website to guide/direct patients as to how they can get help and support with contact details
- Consider use of eConsult – an online system for getting general advice and help or requesting a fit note
- Greater awareness of online prescription service
- Enable online booking of appointments
- Create digital patient records which will support people to have ownership of and access to their own medical records

Choice

People told us they were frustrated by the lack of control and choice about the ways they can access health care. Some people believe offering greater choice will help reduce the pressure on current systems. Some people told us they feel trapped and unable to exercise choice about the general practice they use.

What people suggested:

- Offer patients a preferred method of contact – face-to-face, phone, video call
- Enable more face-to-face appointment
- Evening and weekend appointments
- Offer a regular open surgery where people can drop in but have to wait in a queue
- Continue with house calls for elderly/very sick
- Allow patients to move practice

Capacity of practice

People told us that they were concerned about RMPs ability to deal with the number of patients registered. We heard that people felt that the difficulty in accessing health care at RMP was due to lack of full time GPs, inadequate GP to patient ratio or insufficient administration staff to deal with calls. People told us they were worried about how RMP and general practice in Musselburgh will cope with the increase in population numbers in the area due to new building developments. People felt that RMP were not coping with the demand from the existing population.

What people suggested:

- Reduce number of patients by splitting the practice
- RMP should not accept any new patients
- Explore the GP to patient ratio and increase GPs if required
- Increase reception staff to deal with calls
- Utilise nursing staff to run open surgeries with referral to GP if required
- Offer a sexual health clinic at RMP/in Musselburgh
- Review the physical space available to RMP: they are operating from the same physical space when they had 10,000 patients registered
- Open the planned surgery in Wallyford
- Ensure that there is enough healthcare capacity within the area to cope with the increase in population numbers
- Enable patients to access underutilized capacity elsewhere in the general practice system throughout Scotland
- Remove the territorial exclusivity for GP practices

Triage system

Some people told us they understand the need for a triage system. Others told us that they don't like the way the current triage system operates.

We heard that people object to sharing what they regard as private and confidential information with a non-medically trained receptionist or call navigator. Some people are concerned at being asked to assess whether they are an emergency. Some people are concerned that receptionists/call navigator are not sufficiently qualified to direct them to the right service.

We heard several accounts of people being in a three-way conversation, with the receptionist/call navigator relaying questions and answers to and from the patient to a nurse. These people felt it would be more productive and efficient if they had been able to speak directly with the nurse.

"I get that they have to ask questions and they have to triage you, but the manner they ask things, and they tone they talk back to you in is sometimes very belittling, and they can be quite invasive, be abrupt and they can be dismissive which depending on what you're calling about is not helpful at all. And does sort of, you know, inflame the situation."

"I managed to get through to the surgery to get some advice had the operator, asking me as she does, what was wrong. Explained what was wrong, very calmly. She then spoke to a practice nurse. And then started relaying in back questions from the practice nurse – now this is the operator. I asked to speak to the practice nurse, I was told no, they had to relay the questions back."

What people suggested:

- Stop receptionists/call navigators triaging calls
- Increase training and supervision for call navigators
- Move to a system of nurse triage rather

- Stop the practice of three-way conversations – connect the caller to a nurse instead of being on the end of a conversation between the nurse and the receptionist

> *"A few years ago they did have quite a good system running I thought where you would phone up in the morning, the receptionist would kind of decide whether you could get an actual GP appointment or whether they would refer you through to the sort of NHS 24 system. somebody would phone you back from NHS 24 I think or some other organization at a time, they would call you back and they would do an assessment situation over the phone so it was somebody that they weren't just a receptionist at the practice that was deciding where you would go or what you would do."*

Early intervention, prevention and routine healthcare

Some people told us that they were concerned that opportunities to preempt health care issues were being missed as a result of the difficulties in accessing care.

> *"Provision should not be solely for 'health problems that need treated today'. This effectively rules out routine healthcare."*

What people suggested:

- Initiate regular, scheduled health checks for those over a certain age as a preventative approach
- Proactive annual reviews of chronic conditions to be reinstated

Consistency of care

People told us that they understand that they cannot expect to see the same doctor or nurse every time they visit the surgery, however, this is something that they really miss. We heard that being unable to see the same doctor often means that they have to repeat their story/symptoms. They also told us that locums can be variable in quality and also have a negative impact on continuity of care.

> *I was struggling to cope with my husband's diagnosis of cancer. I saw a doctor who was very helpful and asked that I come back in a fortnight. No appointment was given then and had to wait for a phone call from the surgery. Then I saw another doctor and had to start again as to why I was there.*
>
> *"I had over two months of intense cystitis but because there's no way to see the same doctor, I got no consistency of care. This all happened after my dad died three days into the first lockdown, on the same day my mum was put into a ventilator. So I was going through the most stressful time of my life. Not seeing the same doctor meant I did not get broad spectrum antibiotics for months. I had the added stress of explaining what was going on to at least 5 different GPs."*

What people suggested:

- Allow patients some choice in the GP/nurse they see to support continuity of care and reduce the need to repeat stories
- Limit the use of locums

Education and information

People told us that they were not sure what support they could get from other healthcare staff directly, e.g. physiotherapists, opticians, pharmacists, minor injuries, CWIC service. They told us that they would like more information about this support. We heard that they feel this could reduce pressure on the systems and capacity of the surgery.

