Treating access:

a toolkit for GP practices to improve their patients’ access to primary care
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>3</td>
</tr>
<tr>
<td><strong>Chapter 1</strong> Why a toolkit for practices to improve access?</td>
<td>4</td>
</tr>
<tr>
<td><strong>Chapter 2</strong> Symptoms of problems with access</td>
<td>6</td>
</tr>
<tr>
<td><strong>Chapter 3</strong> Diagnosing an access problem</td>
<td>7</td>
</tr>
<tr>
<td>3.1 GP Patient Experience Survey</td>
<td></td>
</tr>
<tr>
<td>3.2 Using the 3rd available appointment calculator</td>
<td></td>
</tr>
<tr>
<td>Working out the 3rd available appointment for your practice</td>
<td></td>
</tr>
<tr>
<td>Frequently asked questions about measuring the 3rd available appointment</td>
<td></td>
</tr>
<tr>
<td>Assessing the 3rd available appointment results</td>
<td></td>
</tr>
<tr>
<td>3.3 Improving Patient Flow</td>
<td></td>
</tr>
<tr>
<td>3.4 Other measurements to diagnose access problems</td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 4</strong> Treating access problems</td>
<td>12</td>
</tr>
<tr>
<td>4.1 Profiling Capacity and Demand</td>
<td></td>
</tr>
<tr>
<td>4.2 Step 1: Understanding the Total Demand</td>
<td></td>
</tr>
<tr>
<td>4.3 Step 2: Understanding the Demand for same-day and pre-booked appointments</td>
<td></td>
</tr>
<tr>
<td>4.4 Step 3: Understanding the Profile of Demand</td>
<td></td>
</tr>
<tr>
<td>4.5 Managing Follow Ups and Reviews</td>
<td></td>
</tr>
<tr>
<td>4.6 Improvement tools for the Scottish QOF 2014-15 Access Indicator</td>
<td></td>
</tr>
<tr>
<td>4.7 Planning the treatment</td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 5</strong> Treatment choices</td>
<td>22</td>
</tr>
<tr>
<td>5.1 Matching capacity to demand</td>
<td></td>
</tr>
<tr>
<td>5.2 Improving telephone access</td>
<td></td>
</tr>
<tr>
<td>5.3 Use of internet</td>
<td></td>
</tr>
<tr>
<td>5.4 Planned telephone appointments</td>
<td></td>
</tr>
<tr>
<td>5.5 Skill mix</td>
<td></td>
</tr>
<tr>
<td>5.6 Signposting</td>
<td></td>
</tr>
<tr>
<td>5.7 Reducing the impact of home visits on access</td>
<td></td>
</tr>
<tr>
<td>5.8 Appointment reminders</td>
<td></td>
</tr>
<tr>
<td>5.9 Using other services</td>
<td></td>
</tr>
<tr>
<td>5.10 Understanding your patients</td>
<td></td>
</tr>
<tr>
<td>5.11 Seeking patients’ agreement to your management plan to improve access</td>
<td></td>
</tr>
<tr>
<td>5.12 GP triage</td>
<td></td>
</tr>
<tr>
<td>5.13 Continuity of care</td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 6</strong> Fair access for all</td>
<td>33</td>
</tr>
<tr>
<td><strong>Annex A</strong> Working Group Membership</td>
<td>36</td>
</tr>
</tbody>
</table>
Foreword

General medical practice is at the heart of the NHS in Scotland. Excellent access to general practice is therefore a key ingredient of high quality healthcare. The more effectively access is managed, the better the outcome, the better the impact on the NHS as a whole and, crucially, the better the patient’s experience of care. Good access is a key outcome in both the Scottish Government’s 2020 vision and the Vision of RCGP Scotland. Though many patients do have excellent access to their practice, access does remain an issue for many patients and practices.

The RCGP Scotland Treating Access toolkit was first published in 2010. Since then it has been widely used and many practices across Scotland have had RCGP Scotland access training based on it. However, general practice is a constantly evolving discipline and new pressures appear and new ways of working develop. Hence the need for a review.

Healthcare Improvement Scotland and RCGP Scotland have recently collaborated to develop a Quality Framework for Scottish General Practice. This work not only describes the wide range of quality work being currently carried out in Scottish general practice but also highlights areas where work has to be done to improve the overall quality of our service. Updating this toolkit was one such area.

The information in the toolkit, including the many links, has been updated. New areas of advice have been included, for example the use of flow methodology and GP triage in the diagnosis and treatment options sections. The toolkit is complementary to the Access work in the 2013-14 Scottish GMS contract, and is especially useful as it provides additional ideas for improvement in access.

Both Healthcare Improvement Scotland and RCGP Scotland hope that this new version will lead to improvements in access which will be of benefit to both our practices and our patients.

Dr John Gillies, Chair
Royal College of General Practitioners (Scotland)

Dr Brian Robson,
Executive Clinical Director of Healthcare Improvement Scotland
Chapter 1

Why a toolkit for practices to improve access?

Good access to primary care services is very important to our patients, to the NHS Boards, to the Scottish Government and very much to general practitioners and their staff. It is one of the fundamental building blocks of a quality practice.

Many practices in Scotland provide an excellent level of access for their patients. However, some practices struggle to provide as good a level of access and would be keen to improve this.

Patients certainly see good access as an important characteristic of general practice. The Scottish Government has also recognised a need for patients in some practices to experience improved access. Hence, amongst all the stakeholders, there has been a desire to develop a fit for purpose toolkit that can help those practices for whom access is a problem. The first version of this toolkit was developed in 2010. This version has been updated and includes some new ideas on how to manage access. It will complement the work that practices are doing on access as part of the Scottish GMS contract. In particular this document differs from the contract material in that it gives suggestions for improvement which can then populate the report required for the contract.

The toolkit follows a medical model which will be very familiar to practices. It describes the symptoms that exist when access is a problem, how to accurately diagnose the level of access present in a practice and gives advice on how to treat access problems where they exist. There is a health warning around this which is, if we treat access like a long term condition, there are analogies with other long term conditions in that we cannot necessarily completely cure the problem, it may get worse at times and recover again. It will continuously need to be properly managed.

It pulls together in one place a range of material, some more familiar and more relevant to some practices than others, but all designed as a user friendly resource to bring about practical improvement. The tips on how to improve access are pertinent to a wide range of practices working in different ways and not just to those which use a traditional appointment system.
What is good access?

