BARNET LOCAL MEDICAL COMMITTEE MEETING

To be held at 1.30 to 3.30 pm on Tuesday 1 October 2013 in the {Drawing Room
Avenue House, 17 East End Road, Finchley N3 3QE}
A sandwich lunch will be provided

AGENDA

1.0 Welcome and apologies

2.0 Declarations of interest
   Members to declare any conflicts of interest in connection with any items on the agenda
   or in the light of subsequent debate

3.0 Minutes and matters arising not listed elsewhere on the agenda:
   3.1 Minutes of LMC meeting on 4 June 2013 (pages 3-10)
   3.1.1 Requests for information from CCG/NHS E (minute 4.1)
   3.1.2 Payments to practices (minute 4.3)
   3.2 Barnet Medical liaison Group meeting (pages 11-15)
   3.2.1 To discuss any issues arising from the Barnet Medical Liaison Group meeting not listed
       elsewhere on the agenda

4.0 Chairs and LMC members’ reports of meetings attended as LMC representatives
   in relation to meetings including
       TBC

5.0 Items for discussion:
   5.1 Data Sharing Agreement
   5.2 Barnet Healthwatch – Report on GP Appointment System (Pages 16 – 38)
   5.3 Barnet Toolkit Event – Responding to the Challenges - Feedback
   5.4 Inappropriate transfer of work
   5.5 Barnet CCG update
   5.6 Primary Care Strategy Implementation
   5.7 PMS issues
   5.8 Sessional GPs issues
   5.9 LETB – to receive an update
6.0 **Items to receive:**

6.1 **GPC News 20 September 2013**
This can be accessed via the following link:

6.2 **LEAD events**
http://www.lmc.org.uk/visageimages/Events/annual%20calendar%202013%20(updated%20August%202013).pdf

7.0 **LMC newsletter**
To identify items for the next newsletter

8.0 **Date of next meeting:**

3 December 2013

9.0 **Any other business:**
Present: Dr Charlotte Benjamin  
Dr John Bentley  
Dr Laurence Buckman  
Dr Allan Daitz  
Ms Michelle Eshmene  
Dr Martin Harris  
Ms Jacqui Hodgson  
Dr Alexis Ingram  
Dr Ian Johnston  
Dr Nitu Jones  
Dr Tammy Nisner  
Dr Anuj Patel  
Dr Sudama Prasad  
Dr Yvette Saldanha  
Dr Jacqueline Santhouse  
Dr Eleanor Scott  
Dr Carole Solomons  
Dr Clare Stephens  
Dr Tony Uzoka  
Dr Niamh White  

Observers: Mr Gerald Alexander  
Dr Debbie Frost (item 5.1)  
Dr Oge Ilozue  
Ms Teresa Callum (item 5.1)  

In attendance: Mrs Jane Betts, Director of Primary Care Strategy, Londonwide LMCs  
Ms Nicola Rice, Senior Committee Liaison Executive, Londonwide LMCs  