> *"I didn't know that pharmacists can actually prescribe antibiotics or certain antibiotics."*
>
> *"There's also an education piece for staff as a friend was told by reception, she had to go to minor injuries for anti-biotics but she contacted her pharmacist who confirmed they could do it"*
>
> *"(there has been a) failure to communicate with the public about the dramatic changes which have been implemented as a result of the new GP contract. The one group who were not consulted as part of this process were the public".*

What people suggested:

- Clearer information for patients (online and in printed format) about the services they can access and who can do, e.g. pharmacist, optician
- Share info about GPs specialisms or interests e.g. who is a specialist in women's health, children's health, frailty
- Raise awareness of the school nursing services for children
- Using the right-hand side of prescriptions for information and messaging
- Communicate with the public about the range of healthcare professionals, in addition to GPs, who can support health needs

Prescriptions and medication reviews

Some people told us that they have experienced problems getting prescriptions or repeat prescriptions. We heard that the turnaround time for prescriptions used to be 4 days but now the surgery is advising that it can be up to 10 days. Some people told us that they try to order repeat prescriptions well in advance but sometimes this doesn't help, and they have to get help from their pharmacist/chemist. We heard that local pharmacies give medication supplies to patients until their prescriptions are authorized or arrive. People also told us about inaccuracies and delays in prescriptions being dispensed and their frustration at being on the receiving end of this.

People told us that because of previous issues, they are not confident when they submit a prescription request. The only way to check if a prescription is being progressed is to phone the surgery but that getting through is problematic.

People told us that they understand and agree with the need for medication to be reviewed. We heard that people are asked by the surgery to make appointments for medication review, which might

include regular blood testing. However, because of the difficulties in making appointments, it is not possible to do this in a timely way and consequently important medication supplies are interrupted.

> *"If you're on repeat medications, and they send a note to the pharmacists saying we won't renew this until you've had a review, and then you can't get a review, so you're then left for weeks months without medication that you need to maintain your health."*
>
> *"My 89 year old mother who never complains has great difficulty in accessing care and has more or less given up. After she went to the chemist 8 times to try and pick up her prescription, I finally jumped through all the phone hoops and a Doctor in the surgery reordered her online prescription account."*
>
> *"often, receptionists will tell patient's to come to the pharmacy to get an urgent supply as they will be unable to issue the prescription sooner….. When prescriptions aren't issued in time or changes made by the hospital aren't implemented in a timely manner it increases stress for us and the patient/patient family."*

What people suggested:

- Medication reviews to be carried out by nurses
- Medication reviews to be completed via email or online form if possible
- Community pharmacist (at RMP) could conduct medicine reviews
- Employ a prescribing pharmacist
- Enable confirmation and update service for prescriptions made via online form, i.e. received, authorized, dispatched to pharmacy – this would alleviate pressure on the phone system

Communication

People told us that they are concerned about communication and information.

We heard that the online complaints form had been removed from the website. Some people also told us that they had not received responses to letters and complaints they had sent to the practice.

People told us that they want to see more information about RMP. For example, how many GPs are there, how many appointments are available in a week, how many calls are received, how many people did not attend appointments.

We heard that there have been previous reviews and RMP and ELHSCP have promised improvements in access and services, but people do not see these improvements taking place. People are left wondering what has happened to these improvements.

People told us that they would like more openness, honesty and transparency in communication and information.

> *"taking on more staff does not seem to have made any difference to communication and access"*

"when I've complained about things in the past, I have to say that the response that you get from the management there has not really been very satisfactory"

"I just want to record that this feels like a failed experiment, one in which patients had no choice whether to participate and are unable to get out. I feel trapped!"

What people suggested:

- Reinstate the feedback and complaints system online
- Respond to complaints
- Listen to and act on concerns
- Share information openly and transparently, e.g. statistics, information, availability, services available.
- A letterbox at the surgery outside

Accountability

People told us they are curious and confused about who (ELHSCP, NHSL, SG) RMP are responsible to and whether they are part of the NHS or a private organisation.

People told us they would like to understand who they can go to if they are unhappy with the service from RMP. Some people told us they had been frustrated with responses from ELHSCP, NHSL and their MSPs and the lack of clarity about who is ultimately responsible.

People asked whether there were national standards which GPs had to meet in terms of access to as well as delivery of healthcare.

"And I would also like to be clear exactly who the practice is accountable to for the delivery of the service. So I think all of us will probably remember times over the past few years where we've tried to establish an answer to that question. And we've had NHSL saying they are private contractors, and they are nothing to do with us. I've spoken to EL health and social care partnership and not really had an answer to that to that question. So, I think that there needs to be clear, you know, in the public interest that needs to be clearer lines of reporting as to how effective or otherwise a given practice is."

"What is the quality control? Most other companies and businesses, the better they are, the more money they make."

"should there be a standard as to the maximum amount of time people should have to a) wait on a call being answered b) wait for an appointment."