Defining good access is surprisingly difficult. The responses of patients to the BMA consultation document, “The Way Ahead” showed that access is an important issue but there was little consensus on single issues.

The Scottish Government Quality Strategy uses the six domains of quality as person centred, safe, efficient, effective, equitable and timely. Good access does cover all of these domains. Bearing this in mind, this toolkit has been developed so that its use should lead to improvement in the following outcomes:

- Patients are able to access information, care or treatment by a GP or appropriate member of the practice primary care team in line with their clinical need.
- The ability of patients to access the above does not vary on account of characteristics such as age, disability, gender, race, religion or belief, sexual orientation, geography or socio-economic status.
- Clinicians and staff are able to manage both demand and capacity to meet demand effectively so that optimal levels of access are maintained over time.
- The practice works with patients, families and carers to improve their awareness of access to services provided by the practice and other primary care practitioners in the community such as pharmacists and optometrists.
Symptoms of problems with access

Practices with significant access problems will experience a variety of symptoms. These might include some or several of the following:

- Your reception staff are frazzled trying to deal with appointment requests. This could lead to a rapid turnover in staff. Do you carry out exit interviews when a member of staff leaves?
- Only offering appointments for the exact day that a patient contacts the practice.
- Patients having to call back tomorrow because today’s appointments have gone.
- Most requests from patients for an appointment contain the “urgent” word or receptionists are frequently heard to ask patients if their problem is “urgent”.
- Having a mad half hour first thing in the morning when everyone seems to try to get through to get an appointment.
- A serious missed diagnosis has occurred which in part has been compounded by a delay in getting an appointment.
- A large number of “walk-ins” who use this as a means of circumventing the appointment system.
- It is a regular agenda item at your patient group meetings.
- Patients having to attend in person to make an appointment.
- In house patient surveys indicate access is a problem or the national patient experience survey indicates the same.
- You have had complaints and moans from patients about access issues.
- You can feel the tension at the front desk as staff and patients go through a negotiation process before an appointment is made.

If your practice does not experience any of these symptoms then you probably do not have a problem with access. Most GPs and managers will recognise some at least of these symptoms in their own practices, in which case read on to learn how to diagnose the extent of the problem and how to start treating it.
Chapter 3

Diagnosing an access problem

How do you know if you offer good access to your patients?

There are different ways of assessing this. One way is to look at the opinions of your patients on their experience of access and another is to measure data on the 3rd available appointment from your appointment system.

3.1 GP Patient Experience Survey

The opinions of your patients can be judged by looking at the results of the Access section on the 2013/14 Patient Experience questionnaire.

This is available at http://www.healthcareexperienceresults.org

This gives your patients’ views on:

- How easy it is to get through on the phone.
- How polite and helpful the person answering was.
- Whether they can see or speak to a doctor or nurse within 2 working days or are able to book an appointment in advance.
- Whether they can usually see their preferred doctor.
- The time waiting to be seen at the GP surgery.
- The overall arrangements for getting to see a doctor or nurse.

You can compare the results of your own patients’ views on access with other practices’ patients’ views. You can also compare your 2013/14 results with those in previous surveys.

Patients may also have made comments about access as part of the survey. These are accessed at www.healthcareexperienceonlinereporting.org. As these are not open to the public, you need to use the login and password sent to you with the hard copy of your practice results. If you have lost these details, email patientexperience@scotland.gsi.gov.uk.
3.2 Using the 3rd Available Appointment calculator

To assess the availability of routine pre-bookable appointments you can measure your 3rd available appointment. This is not a requirement of the contract but you may wish to change the proportion of same day appointments and pre-bookable appointments and this is best monitored using this tool. The 3rd available appointment is a reliable, simple measure which is recognised as the international standard measure for assessing how effectively an access system is functioning. The 1st or 2nd next available appointments are subject to random effect such as a sudden cancellation, while the 3rd available appointment is a more reliable and authentic measure of your patients’ experience in trying to get an appointment. The 3rd available appointment can be easily determined by the use of a Microsoft excel based calculator.

The calculator uses a macro to work out the final calculation. If no result appears in that box, then you need to enable macros by going into Tools on the excel file, selecting Macros then Security. Click on Medium. Then close the file and then re-open it.

### Instructions

1. Fill in the name of the practice and the month.
2. Insert the GP’s /Practice Nurse name and their whole time equivalent (WTE).
3. You do need to work out what a whole time equivalent is for your practice. (Please note that the GMS contract does not define WTE for general practitioners. The use of the concept of WTE here is purely so that a practice can monitor availability over time.)
Working out the 3rd available appointment for your practice

1  Pick a different day each week of four consecutive weeks on which measurements will be taken. Always include one Monday in your data collection.

2  On each measurement day at 12 midday, look at your appointment system. Identify the next three soonest available appointments for each GP and Practice Nurse e.g.

<table>
<thead>
<tr>
<th>Appointment</th>
<th>Time</th>
<th>Days until next available</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st appointment</td>
<td>4.00 p.m. today</td>
<td>= 0 days</td>
</tr>
<tr>
<td>2nd appointment</td>
<td>4.30 p.m. today</td>
<td>= 0 days</td>
</tr>
<tr>
<td>3rd appointment</td>
<td>8.45 a.m. tomorrow</td>
<td>= 1 day</td>
</tr>
</tbody>
</table>

3  Consider when the third available appointment falls. In the example given above, 8.45 a.m. tomorrow translates to a 3rd available appointment of 1 day. If the 3rd available appointment falls today the measure is zero. If it falls the day after tomorrow, it is 2 days and so on.

Do Not Include:

- Results for any GP or Practice Nurse who is on holiday for 3 days or more during the measurement week, unless they are covered by a locum.
- Any appointments you keep for urgent cases that may become reclassified later for routine cases. They are not routine appointments at the time of measurement as they would not be available for a patient at the time of request.
- Saturday or Sunday as next days (i.e. when collecting data on a Friday, if the 3rd available appointment is on a Monday, this counts as one day).

Link to Frequently Asked Questions

Assessing the 3rd available appointment results

We have not set a national benchmark against which practices can measure themselves. The tool is more helpful when the practice uses it over a period of time to hopefully demonstrate a reduction in waiting times for appointments. In effect, the practice uses its own current results to benchmark itself against. Thus, it is useful to do the measurements regularly over perhaps a six month period while changes to improve access are being made.