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<tr>
<th>Item no.</th>
<th>Action</th>
<th>Organisation / person responsible</th>
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<tr>
<td>1.0</td>
<td>Apologies for absence</td>
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Apologies for absence were received from Dr Sanjiv Ahluwalia, Dr Daniela Amasanti-Debono and Dr Nitin Lakhani  |
| 2.0     | Declarations of interest |  
There were no new declarations of interest.  |
| 3.0     | Minutes and matters arising not listed elsewhere on the agenda: |  |
| 3.1     | Minutes of LMC Part 1 meeting on 9 April 2013 |  
The minutes of the meeting on 9 April 2013 were agreed as a correct record.  |
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<tr>
<th>3.1.1</th>
<th>Co-opt of a practice nurse representative (minute 3.1.1 refers)</th>
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<tr>
<td></td>
<td>The Committee welcomed Ms Jacqui Hodgson who had been</td>
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<td></td>
<td>nominated by her peers as the Practice Nurse representative</td>
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<td></td>
<td>on the LMC. Ms Hodgson thanked the LMC for inviting a practice</td>
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<td>nurse representative onto the Committee and advised that the</td>
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<td>118 practice nurses in Barnet were beginning to network once</td>
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<td>again. Ms Hodgson explained that there was still a need to</td>
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<td>recruit to the Practice Nurse Development Lead and noted that</td>
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<td>the practice nurse group was funded by the goodwill of GPs as</td>
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<td>it did not receive funding from the CCG. Ms Hodgson agreed</td>
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<td>that her email address could be included in the next newsletter</td>
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<td>as a point of contact should anybody have any practice nurse</td>
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<td>related queries.</td>
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<tr>
<th>3.1.2</th>
<th>Co ordinate my Care (CMC) (minute 5.1.2.2 refers)</th>
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<td>The Committee noted again that even though people</td>
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<td>may have attended CMC training it was not obligatory</td>
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<td>that they used CMC.</td>
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| 3.1.3 | Acute discharge letters/inappropriate transfer of work from |
|-------|secondary to primary care (minute 5.1.2.3 refers)           |
|       | Dr Saldanha advised that she had met with Dr Debbie Frost |
|       | and Ms Teresa Callum on 2 May 2013 to discuss the LMC’s  |
|       | concerns about the transfer of inappropriate work from    |
|       | secondary to primary care. They looked at examples which  |
|       | had been collected previously and agreed to focus on the  |
|       | following areas: pre-operative assessments by GPs,        |
|       | psychiatrists needing to order blood tests, consultant    |
|       | to consultant referrals, hospital clinicians following    |
|       | up investigations they have requested and clear discharge|
|       | letters. Dr Buckman noted that unless GPs started to say  |
|       | no inappropriate work would continue to be passed to GPs. |
|       | He emphasized that there would be a need to be clear that |
|       | the reason why GPs were saying no was because they were    |
|       | not resourced to do this work and they were concerned that |
|       | patients could fall through the net. Dr Bentley considered |
|       | that the crux of the problem was the lack of clarity      |
|       | around the contractual obligations of both secondary and   |
|       | primary care. Ms Hodgson cited an example whereby one of  |
|       | her patients who had undergone a colonoscopy had not been |
|       | given a prescription for picolax which very few community |
|       | pharmacists stocked. Dr Saldanha suggested that it would  |
|       | be helpful for the practice nurse group to collate a list  |
|       | of similar things being passed on inappropriately. It was  |
|       | noted that GPs had recently received a communication with  |
|       | a list of things they needed to do before making a referral |
|       | to secondary care. Dr Patel queried whether some of the  |
diagnostics GPs were being asked to arrange had already been paid for and it was agreed that the LMC should clarify with the CCG what tests had already been paid for to avoid duplication.

Dr Benjamin agreed that the CCG and the LMC needed to work together on this issue but pointed out that while some issues could be taken into account in the contracting round discussions it was a complex area as there were so many bundles of costs involved.

Dr Buckman suggested that one way forward would be to have an overarching Heads of Agreement where there were multiple contracts. Such Head of Agreement would cover generic issues such as hospitals being responsible for doing their own investigations for example with separate detailed agreements for each provider.

Dr Saldanha confirmed that Dr Buckman had forwarded to the LMC office a template letter which could be used by GPs to say no to work which would be modified and sent out to GPs. In addition a letter would be sent to the Trusts setting out the LMC’s concerns about the inappropriate transfer of work.

It was agreed that this should be a standing item on both the LMC agenda and the Barnet Medical Liaison Group meeting agenda.

3.1.4 Communications between pharmacists and GPs (minute 9.1 refers)

Noted.

3.2 Minutes of Barnet Medical Liaison Group on 2 May 2013

The minutes of the LMC Part 2 meeting were received. The following issues were raised:

3.2.1 Financial position (minute 5.3 refers)
It was noted that Barnet CCG was the most financially challenged CCG in England and Dr Saldanha considered that it was useful for the LMC to know the context in which the CCG was working.

4.0 Chairs and LMC members’ reports of meetings attended as LMC representatives in relation to meetings:

4.1 Meeting with Ms Mary Cleary, Interim Senior Manager, Public Health Commissioning, on 30 April 2013

Mrs Betts noted that she had felt encouraged by the meeting as it was clear that public health was keen to work collaboratively with the LMC. Dr Saldanha advised that Ms Cleary had noted that her local authority colleagues had no understanding of general practice and were not used to having lots of contracts with individuals. Ms Cleary advised that the local authority would prefer to pay networks of GPs rather than individual practices and
so networking could be a way forward.

Ms Cleary had reported that the local authority had been shocked regarding the coverage of health checks. Health checks was a huge priority for the local authority and they wanted to ensure as wide a coverage as possible so Dr Saldanha considered that this might be a threat for those who provide this LES.