What people suggested:

- Share information about the status of RMP and who the practice is responsible to
- Clarify the relationship between RMP and ELHSCP and NHSL
- Share information about general practice standards and monitoring systems

Working with the Patient Participation Group (PPG)

Some people weren't aware that PPG existed and suggested a patient action group be set up. One person said they had enquired about becoming a member but hadn't had a response.

We heard that the PPG had issued surveys to patients (2018, 2019) and carried out consultation students at Musselburgh Grammar. We met with some members of the PPG who said they were frustrated about lack of progress with suggestions for improvement they have made over the years. They told us that they don't fully understand why some suggestions have not been implemented. We heard that the issues raised in the 2018 and 2019 surveys reflect the current situation.

We heard that PPG members have a broad range of skills and are keen to support the practice with these, not just "stuff envelopes"

What the PPG suggested:

- Use the PPG to test out new ideas, improvements and plans being considered
- Harness the full range of skills and experience of the PPG members
- See the PPG as a conduit to communicate with patients and as an early warning system in flagging up issues.

Perceptions and concerns

People told us that:

- There is a lack of trust and confidence in RMP
- RMP has a poor reputation in the community, with pharmacies and hospitals
- Waiting rooms and consulting rooms appear empty
- Friends and family in other locations do not share the same experiences trying to access care
- They are concerned that future health needs are not being factored into planning and housing expansion locally
- Difficulties in access are widening the health inequality gap, reducing the opportunities to access care at the right time.

Recommendations for continued community engagement

The review has created an opportunity for individual patients, communities and other stakeholders to share their views and contribute to improvements related to accessing healthcare at RMP.

A continuous, constant and collaborative approach to involving and engaging honestly and transparently with patients and communities will go a long way to restoring confidence and strengthening relationships.

Our recommendations are:

RMP and ELHSCP refamiliarize themselves with the National Standards for Community Engagement: these are good practice principles designed to improve and guide the process of community engagement.

RMP and ELSHCP should make use of the VOiCE tool to support the design and delivery of effective community engagement.

RMP and ELSHCP should take account of Planning with People guidance from the Scottish Government: this guidance is designed to support greater collaboration between those making decisions about care services in Scotland, those delivering services, and people in communities who are affected.

Develop and publish a rolling involvement and engagement plan considering the following features:

- Collaborate with key partners to develop the plan e.g., patients, PPG, community organisations, MSPs, health colleagues
- Offer a range of involvement opportunities to suit practice population and key partners, for example
    - Available anytime Paper based feedback form
    - Available anytime online feedback form
    - Satisfaction surveys
    - Digital kiosks
    - Open days
    - Community events
    - Working groups
    - Patient participation group
    - Use of independent feedback mechanisms e.g., Care Opinion
- How will the range of opportunities be advertised to patients and to community partners e.g., community and voluntary sector organisations e.g., via website, text, newsletter, local press
- Detail the ways in which the impact of involvement and engagement will be shared, i.e., closing the feedback loop
- Update progress with the engagement plan

Review communications plan and strategy with a focus on listening to patients as well as sharing information. Consider approaches to:

- Use of social media
- Updating the website
- Working with local media

Improve utilization of existing Patient Participation Group, their skills, experience and knowledge with an emphasis on their role in:

- Seeking and collating feedback
- Being a testing ground for improvement and ideas

Appendix 4 Meetings held

The Review Team met as a group weekly from April – September 2022 for planning, analysis and to complete the writing of the Report.

Beyond this the following meetings were held as part of the review.

Date/Format	Attendees	Reviewer in attendance
14 March 2022 *Microsoft® Teams*	East Lothian HSCP: Alison MacDonald Claire Goodwin Iain Gorman Scottish Government: Michael Taylor	Dr David Shaw Dr Scott Jamieson
6 April 2022 *Microsoft® Teams*	East Lothian HSCP: Iain Gorman Alison MacDonald	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
3 May 2022 *Microsoft® Teams*	Riverside Medical Practice LLP: GP Partner Business Manager Communications Manager	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
10 May 2022 *Microsoft® Teams*	Patient Participation Group Chair Margaret McKay	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
10 May 2022 *Microsoft® Teams*	Colin Beattie MSP	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
11 May 2022 *Microsoft® Teams*	Sarah Boyack MSP	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
11 May 2022 *Microsoft® Teams*	NHS 24 Medical Director Dr Laura Ryan	Fiona Duff Dr Scott Jamieson
31 May 2022 *Microsoft® Teams*	East Lothian HSCP: Iain Gorman	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
8 June 2022 *In-person visit*	Riverside Medical Practice LLP: GP Partners Business Manager Communications Manager Care When It Counts: Kelly Moffat Alastair Clubb	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
10th June *Microsoft® Teams*	Community Engagement planning – Gina Alexander	Dorothy Armstrong Fiona Duff
17 June 2022 *Microsoft® Teams*	Pharmacy Locality Lead Alan Millarvie	Dr Scott Jamieson
21 June 2022 *Microsoft® Teams*	Pharmacy Locality Lead Alan Millarvie	Dorothy Armstrong Fiona Duff Dr David Shaw
23 June 2022 *Microsoft® Teams*	Riverside Medical Practice LLP: Communications Manager	Fiona Duff