3.3 Improving Patient Flow

Poor patient flow leads to increased cost, less than perfect patient and staff experience and potentially to failures of care. Evidence suggests that enhancing patient flow increases patient safety and increases the likelihood of patients receiving the right care, in the right place, at the right time, all of the time (Health Foundation 2013, Joint Commission Resources 2010). Improving patient flow is one of a range of potential solutions to be considered when improving access and managing increasing demand.

Flow methodology has been developed and tested in secondary care and proof of concept testing in NHSScotland is underway in some hospitals. There is significantly less experience in primary care and fewer case studies to draw on. In Scotland a small number of practices are testing and applying the principles and methodologies that have been developed to date.
Any practice aiming to make improvements in patient flow needs to first use data to understand the flow of patients into, through and out of the practice and quantify any underlying causes of poor flow. The practice should also consider what’s happening in secondary care and community services that may impact on the practice. An example of a practice patient flow diagram is shown below. Most practices will have an even more complicated patient flow system. The diagram should always be drawn from a patient’s perspective. The start and finish points of the patient’s journey needs to be decided first.

![Patient Flow Diagram](image)

Work that has been undertaken in both secondary care and primary care has involved:

- Separating demand into scheduled and unscheduled flows. This is well described in the Shaping Our Future Practice module of Productive General Practice.

- Identifying and then either eliminating or minimising artificial variation in the demand we face. Artificial variation is the variation which we introduce into the system in the way that we design or deliver our services and care. An example is that closing for protected learning time inevitably leads to appointment pressures for the next few days. A high level of both natural and artificial variation in demand exists in healthcare. Sources of variation can be described as being clinical e.g. differing severity of conditions among patients, flow e.g. patients present when the need arises and professional e.g. different clinicians take different times to perform the same functions.

- Working out the queues that patients are in and measuring the length of time that they are in these.

Treating Access: a toolkit for GP practices to improve their patients’ access to primary care
Then, determining where there are blocks or delays in the processes that are part of the overall patient flow and allocating practice resources to deal with these.

3.4 Other measurements to diagnose access problems

You may also wish to think about other measures which could help to give a fuller picture of the appointment system e.g.

- The proportion of free appointments available next week.
- The daily under or over use of appointments. This data will be collected under the contract.
- The number of “extras” seen in a week. This too will be collected under the contract.
- The opinions of patients received either through a formal patient group or through complaints or comments given by use of e.g. a comments box.

It is also possible to use systems which give you feedback on how easy or difficult it is to get through to your practice telephone system. This may indicate other access problems for your patients.
Chapter 4

Treating access problems

If you wish to improve access to your practice you will find the following exercises helpful in understanding and profiling the demand on your practice and the services it provides. The exercises will take you through some simple but effective ways of capturing the information you require to bring about change through expanding the range of options available to your patients when accessing services.

4.1 Profiling Capacity and Demand

Patient demand is largely predictable. The key is to understand not just the demand for urgent or same day care but the totality of the demand. Understanding demand means the practice can schedule the necessary capacity. This means that the practice system meets the requests of patients regardless of these being for a same day appointment or relating to a problem that can be addressed in the future.

In order to make changes to improve access you need to understand your practice’s demand. The information that you gather will help develop a fuller understanding of the practice’s capacity. The best way to measure demand is by counting the number of requests for appointments on each day of the week.

Remember that daily activity is not the same as daily demand.

The easiest way to collect this information is to use a tick-sheet, keep the task as simple as possible. Ensure that reception staff fully understand the importance of this step and their role in collecting the data. This first step depends on accuracy of collection as decisions will be made based on the findings from the data.

The Scottish contract provides a single data collection sheet which covers the following Step 1 and Step 2 so by necessity it is more complicated and will require more training for staff. Click here to download the contract guidance. The form is on p4 of the guidance.
4.2 Step 1: Understanding the Total Demand

Understanding how much demand arises each day and in total across the week is important in helping to ensure that there is enough total capacity each day. This form is designed to help collect information about total demand for appointments. The information you gather may not be perfect but it will be good enough to get you started.

Total weekly demand data collection

- Please tally all appointment requests during the course of this week.
- This should include appointment requests made by telephone; those made in person. Include follow-up appointments.
- Requests for appointments should be recorded against the day that the appointment was requested regardless of whether it was required for that day.
- You may need to have several of these forms at each point where appointments are being requested to capture all appointments requests.

Total Demand Form

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>TOTAL</th>
<th>TOTAL</th>
<th>TOTAL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
<td></td>
<td>Grand Total</td>
</tr>
</tbody>
</table>

Click to download the above form

Once the sheet has been completed, you have the total demand on your services for that week.

Now count up the total number of appointments that were available for that week. Comparing the two will quickly give you an idea of whether your capacity meets the demand.

It may be that the week in question was not a typical week in which case you will need to repeat the exercise for another week or maybe longer till you are fairly sure what your demand and capacity figures are.
4.3 Step 2: Understanding the Demand for same-day and pre-booked appointments

Understanding the different demands for same day access and book in advance appointments will help you gather information on the proportion of people that would normally expect to book in advance each day.

Understanding what proportion of appointments are likely to be pre-booked each day is important in helping to ensure that there is enough total capacity each day. Many practices are surprised to find that despite the constant feeling of pressure within the surgery, their demand and capacity are usually matched. Sometimes practices find that the totality of demand is similar to capacity but there are problems on certain days of the week that they need to address.

Measuring demand on a regular basis (e.g. weekly to begin with then monthly or quarterly) is invaluable in helping to build a comprehensive understanding of what to expect and to identify fluctuations and their causes, such as seasonal variations.

The form on the next page is designed to help collect information about the total number of appointments needed each day and the proportion that will normally be pre-booked.
Instructions – click here to download form

Please tally all appointment requests during the course of the week.

- This should include requests made by telephone; those made in person and follow ups.
- Requests for appointments on-the-day should be recorded in the left column regardless of whether an appointment could be made or not.
- Use the right column to tally requests for pre-booked appointments. It does not matter how many weeks in advance the appointment is requested for but just mark the day for which the request was made.
- You want to find out the variation in demand for the same day appointments and how many appointments are needed each day.