Dr Stephens advised that she had recently met with public health colleagues regarding immunisations and screening. When she asked who was responsible for cascading communications to GPs as in the recent MMR campaign there was a debate as to whether it was Public Health England or the local public health offices. Dr Stephens considered that this was an area of risk and clarity was needed around what the failsafe arrangements were.

Dr Saldanha noted that she had written to Dr Andrew Howe, the joint Director of Public Health for Barnet and Harrow, to ask what the MMR coverage rate in Barnet was and he had advised that she needed to contact NHS E. The LMC agreed that it was not acceptable that he felt unable to respond to this query.

Ms Hodgson reminded members that immunisations fell within the remit of practice nurses and noted that although new PGDs had been issued they were still outstanding in relation to typhoid and other travel vaccinations and rotavirus. It was not clear who they should contact about this. Dr Stephens advised that it had been acknowledged at the meeting which she had attended that not as many PGDs had been available as they would have liked. Dr Stephens further noted the statement of intent from NHS E that any contractors would now have to fund any training as NHS E did not see it as part of its role to provide funding to train a contractor to provide a service.

Dr Buckman advised that the GPC was still negotiating with NHS E regarding the MMR campaign and that was why there was no clarity although a set of FAQs would be published in the near future. He confirmed that PGDs for MMR, rotavirus and shingles would be made available in the near future. He further advised that initially the DH had wanted GPs to provide data to public health but the GPC had argued against this and this requirement had gone.

Dr Buckman noted that Barnet GPs had recently been asked to provide information to public health in relation to immunisations and he suggested that GPs should not do anything. Dr Saldanha suggested that if members received requests asking them to collect data please let the LMC office know as they were not always aware and such requests might be inappropriate.

Dr Stephens suggested that the LMC might wish to consider what should be done in relation to possible requests for information in the future from the CCG in addition to requests from NHS E. It was agreed that this should be discussed at the next LMC meeting.
### 4.2 Report of Annual Conference of LMCs on 23 and 24 May 2013

It was noted that Dr Harris and Dr Scott had attended the annual conference on behalf of Barnet LMC. Dr Scott reported the following:

- Dr Buckman had given an amazing speech and had received a standing ovation
- Conference expressed concern about the sharing of complete medical records to non NHS bodies
- Conference rejected taking back responsibility for out of hours and a 7 day week for routine appointments
- There were calls to reverse the government’s position with regard to practices paying the 14% locum superannuation
- That QOF was no longer fit for purpose as patient focus had been lost and it amounted to tick box medicine
- That performance management should not be undertaken by CCGs
- That there was a conflict between the GP’s statutory obligations to the CCG and professional responsibility to patients
- There was a concern regarding the falling numbers of GP trainees

Dr Saldanha led the Committee in thanking Dr Buckman for representing GPs as Chairman of the GPC.

### 4.3 Practice Manager Report

Mrs Eshmene reported that the following issues had arisen at the recent Practice Managers Forum:

- There was concern about the lack of clarity about what funding PMS practices would receive in relation to the pension contribution payment for locum GPs

- There had been confusion among practices following the recent communication that NHS 111 should not be used between 8 am to 6.30 pm. Dr Buckman confirmed that NHS 111 would not take calls on a practice’s behalf in hours but practices could have an arrangement with an out of hours provider. Mrs Eshmene noted that Barndoc had recently published a direct line number for practices to use.

- A GP partner who was the Registered Manager for CQC purposes had recently retired and this had created a huge amount of work as his replacement had to undergo a CRB check.

- There had been problems in relation to the organisational domains of the QOF so there were many appeals underway. Mrs Betts advised that she was taking this up with the Area Team leads across London the following week. It was agreed that a communication would be sent to all practices
in Enfield to ask for examples for Mrs Betts to take to the meeting.

- The deadline for submitting bids for improvement grants passed the previous week. There appeared to be some uncertainty by the former NCL Cluster team’s as to whether certain types of flooring were CQC compliant. Dr Buckman noted that the CQC was not interested in flooring or legionella testing but Dr Saldanha noted that these areas were being flagged red by Oakleaf who had been commissioned by the NCL Cluster to visit practices to help them prepare for CQC.

- Practices were experiencing problems in receiving payments and that it was difficult to contact anybody as only a generic email address had been provided. Dr Saldanha noted that Dr Grewal was in the process of discussing this with the Area Teams and that he had undertaken to feedback outcomes of his discussion with the Area Team.