28 June 2022 *Microsoft® Teams*	Musculoskeletal Service Louise Dickson	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
4th July 2022 *Microsoft® Teams*	Office of Colin Beattie MSP	Dorothy Armstrong
12 July 2022 *Microsoft® Teams*	External benchmarking assessment	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
12 July 2022 *Microsoft® Teams*	Inveresk Medical Practice GP Partner Practice Manager	Fiona Duff Dr Scott Jamieson
12 July 2022 *Microsoft® Teams*	Care and Treatment Assessment Centre Pamela Erasmusonn	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
18 July 2022 *Microsoft® Teams*	Riverside Medical Practice GP Partner Business Manager	Fiona Duff Dr Scott Jamieson
19 July 2022 *Microsoft® Teams*	East Lothian Care Home Team Suzanne Brown	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
25th July *Microsoft® Teams*	Admin and Support Team	Fiona Duff Dorothy Armstrong
26 July 2022 In-person visit - Hybrid	Riverside Medical Practice GP Partners Business Manager Communications Manager Admin & Support Staff Nurse Manager Inveresk Medical Practice: Practice Manager	Dorothy Armstrong – in person Fiona Duff – in person Dr Scott Jamieson - Teams Dr David Shaw – Teams Fiona Duff – in person
28 July 2022 *Microsoft® Teams*	Communications Manager	Dorothy Armstrong
16th August 2022 *Microsoft® Teams*	Riverside Medical Practice GP Partner Business Manager Communications Manager Admin & Support Staff Nurse Manager	Dorothy Armstrong Fiona Duff Dr Scott Jamieson Dr David Shaw
23rd August 2022	Care When it Counts (CWIC) Mental health team Fiona Graham	Dorothy Armstrong Dr David Shaw
25th August 2022 In-person visit - Hybrid	Riverside Medical Practice GP Partners Business Manager Communications Manager Admin & Support Staff Nurse Manager	Dorothy Armstrong – in person Fiona Duff – Teams Dr Scott Jamieson - Teams Dr David Shaw - Teams

Table 14 - Meetings held

Appendix 5 Benchmarking wider Clinical Consequence

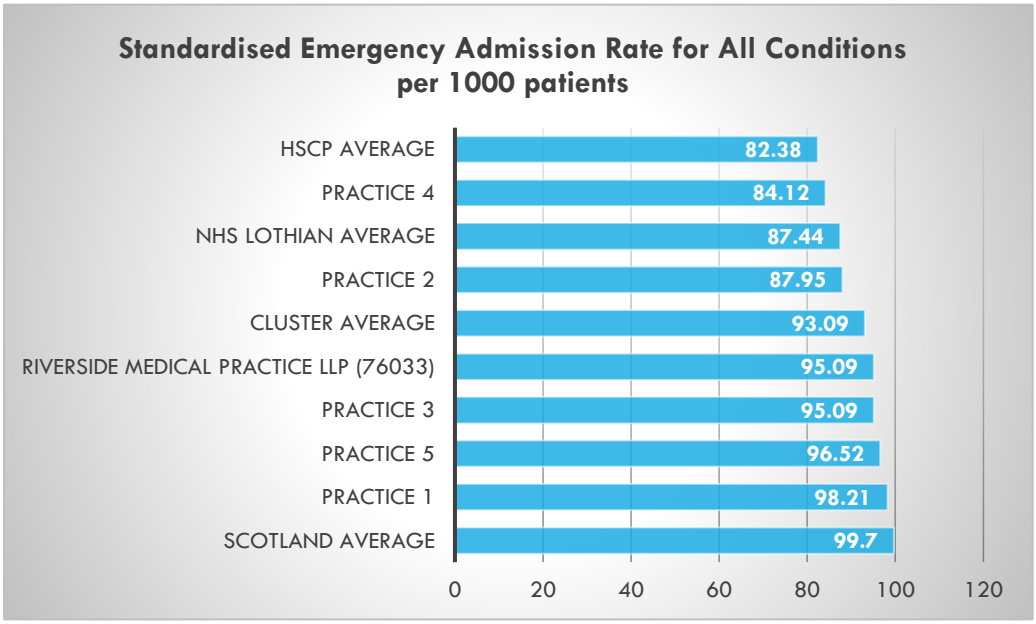


Table 15 - Standardised emergency admission rate for all conditions per 1000 patients