<table>
<thead>
<tr>
<th></th>
<th>Appointment requested for today</th>
<th>Book in advance appointment request for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Any day</td>
</tr>
<tr>
<td>Monday</td>
<td></td>
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<tr>
<td>Tuesday</td>
<td></td>
<td></td>
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<tr>
<td>Wednesday</td>
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<td>Thursday</td>
<td></td>
<td></td>
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<tr>
<td>Friday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
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</tbody>
</table>
You can now compare the demands on your practice for each day of the week against the capacity to cope with the demand.

- Is there a day where the demand exceeds capacity?
- Is there a day where capacity exceeds demand?

The data collected by the above process can be entered into an Excel spreadsheet, and converted into a bar chart, example below.

![TOTAL GP DEMAND OVER MAY](image)

In the example above, reception teams populated tick sheets to capture every patient request for an appointment (GP and nurses). These requests were then profiled against the actual capacity offered during the same period. These results allowed the average weekly profile to be calculated. In this case, the average daily demand was 91 appointments while the average capacity was only 73 leaving a shortfall of 18 appointments each day.

**Activity throughout Scotland**

We have pointed out that activity is not the same as demand nor is it the same as capacity. However, there is some merit in checking how your activity compares with other practices. You may want to look at the Scottish national data on activity generated through the Practice Team Information (PTI) programme of the Information and Statistics Division of the Scottish Government. There are 60 PTI practices in the national sample. Note that the collection of data through PTI stopped in 2013.
The total annual contact rate for 2012/13 (including all face-to-face contacts with either a GP or a practice-employed nurse) varies from **3,000 to over 7,000 contacts per 1,000 registered patients**. How this workload is divided between GPs and nurses varies greatly between practices. In most practices the GPs do the bulk of the consultations – on average two thirds in this sample of PTI practices. However, in some practices the practice nurses account for more patient contacts than the GPs (up to 55% in one instance).

The estimated combined contact rate based on all 60 PTI practices and standardised to the Scottish population is 4,374 per 1,000 patients, with GPs accounting for 67% of the contacts. This would equate to a total of about **85 face to face contacts per 1,000 patients per week, (56 GP contacts)** – for an average standardised practice. It is likely that many practices would require more than this. The full reports are available at [www.isdscotland.org/Health-Topics/General-Practice/GP-Consultations/](http://www.isdscotland.org/Health-Topics/General-Practice/GP-Consultations/) However, data collected from PTI practices may not be wholly representative of the average practice in Scotland nor the activity in practices serving deprived populations.

A review of practices in one English Primary Care Trust showed that practices routinely offering more than **70 GP appointments per 1,000 patients per week** were more able to meet patient demand than those offering less. Those offering a supply of less than 70 appointments per 1,000 per week often experienced difficulty with access according to patient and staff feedback.

### 4.4 Step 3: Understanding the Profile of Demand

Raw demand data in itself may not give a true reflection of the demands of your patients for appointments. This can be better judged by the clinicians as they consult with patients. One way of doing this is to use a Profile of Demand form. This allows you to broadly classify the type of work being done and to decide if the patient’s problem could have been dealt with in a different way. Ask the doctors to collect data about each face to face and telephone consultation in the surgery over a week. This will help you to understand what type of work the individual clinicians are actually undertaking. You may also wish to add a column to record consultations that could have been dealt with by another team member that you do not currently employ. Examples might be a Healthcare Support Worker or Mental Health Worker.

You may wish to carry out a similar exercise for the practice nurses to see what work they currently carry out. This could identify areas of work that could be safely delegated to a health care assistant.

An example of a Profile of Demand form can be downloaded by clicking here. This is one way of collecting the data but is modifiable for your practice to add or delete columns as you wish. A similar data collection sheet for measuring the profile of demand for appointments is found on p13 of the Appendix to Scottish QOF 2014-15. Click here
Profile of Demand Form [click here to download]

Day ----------------------------------

This sheet is designed for clinicians for use during consultations. It will help you understand what type of work you are doing.

Instructions –

- Place ticks in the appropriate columns for each patient contact, both face to face and telephone.
- Record the type of problem, whether a new or follow up appointment, who could have dealt with it and whether a telephone appointment would have been appropriate.
- Decide as a practice whether you want to record all the problems raised in a consultation or just the principal one.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Type of problem</th>
<th>New or follow-up?</th>
<th>Could have been dealt with by</th>
<th>Telephone consultation would have been appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental Health</td>
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<td></td>
<td>Other Chronic</td>
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<td></td>
<td>Problem</td>
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<td>Acute Problem</td>
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<td></td>
<td>Multiple Problems Presented</td>
<td>New Episode</td>
<td>Follow – up</td>
<td>Best dealt with by myself</td>
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<tr>
<td>1</td>
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<tr>
<td>9 etc</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
4.5 Managing Follow Ups and Reviews

If when analysing the Profile of Demand forms it seems that there is an excess of appointments generated through follow ups, you may consider implementing a system of using Review Slips. This may be particularly helpful if one or two doctors seem to generate a higher proportion of follow up appointments for their consultations. Of course, this may be due to the case mix that these doctors deal with so interpretation of the data must be done sensitively.

Review slips are issued to patients by clinicians to monitor follow-up appointments. The clinician takes responsibility for populating the review slip data, including indicating the most appropriate healthcare professional. The patient takes the review slip to reception where a return appointment is arranged. The reception team retain the review slips for analysis.

An example of a review slip is given below. It can be modified for your particular circumstances.

**Review Slip**

<table>
<thead>
<tr>
<th>Appointment Request</th>
<th>Appointment Requested by: __________________________ (GP initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient:</strong> Please pass this sheet to the receptionist who will make an appointment for you.</td>
<td></td>
</tr>
<tr>
<td><strong>Receptionist:</strong> Please make an appointment with:</td>
<td></td>
</tr>
<tr>
<td>Health Care Assistant</td>
<td>Phlebotomist:</td>
</tr>
<tr>
<td>Any GP / Specific GP (Name)</td>
<td></td>
</tr>
<tr>
<td>Telephone Appointment</td>
<td>OR</td>
</tr>
<tr>
<td><strong>Primary reason for Review:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Please make an appointment in:</strong> (Avoid Mondays)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Next available</td>
<td>1-2 WEEKS</td>
</tr>
<tr>
<td>Specific Date &amp; Time:</td>
<td>Other:</td>
</tr>
</tbody>
</table>
Review slip benefits:

1. Practices are able to quickly quantify the number of appointments needed to satisfy the follow up demand for each clinician during the forthcoming rota period. Data collected identifies peaks of demand, thus improving knowledge for contingency planning.