4.4 NCL Joint Formulary Committee meeting on 25 April 2013

The notes of the meeting which had been attended by Dr Tathagata Sadhu, an Enfield LMC member, on behalf of the NCL LMCs were received.

5.0 Items for discussion:

5.1 CCG led practice visits

Dr Saldanha advised the Committee that the LMC members who had attended the last Barnet Medical Liaison Group meeting had expressed concern about the CCG’s proposals to visit practices as it could be perceived that this was performance management. The CCG had responded to advise that the visits would help the CCG fulfil its responsibility to improve the quality of primary care and that the aim was to give practices an opportunity to reflect on how they were working and to learn what their development needs were. Dr Saldanha advised that she and Dr Tony Grewal had drafted some terms of reference which the CCG had agreed to send to practices.

Dr Buckman advised that he had agreed to be one of the pilot visits and reported that it had been innocuous, facilitative and comfortable.

Dr Frost noted that over the past 10 years there had been little engagement between the PCT and practices and it was the CCG’s intention to increase engagement. She explained that reasons for the visit were to hear practices’ ideas about what the CCG could be doing, to advise practices of the different services available and to go through the practice profile data with them to see whether they were outliers. Dr Frost confirmed that this was
In response to Dr Solomon's query as to what the CCG would do with the data collected during the visits Dr Frost advised that meetings were being held with the visitors to discuss the information that had arisen but only where the practices had agreed to the information being shared. Dr Frost assured the LMC that the information would not be circulated more widely.

Dr Frost considered that it would be helpful if the LMC could support the proposal in order to encourage GPs to engage with the CCG more and the visitors did not want to feel that they were going against the LMC when undertaking the visits. The LMC agreed to support the proposal given the robust Terms of Reference it had drawn up which the CCG would need to circulate to practices.

5.2 Network/collaborative working

The LMC noted that the message which was made clear at the event on 29 May 2013 was that doing nothing was not an option for practices anymore and that the opportunities open to them would be by working together.

It was considered unfortunate that not all practices were represented at the meeting and Dr Bentley considered that this might have been because GPs might have been too busy to attend or were not aware of it. He suggested that the communication to practices about the next networking event should explain in simple terms why it was essential that they attend.

5.3 Barnet CCG update

Nothing specific was raised under this item.

5.4 Primary Care Strategy Implementation:

5.4.1 Medically Unexplained Symptoms (MUS) enhanced service

Dr Benjamin noted that the aim of this enhanced service was to introduce something into general practice which would lighten the workload. There was funding for 15 practices which would be selected on a first come first served basis and data would be collected to see if it could be rolled out across Barnet. It would involve practices looking at 10 patients on a retrospective basis over a year to see how many diagnostics they had.

Dr Benjamin advised that the CCG was experiencing difficulty in rolling this out as it was not clear what mechanism it could use. Mrs Betts noted that previously such schemes would have been called an invest to save scheme and considered that this would be a mechanism to take this forward. It was agreed that she would liaise with Dr Benjamin about this outside the meeting.
agree what it should be called and how it could be contracted.

Dr Saldanha considered that this was very much a worthwhile project and thanked Dr Benjamin for working up a scheme which would be useful to GPs and would improve the quality of life of patients and GPs. Dr Saldanha suggested that it might also be helpful to collate data on patients with no interventions also in order to compare outcomes. Dr Benjamin noted that this might be difficult to do as it was not a research project and the techniques were all evidenced based.

Dr Benjamin hoped that this would be implemented in one month.

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<th>5.5</th>
<th>PMS issues</th>
<th>JB/CB</th>
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<td></td>
<td>No particular issues were raised.</td>
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<th>5.6</th>
<th>Sessional GP issues</th>
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<td>No sessional GP issues were raised.</td>
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<th>5.7</th>
<th>HE NCEL (formerly LETB)</th>
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<td>This item was not discussed due to time constraints.</td>
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<tr>
<th>6.0</th>
<th>Received items::</th>
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<tr>
<th>6.1</th>
<th>GPC News 9, April 2013</th>
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<th>6.2</th>
<th>LEAD events</th>
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<td>Noted.</td>
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<th>7.0</th>
<th>LMC Newsletter</th>
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<td>No additional items were identified.</td>
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<th>8.0</th>
<th>Date of next meeting:</th>
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<td>1 October 2013</td>
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<th>9.0</th>
<th>Any other business</th>
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<td>There were no items of any other business.</td>
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**Barnet Local Medical Liaison Meeting**