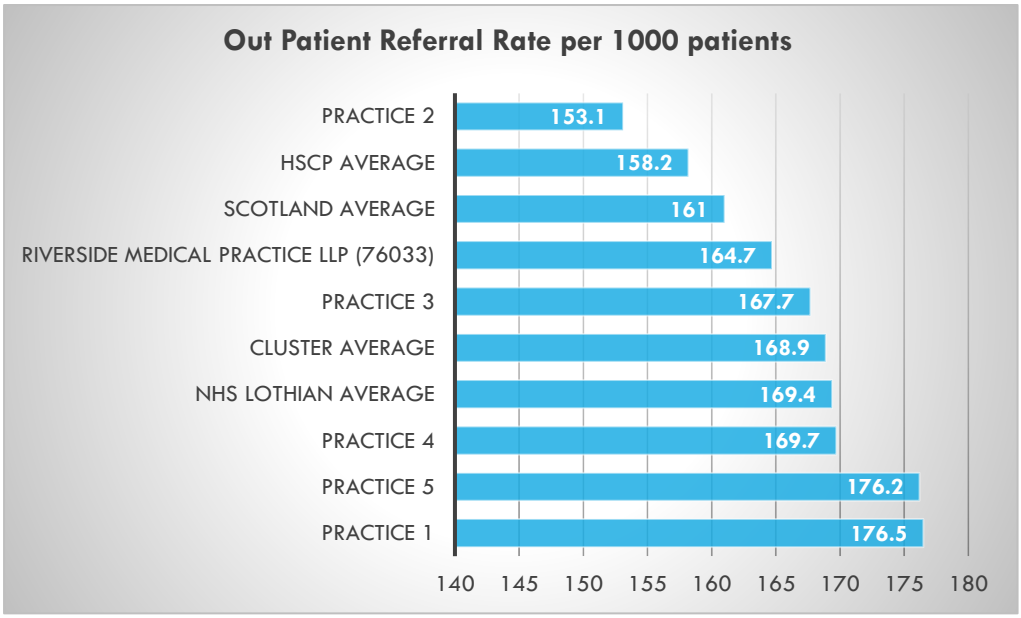


Table 16 - Out patient referral rate per 1000

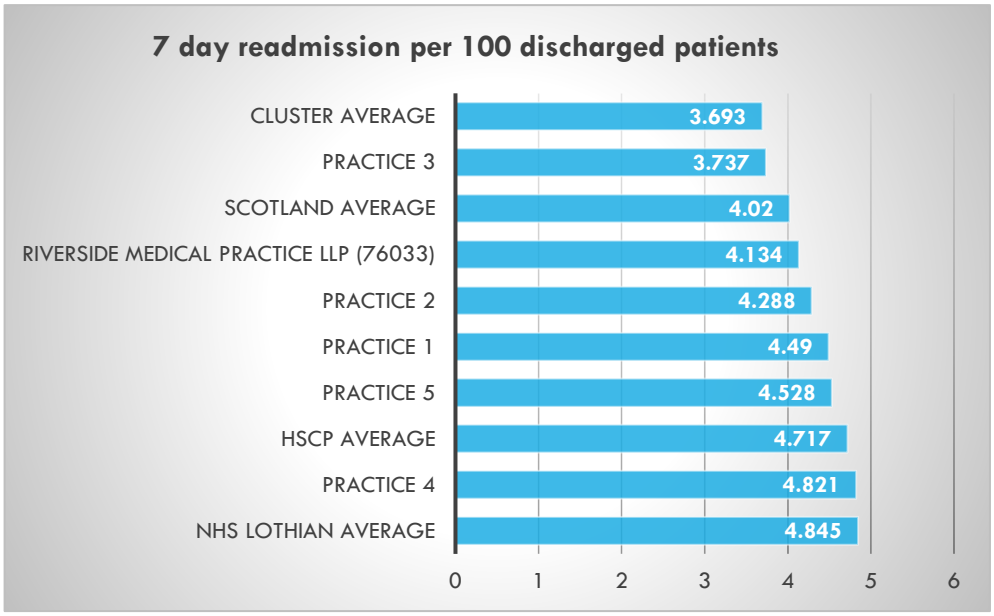


Table 17 - 7 day readmission per 100 discharged patients

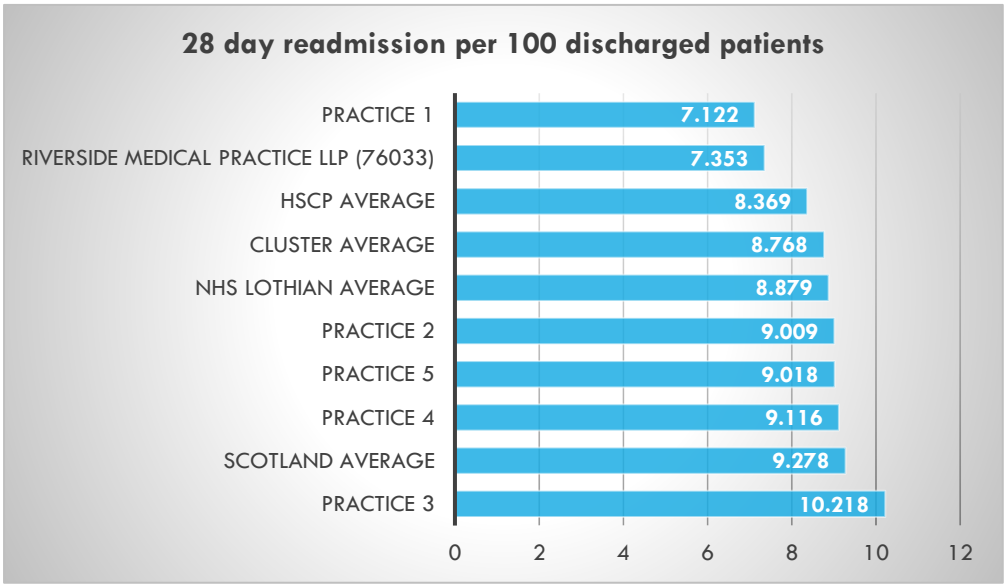
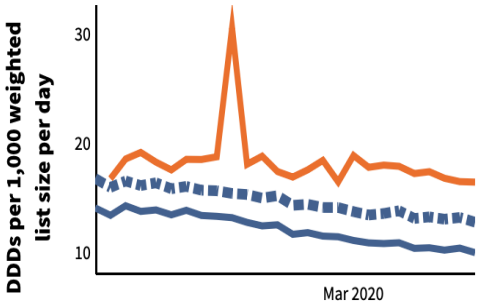