2. Capacity options prompt the clinicians to consider and identify the most appropriate healthcare professional and method (utilising telephone appointments to conduct reviews where appropriate).

3. Reception teams are prompted to avoid Mondays when booking return appointments, ensuring capacity is protected on the highest demand day.

4. Capturing the ‘primary reasons’ for return, leads to a better understanding of typical workload and helps identify trends. This aids the practice when shaping the handling of demand.

In some practices, patients request a return appointment unnecessarily resulting in inappropriate use of GP appointments. By implementing a ‘no slip, no appointment’ policy, the reception team are able to identify appropriate requests without the need to check with clinicians or run the risk of an inappropriate booking.

Review slips are a tool to better understand total demand and plan for contingencies. Utilising review slips can lead to a decrease in return demand which can lead to a 15% reduction in total demand.

Clinicians using the review slips are prompted to consider all returns carefully, rather than automatically suggest that a patient comes back. Review slips have a positive impact on reducing demand purely from raising awareness of the reason for return and the most appropriate person to carry out the review.

4.6 Improvement tools for the Scottish QOF 2014-15 Access Indicator

There are several access improvement tools in the appendix to the guidance for the Scottish QOF 2014-15. In addition to the previously mentioned data collection forms for recording appointment requests and understanding the profile of demand (right time/right person information), there are tools to help you understand the consultation use of your nursing and health care support staff, your appointment capacity and your lost capacity. There is also a capacity management tool where you can input your demand for appointments against your capacity. This all helps to give a broader picture of any access problems. Click here to download the document.
4.7 Planning the treatment

Improving access in the practice will involve input and commitment from the whole team as well as input from patients.

**It will need to be carefully planned with achievable targets set, implemented and monitored.**

You will need to think about how to involve the team, perhaps utilising a protected learning session to identify what you already do well and also those areas that require improvement. Consider what training materials are needed and ensure that members of staff understand the data collection materials in this tool. Decide on your start date and when you will review your progress using the 3rd available appointment data as part of the monitoring system. Discuss how you are going to cope with exceptional circumstances such as holiday weekends or the unexpected absence of a doctor.

Plan how you are going to evaluate the success of your changes. You will want to ask your patients their views but also ask the opinions of the reception staff and clinicians. One good way of carrying this out is to do it as a PDSA cycle (Plan, Do, Study, Act).
Chapter 5

Treatment choices

The choice of treatment to improve access will depend on your assessment of what the problem was in the first place. It may be that several approaches are needed. It may be that some will not work and an alternative may need to be tried.

Consider the potential of your patients in identifying the possible treatment options. Patients can do more than simply tell you that a problem exists. They may also be able to actively give you suggestions for solutions.

The following are possible treatments:

1. Matching your capacity to the demand
2. Improving telephone access
3. Use of internet
4. Planned telephone appointments
5. Skill mix
6. Signposting
7. Reducing the impact of home visits on access
8. Appointment reminders
9. Using other services
10. Know your patients
11. Seeking patients’ agreement to your management plan to improve access
12. GP triage
13. Continuity of care

5.1 Matching capacity to demand

This is probably the most useful treatment for access problems.

You can only start to match this when you have the data on your demand, both same day access demand and book in advance demand. Look for any mismatches.

- Mondays are usually the busiest day, have you enough capacity then?
- Are there other times when demand exceeds capacity?
- Can you move part time clinicians to cover the peak times of demand?
- Do you have doctors involved in activities such as teaching or planned clinical activities such as diabetic or child health surveillance clinics at times of peak demand?
It may be necessary to have a balance between the number of appointments available to book on the day and book in advance. If you do this, do you have the correct balance of book on the day and book in advance appointments? If your capacity and demand almost match but your patients and receptionists and the results from the 3rd available appointment calculator indicate that there is a problem, then it may be that a backlog has been created which needs to be cleared.

The evidence suggests that having one third of your appointments available for booking on the day and two thirds for book in advance seems to be the right balance for many practices. But this will be very different if you practice in a deprived area with high unemployment when the balance should swing to more book on the day. On the other hand, if you serve a large commuter population there will be a need for more book in advance appointments, perhaps with a greater emphasis on capacity first thing in the morning and then late afternoon or early evening. The exercises in chapter 4.3 will have given you an idea of the demand you experience for same-day and pre-booked appointments.

It is not thought to be beneficial to have a more staggered release of appointments e.g. those opened for 48 hour in advance.

5.2 Telephone access

Consider your telephone system. How many lines are there for patients to call in? Are there enough reception staff to cope with peak demand? If not, is it possible for other administrative staff to answer the phones when the demand is at its highest?

Can the demand be spread by ensuring clinicians do not phone out or have booked telephone slots at busy times? If you accept requests for repeat prescriptions over the phone, consider asking patients not to phone for repeats at times when the lines are busy but bear in mind that only allowing patients to order repeats at very restricted times creates a new barrier.

Could an answering machine on a separate number be used for calls ordering repeats? Would an automated answering system help?

If you wish to work out how many staff you need to answer the phone at different times of the day, see section 1.3, page 13 of “Improving access, responding to patients”

5.3 Internet access

Have you an up to date website which gives patients help in deciding which part of your service they should be accessing? Some practices have developed their own website but commercial web design companies can be used.
If they could order repeats or book appointments online, would that take some pressure off the phone lines? Are online consultations a possibility?

This video describes the benefits of online appointment booking and repeats online through Emis Patient Access as experienced by one practice. Click vimeo.com/96916558

Both EMIS and Vision offer new opportunities for improving access and the efficient use of appointment systems.

- www.emisaccess.co.uk/ - This does require a password from EMIS.
- inps4.co.uk/vision/products/online-access-for-patients

If you wish to find out more about what opportunities are, or may become, available to you, please speak to your local eHealth department or Clinical Lead in IT.

5.4 Planned telephone appointments

Telephone consultations can be cheaper and quicker than seeing patients face to face but they do carry some risks. In the right circumstances, they can increase efficiency, improve access and boost patient satisfaction. Telephone appointments replace face to face appointment slots at a 2:1 ratio that is one 10 minute face to face slot converts to two 5 minute telephone slots. This increases the number of available consultation slots for the clinicians. The number of telephone slots you should provide can initially be calculated from your data in carrying out Step 3, Understanding the Profile of Demand section 4.4, page 15.

The telephone may be used in surgeries for a variety of reasons:

- A clinician assessing a new clinical problem and recommending appropriate action such as a home visit, surgery appointment, hospital visit or self-care.
- Giving advice, particularly when the patient is well known to the doctor.
- Following up a clinical problem.
- Discussing repeat medication or investigation results.
- Issuing medical certificates.
- Third party discussions with relatives or other care agencies.
- It allows for multi-tasking, e.g. conducting a surgery while on call for emergencies.
The benefits of telephone consultations include:

- Patients have another channel through which to access primary care. This is particularly useful for people with reduced mobility or very little spare time.
- Telephone consultations can increase the opportunity for a patient to consult their preferred doctor, reinforcing the relationship, to the benefit of both parties.
- There is increased efficiency. By talking to patients before they make an appointment, doctors can ensure they only see people who would benefit from a face-to-face consultation. However, there is no clear consensus that telephone triage of requests for all 48 hour access appointments is an efficient use of time. A significant percentage of those who initially receive telephone advice on triage do subsequently end up having a face to face consultation in the next week. Some practices do find telephone triage helpful; others have tried it and given it up.
- Waiting times and appointment systems can be better managed, leading to greater patient satisfaction and lower staff stress levels.

There are some drawbacks however and these include:

- Clinicians rely to an extent on visual cues for diagnosis and these are absent in phone consultations. This could lead to a greater risk of a wrong diagnosis.
- Phone calls are dependent on the setting, with both parties influenced by their surroundings and mood. Patients won’t necessarily share the full details of their health problem over the phone and clinicians won’t always interpret what they say correctly.
- People who don’t speak English as their first language are not always confident at self-expression. Decision-making is thus difficult for the GP. Involving interpreters is complicated and costly.
- People with hearing problems or learning difficulties may find the phone less helpful.
- While some patients appreciate telephone consultations, others regard it as a blocking tactic.
- Telephone consultations can result in higher phone bills.
- Not all conditions are suitable for phone management. Some will need a personal examination.

There are specific skills in carrying out telephone consultations and those clinicians who are less confident in carrying them out should consider going on a course or reading more about it. A suitable resource is “Telephone Consultations in Primary Care” by Tony Males which is available at the RCGP Bookstore.
5.5 Skill mix

Skill mix within the Practice Team is another way to assist with improving access. It involves looking at the activities undertaken in the practice and subsequently putting in place team members who can carry out these activities. It maximizes the contribution of all staff to patient care and does away with the barriers that state that only, for example, doctors and nurses can provide particular types of care. It makes the best use of the range of team members’ skills and knowledge. It can also be a more cost-effective way of delivering care.

The development of skill mix needs to involve education and training to ensure that team members are equipped with the necessary skills and competencies. As a consequence there is the development of new, more flexible careers for all staff and an improved capability of the workforce to meet both current and future demands. There are a variety of qualifications, training and other forms of personal development to assist both existing team members (such as receptionists) and those beginning a career in practices to take up the variety of roles.

Advanced Practitioners and Healthcare Support Workers

Two particular roles can assist with the implementation of an appropriate skill mix within practices. That is, the roles of advanced practitioners and healthcare support workers.

Further details about the required competencies and toolkits to assist with the development of these roles can be found at:

www.hcswtoolkit.nes.scot.nhs.uk/

www.advancedpractice.scot.nhs.uk/home.aspx

www.nesgpntoolkit.scot.nhs.uk/home.aspx
Career and development framework for general practice nursing is found at:

www.mnic.nes.scot.nhs.uk/media/52579/gp_nursing_framework_final.pdf

unison.org.uk

Step by step guide to implementing skill mix

- Look at the results of your Profiling the Demand data collection to see if there is the potential for an increase in skill mix.
- Analyse what is being done by who, how often and for how long – undertake some simple data collection over a period of perhaps 2 weeks or a little longer.
- Work out the skills that would be needed for the various staff groups to take on new roles.
- Assess their current competencies and decide on what training is required.
- Ensure competence is assessed and delegation properly managed.
- Make sure that you reinforce policies and procedures in a written form that is easily accessible.
- Communicate with the staff at all times; perhaps have a lead GP and nurse to support the practice manager in this work.
- Make sure patients understand the new roles in the practice.
- Continue to support the staff in their new roles.
- Monitor the process by seeking the views of staff and patients.

The benefits of skill mix include:

- Access to a healthcare professional should improve.
- Patients benefit from seeing the most appropriate professional.
- Continuity and follow-up of care can be improved and managed more effectively.
- Allows all team members to develop their particular knowledge and skills and so improves motivation.
- Regular skill mix reviews can provide development opportunities for staff as well as assisting with recruitment and retention of team members.
- A flexible approach can be provided to all aspects of care.
Drawbacks of skill mix might be:

- Patients may have concerns about team members taking on new roles. This needs to be managed through informing patients of the changes.
- Cost-effectiveness of the changes can be difficult to establish. A revised skill mix is not necessarily more cost-effective than more traditional care models.
- A skill-mix approach can blur the role boundaries between staff which may threaten professional identity – this could have an effect on teamwork.
- Investment in training for the increase in role duties may be required.

5.6 Signposting

Signposting involves practices directing patients to the most appropriate person to deal with their problem.

Reception staff can then help ensure that all team skills are used as effectively as possible. Some practices have introduced a system where receptionists ask patients for an indication of why they want an appointment. The patient is then routed to a “Planned Care” team appointment or an “Unplanned Care” team appointment. Each team will consist of a mixture of GPs, Practice Nurses, Nurse Practitioners, HCAs and possibly others. The appointments offered by each team may be available immediately or in advance depending on how the team is organised.

There are other ways of managing signposting; what will suit one practice may not suit another and different models pose differing risks and benefits.