Table 18 - 28 day readmission per 100 discharged patients

Riverside Medical Practice LLP, Musselburgh (76033) — NHS LOTHIAN — SCOTLAND

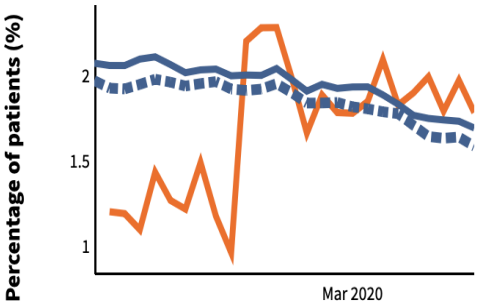
Indicator Group: All

Indicator: Analgesics (opioid DDDs) weighted



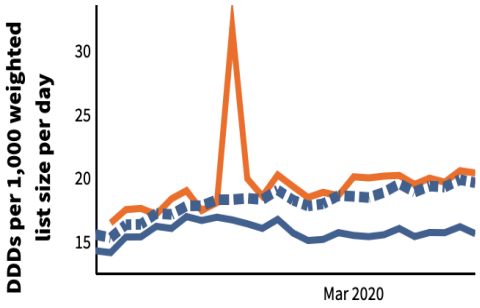
Indicator Group: All

Indicator: Opioid and gabapentinoid dependency (high (



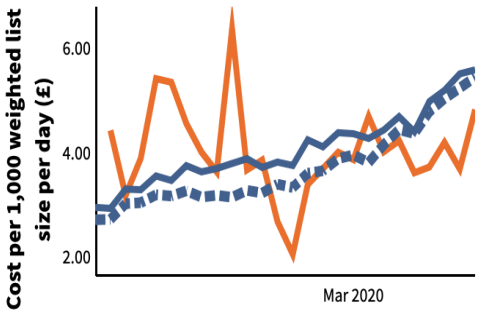
Indicator Group: All

Indicator: Analgesics (gabapentanoid DDDs) (weighted)



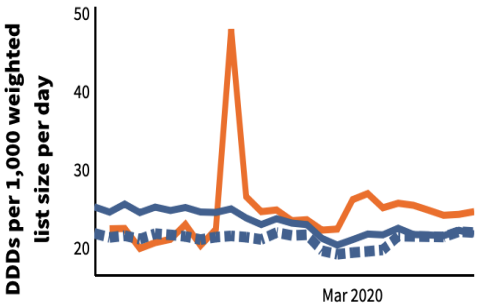
Indicator Group: All

Indicator: Topical Anaesthetic (lidocaine plaster costs) w



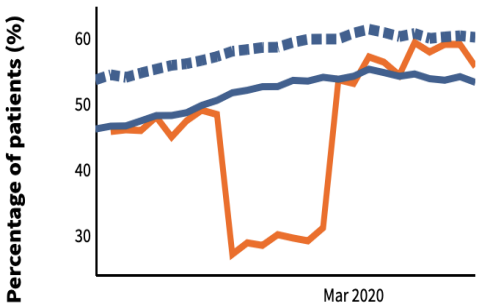
Indicator Group: All

Indicator: Hypnotics and Anxiolytics (DDDs) weighted



Indicator Group: All

Indicator: Opioid and gabapentinoid dependency (long t



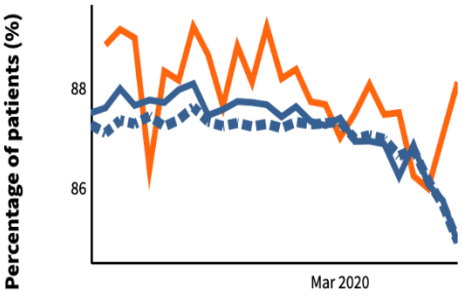
Riverside Medical Practice LLP, Musselburgh (76033) NHS LOTHIAN SCOTLAND

Indicator Group:

All

Indicator:

Antidiabetic drugs (metformin %)

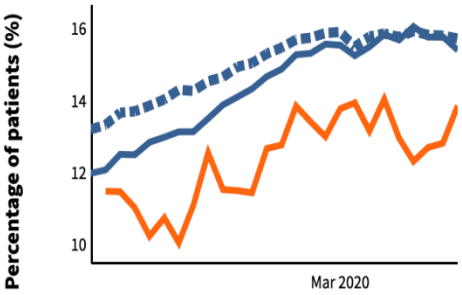


Indicator Group:

All

Indicator:

Anti-diabetic Drugs (polypharmacy %)

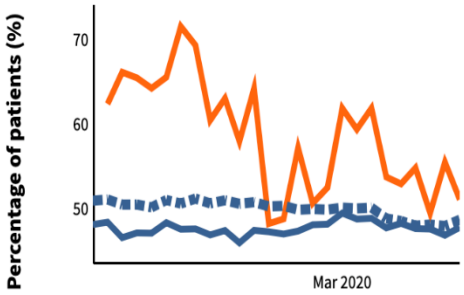


Indicator Group:

All

Indicator:

Falls, Fractures and Delirium (oral steroids no

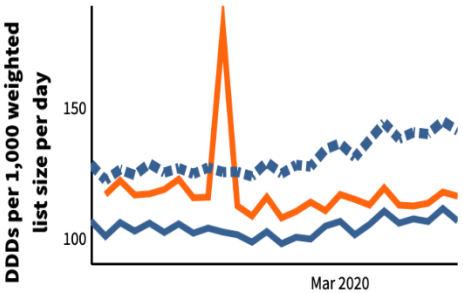


Indicator Group:

All

Indicator:

Proton Pump Inhibitors (DDDs) weighted

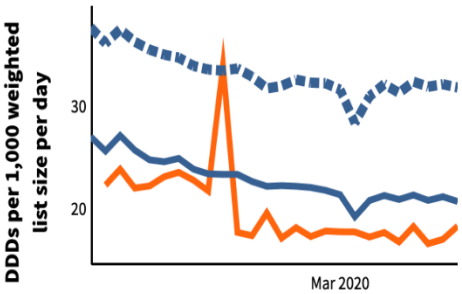


Indicator Group:

All

Indicator:

NSAIDs (DDDs) weighted

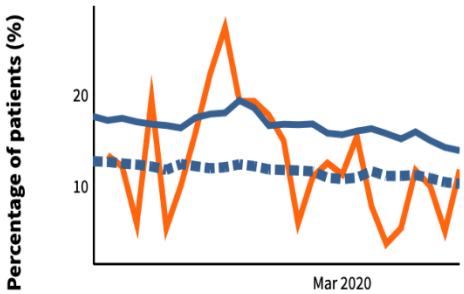


Indicator Group:

All

Indicator:

Bone Marrow Suppression (methotrexate no f



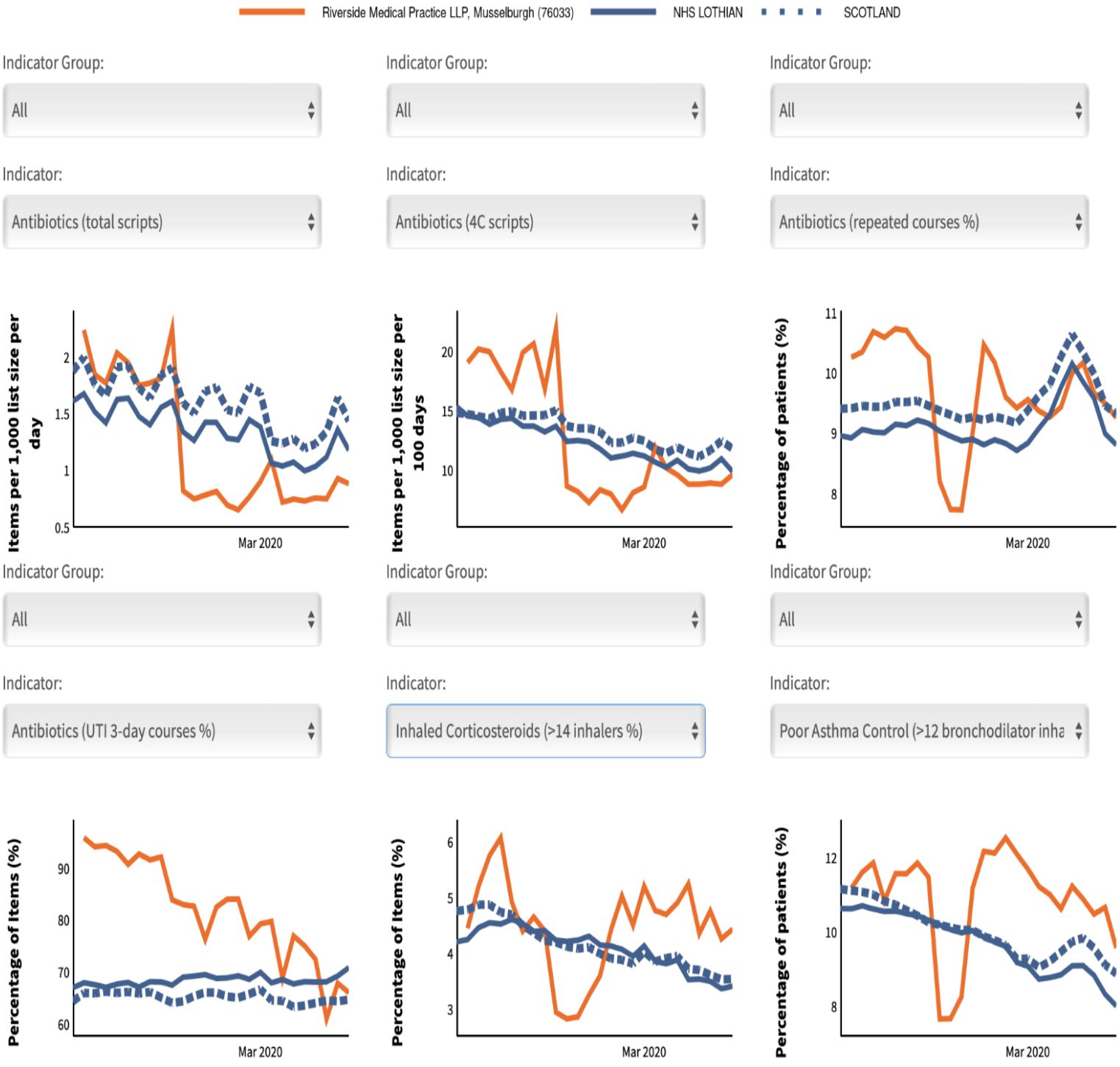


Table 19 - Wider Clinical Impact

Appendix 6 – NHS Lothian HACE Survey Access Positivity plotted against list size

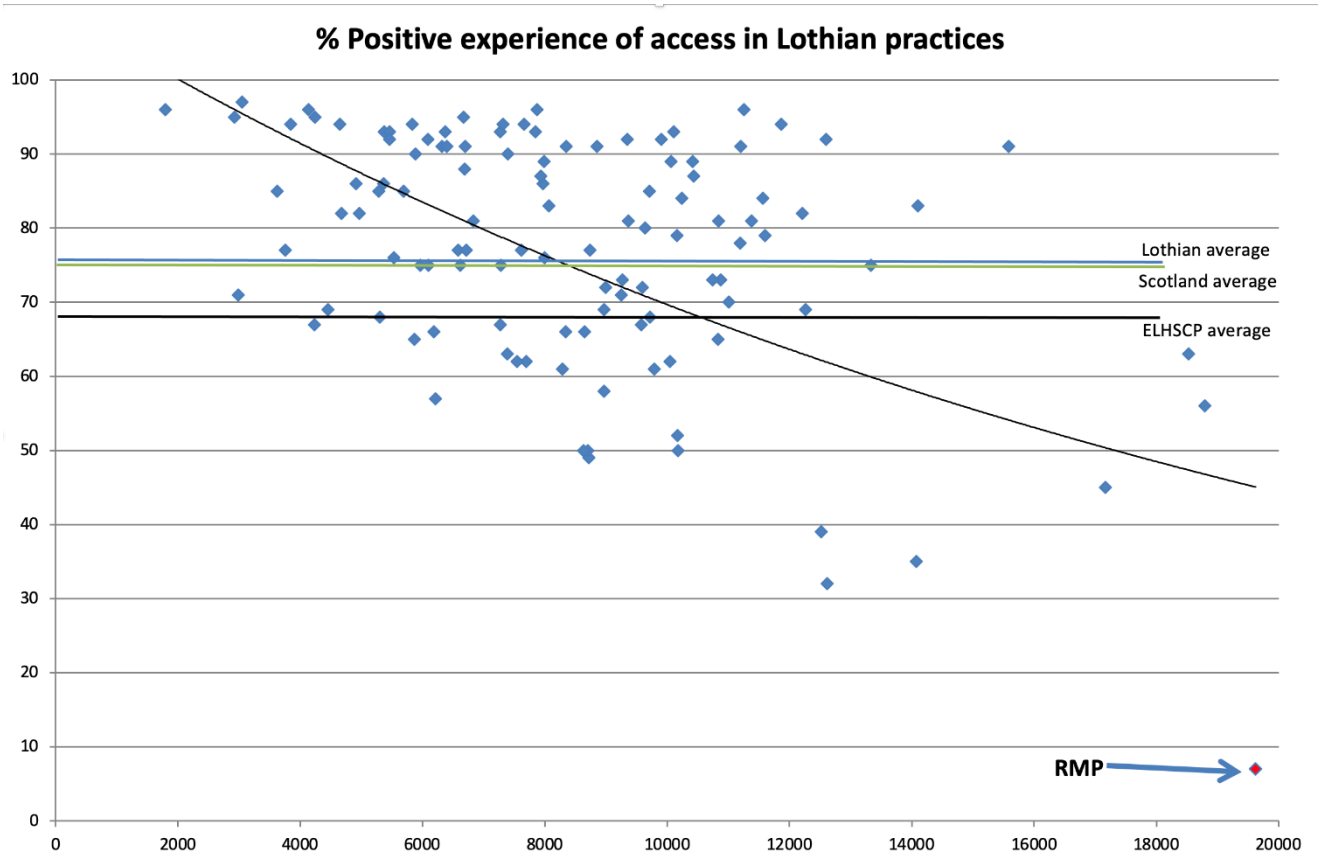


Table 20 - NHS Lothian HACE Access Positivity against list size