For example:

- Patients may be routed based on whether they have a new problem or a continuation of an existing one, followed by routing depending on urgency.
- Patients may be routed based on what part of the clinical team they want to see, rather than the reason they are consulting. Further steps in the protocol might lead the receptionist through other routing alternatives based on the length of appointment, condition, and choice of team member.

For this to be safe and effective:

- Receptionists must work to telephone protocols that minimise risk.
- Receptionists must be trained in the safe use of these protocols.
- Patients may take a little while to get used to this way of working and will need information on this new way of working.
• If your skill mix is about right, then this can improve efficiency and cost effectiveness as well as access.

• We know from the patient survey that privacy at reception can often be a problem. This needs to be addressed if signposting is introduced.

An example of a signposting protocol can be seen here.

Some practices have developed a detailed plan of who patients should see for a wide range of conditions. This can be seen by clicking on Who to see for Conditions.

An example of a poster to inform patients why the receptionist asks for an indication of the reason for the appointment request is available at Reception staff asking questions.

5.7 Reducing the impact on access of home visits

If surgeries are being interrupted by doctors having to go out on home visits, then think about alternative options for the management of home visit requests.

Possible solutions might be:

• A duty doctor covering home visits along with other surgery based tasks that session.

• Phoning back any request for a home visit to check that that is the most appropriate management choice for the request.

5.8 Appointment reminders

Appointment reminders can be sent by text to patients at a practice defined set time before the time of an appointment. This facility can be added to most computer systems and it has been shown to reduce non attendance rates. If a high level of non-attendance is a significant contributing factor to access difficulties then texting may be one solution.

5.9 Using other services

There are other services for patients which may be more appropriate than a GP consultation for some conditions. Examples include:

• Making patients aware of the NHS Minor Ailments Service offered by community pharmacists. Patients who are exempt from prescription charges can register for the NHS Minor Ailment Service with the community pharmacy of their choice. The service consists of a consultation with a pharmacist who will assess
the patient’s presenting condition. The pharmacist will either provide advice or an appropriate treatment for the condition on the NHS or refer the patient to another member of the primary care team. The service is designed to cover a range of common conditions such as minor eye infections, pain, head lice, infections such as thrush, threadworm and constipation. Further details on the service are available at: www.communitypharmacy.scot.nhs.uk/core_services/mas.html.

- Patients with an eye related problem can attend an optometrist of their choice in the first instance. The optometrist will undertake an eye examination appropriate to the needs of the patient and manage that patient within their practice, or if the patient's condition requires, refer the patient to you or to an Eye Unit within a hospital. Examples where this is appropriate include red eyes, foreign bodies, reduced vision, definite cataracts and children with a suspected squint.

- Any patients contacting or presenting at your practice with a dental related problem should be advised to attend their own general dental practitioner or, if they are unregistered, the area’s local dental access centre or a general dental practitioner of their choice in the first instance.

- **NHS Inform** provides one access point to quality assured health information. The service can be accessed by 3 main routes; online, telephone and in due course through face to face providers in local communities such as Pharmacies, Citizens Advice Service, GP Practices, Libraries etc. It provides a range of information supplied by Healthcare Bodies and the Voluntary Sector to support patients, carers and the public who are seeking general health information. Various levels of information are available dependent on the user’s requirements. The information available will in time provide details of access to local services and support groups, condition specific health information, self-assessment health tools and information on specific areas of focus such as the Carers Zone and Live Well Zone.  **NHS Inform**

- Referring patients to the voluntary sector such as follow up bereavement counselling by Cruse. As health and social care integration becomes embedded, it may be that community resources for patients with long term conditions become more accessible.

All NHS Boards have been issued with a toolkit to help raise awareness with the public of how to access NHS services – “Know who to turn to”. The boards will be developing this resource for local use and practices should contact their local health board if they wish further information regarding this.
5.10 Understanding your patients

Any treatment of access requires the changes to be made taking account of your practice’s patients. The particular mix of patients in a practice will decide which approach to improving access is correct for you.

You need to be particularly aware of the prevalence of illness and related patient needs. This will be influenced by the following factors:

- age/sex distribution
- your deprivation score
- ethnicity of your patients
- disability issues
- local transport issues
- local community groups

5.11 Seeking patients’ agreement to your management plan to improve access

In exactly the same way that clinicians seek agreement about a clinical management plan during a consultation, a practice should listen to the voice of their patients when access problems are being treated.

That voice may come from a formal practice patient participation group, or a focus group may be set up to provide input into the access changes alone. Patient surveys may also provide some guidance for practices. A simple suggestions box or comments received on a website can also create patient engagement.

Help from the Scottish Health Council on setting up a patient participation group and other means of engaging with patients is to be found here.

The following are useful suggestions from workshops held in various parts of the country:

- Ask all GPs to say what they want to get out of patient participation before you start to gain commitment.
- Call it something like “The Patient Voice Scheme” to help move away from the idea that it must be a group.
- Start with a particular focus (e.g. access/premises/clinical area) or a task in the practice (sorting out the waiting room and notice boards).
- Identify “Patient Champions” using community groups. Remember to try school or youth councils or Facebook.
- Use on-line resources and email for feedback rather than having to meet up.
5.12 GP triage

Some practices have decided to have GPs, (sometimes supported by experienced practice nurses) triage all patient requests for clinical contact. The expectation is that a large proportion of requests for GP appointments can be dealt with on the telephone so reducing the number of patients that need to be seen face to face. There are two commercial organisations which advocate this approach, GPAccess at gpaccess.uk (formerly Patient Access) and Doctor First www.productiveprimarycare.co.uk/doctor-first.aspx (note that this is not the same as Productive General Practice). For a fee, either will guide a practice through the process of changing to this system. These organisations report high success rates in reducing face to face consultations but there has been no independent research to confirm this.

In Scotland, the anecdotal evidence on the effectiveness of doctor triage is mixed. Some practices report that it is the only way they can cope with demand and are supportive of doctor triage. Others report that it has created excess supply-induced demand and that once that demand has been generated it is very difficult to reduce it. Some practices have found that it has thus increased rather than reduced GP stress. Many patients seem to like it but that will depend on what the level of access was prior to moving to GP triage. It may constitute a barrier for older people, minority ethnic groups, those with hearing difficulties and learning disabilities.

If you are thinking about changing to this system then speak to a practice using it. If they find it successful, then check that their measures (such as patient demand for appointments and GP willingness to spend a large part of each day on the phone) match your own.

13 Continuity of care

At first glance continuity of care and improving access may seem to be diametrically opposite. There is good evidence, however, that providing better personal continuity of care can reduce overall patient demand and so improve access. You may wish to read more about this in the RCGP Continuity of Care Toolkit at www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP%20CoC%20toolkit.ashx
Chapter 6
Fair access for all

It is important that all sections of society get good access to practice services. The following section describes some tips to ensure this takes place.

Those practices who have engaged in the Deep End project report the particular difficulties they have in ensuring good access for their patients in their deprived communities. They report that:

- Patient education is harder, so all team members must commit to it
- Self-referral suggestions are less helpful, so promote the use of the Minor Ailments service
- There are mobile phone issues, so make sure the receptionist takes a note of the number that is correct at that time
- There is less demand for book in advance appointments, so provide more book on the day
- The behavioural responses to negotiating for an appointment are more extreme, so be prepared for that
- Developing patient groups is hard, but some similar practices do have successful groups so talk to them

To ensure your practice meets the needs of patients who belong to an ethnic minority group, consider the following:

- Do you actually know the significant ethnic minorities in your population?
- Improve communication with your patients by being aware of available translation services.
- Engage with the minority ethnic community either at a practice level or at Community Health Partnership (CHP) or NHS Board level.
- Raise awareness of these issues amongst all front line staff and provide training on this where appropriate.
- If you have a large number of patients whose first language is other than English (Polish for example), could you run a “Polish” surgery with an interpreter there for the duration of the surgery
Patients with a **hearing difficulty** will have problems making appointments. Issues to consider include:

- Find out if **Text Relay** is used by patients. With this method, the patient type into their equipment and an operator reads this out to the receptionist and the response is then typed and sent back to the patient. Make sure reception staff are aware of this system if it is used.

- Increase staff awareness of the problems that deaf people have in arranging appointments.

- Ensure hearing loops are functioning and advertised.

Those patients with **visual loss** have a different set of problems in obtaining good access.

- They are unable to read the standard format of literature on how to make an appointment in practice leaflets or notice boards or websites. Alternative methods need to be made available.

- Staff may need training in dealing with these specific problems.

Patients with **learning disabilities** have another set of problems in accessing services particularly in regard to communication, with 80% of people with learning disabilities experiencing additional communication difficulties.

- Encourage a culture where staff see the patient and not the disability.

- Ensure your learning disability register is up to date and consider flagging notes so reception staff are aware of the situation at the first point of contact.

- Use plain language with familiar words and short sentences. Avoid the use of jargon.

- Make sure patients with learning disabilities have enough time to understand when their appointment has been made. Consider asking them to repeat the appointment information to confirm.

- Consider the use of easy read / symbolised appointment reminders such as a clock face.

- Consider offering an appointment on the hour as this may be an easier time for the patient to remember.

- Consider offering double appointments for patients with communication difficulties and/or complex health needs.
• If a carer is present, then still speak first to the patient and only involve the carer if it seems the patient has not fully understood the arrangements.

• Engage with people with learning disabilities, their carers and support providers either at a practice level or at CHP or NHS Board level.

Autism Spectrum Disorders might impact on the behaviour of a patient when he/she presents for an appointment. NHS Education Scotland (NES) have introduced a learning resource for GPs and Primary Care Practitioners available at: www.nes.scot.nhs.uk/asd/.

If you find that any of the weblinks in this toolkit are not working please contact diane.rich@rcgp.org.uk
### Annex A

Working Group Members 2010

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Dr Ken McLean</td>
<td>Co-chairman, RCGP Quality Practice Award</td>
<td>Chair of group: Royal College of General Practitioners (Scotland)</td>
</tr>
<tr>
<td>John Alvin</td>
<td>Primary Care Policy Advisor</td>
<td>Scottish Government</td>
</tr>
<tr>
<td>Catherine Buchanan</td>
<td>Programme Manager, Improvement Programmes</td>
<td>Scottish Government</td>
</tr>
<tr>
<td>Bernadette Campbell</td>
<td>Practice Nurse, Midlock Medical Practice</td>
<td>Practice Nurse Network</td>
</tr>
<tr>
<td>Fiona Dalziel</td>
<td>Practice Manager, Elmbank Medical Practice</td>
<td>NHS Grampian</td>
</tr>
<tr>
<td>Steve Faulkner</td>
<td>Primary Care Manager</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Catriona Hayes</td>
<td>Analytical Services</td>
<td>Scottish Government</td>
</tr>
<tr>
<td>Susan Kinsey</td>
<td>Patient representative</td>
<td>Chair RCGP Scotland P3</td>
</tr>
<tr>
<td>Kevin Lawrie</td>
<td>Practice Manager, Dalkeith Medical Practice</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Dr Sheena MacDonald</td>
<td>Senior Medical Advisor</td>
<td>Scottish Government</td>
</tr>
<tr>
<td>Marion MacLeod</td>
<td>National Coordinator of the Scottish Practice Management Development Network</td>
<td>NHS Education for Scotland</td>
</tr>
<tr>
<td>Dr Dean Marshall</td>
<td>Chairman</td>
<td>Scottish GP Committee of BMA</td>
</tr>
<tr>
<td>Carol Sinclair</td>
<td>Programme Director, Better Together Programme</td>
<td>Scottish Government</td>
</tr>
<tr>
<td>Dr Bill Taylor</td>
<td>Executive Officer for Quality, Scottish Council</td>
<td>RCGP Scotland</td>
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**Review Group Members 2014**

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<td>GP</td>
<td>Chair of group: RCGP Scotland</td>
</tr>
<tr>
<td>Dr Bill Taylor</td>
<td>GP</td>
<td>RCGP Scotland</td>
</tr>
<tr>
<td>Steve Faulkner</td>
<td>Primary Care Manager</td>
<td>Lothian Health Board</td>
</tr>
<tr>
<td>Lizzie McGeechan</td>
<td>Quality Manager</td>
<td>Lothian Health Board</td>
</tr>
<tr>
<td>Susan Bishop</td>
<td>Quality and Efficiency</td>
<td>Scottish Government</td>
</tr>
<tr>
<td></td>
<td>Support Team</td>
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</tr>
<tr>
<td>Jenny Wilson</td>
<td>Practice nurse</td>
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