Minutes from the meeting held at 2pm on 5th September 2013
in Westgate House, Edgware Community Hospital, Burnt Oak Broadway, HA8 0AD

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<tr>
<th>Present:</th>
<th>LMC Members:</th>
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<tr>
<td></td>
<td>Dr Nitin Lakhani</td>
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<td>Dr Anthony Uzoka</td>
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<td>Dr Niamh White</td>
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<tr>
<th>Visitors:</th>
<th>CCG Members:</th>
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<td></td>
<td>Dr Sue Sumners (Chair)</td>
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<td>Ms Muyi Adekoya</td>
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| In Attendance: | Mr Greg Cairns, Director of Primary Care Strategy, Londonwide LMCs |
|               | Ms Debbie Griver, Committee Liaison Executive, Londonwide LMCs |
|               | Ms Sarah Martyn, Committee Liaison Executive, Londonwide LMCs |

1.0 **Welcome and Apologies**

Apologies for Absence were received from:
- Dr Yvette Saldanha
- Dr Martin Harris
- Dr Eleanor Scott
- Dr Julie Sharman
- Ms Helen Musson
- Dr Amol Joshi
- Mr John Morton
- Ms Mary Cleary

Greg Cairns confirmed that he was now covering the areas of Barnet, Camden, Islington, Haringey and Enfield and would be attending these LMC meetings in future.

2.0 **Declarations of Interest**

There were no declarations of interest.

3.0 **Minutes of the meeting held on 4 July 2013**

3.1 The minutes of the meeting held on 4 July 2013 were agreed as a true and accurate record, subject to the correction of the two typographical errors on page 4 and 5.

DG

4.0 **Matters Arising**

3.1.1 **CCG Practice Visits (minute 3.1.1)**

The meeting felt that the issue around the CCG’s proposal to visit practices had now been resolved as an email asking that practices undertake to put time into these visits had now been circulated. It was suggested that this topic should be added to the Terms of Reference. It was also recommended to feedback how long these visits are taking each practice and the lack of funding for them.

3.1.2 **NHS Standing Contract (minute 5.2.2)**
It was agreed that the existing contract is very dense and a more user friendly document should be produced. It was agreed to have a further discussion about this and the NHS contract for Locally Commissioned Services outside the meeting.

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<th>3.1.3</th>
<th>Phlebotomy LES (minutes 5.2.3)</th>
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<td>Nicola Rice would be asked to circulate the response she had received.</td>
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**CCG Chief Officer’s Report**

4.1 Dr Sumners noted that there is a ‘call to action’ and proposals are going out to engage the public, set in the context of a recovery plan. There will be two public engagement events on 1st October. The acquisition process will be built into the ‘call for action’ which would be looking at sharing potential benefits around better quality of care. It was hoped that there would be less red tape around processes and a centre of excellence developed, as well as addressing financial issues and providing care closer to home, which will impact on secondary services.

4.2 Dr Sumners explained that all hospitals will need to become Foundation Trusts and it had become clear that neither Barnet Hospital or Chase Farm could do this successfully on their own. The acquisition of Barnet and Chase Farm by the Royal Free has a short timeframe and from a clinical perspective all organisations needed to work together which is why Barnet, Enfield and Haringey had developed a joint Clinical Strategy. It is difficult at this stage to know the impact on Barnet residents but we need to look at services across all three Boroughs. The CCG needed to ensure that it was involved in the development of clinical pathways. It will be very unsettling for staff and CCG and LMC need to have as much input as we can into the process, but need to be mindful that the Royal Free are leading on this acquisition. Dr Sumners confirmed that this information is already in the public domain, and has been reported in the local papers.

The LMC noted that there was a communications strategy which included engagement events with GPs and it was agreed that information on the acquisition would be put into the newsletter.

4.3 Dr Lakhani raised the need of making access and transport available for patients travelling further for treatment, bearing in mind that it was difficult to get to the site by public transport and lack of parking facilities. Dr Sumners advised that the Royal Free would be a hub but it was not yet clear how much patient care would take place in the hub. The Royal Free was not a large hospital and capacity would be an issue particularly if they wanted to take on specialised commissioning too.

4.4 The CCG Communications

4.1.2 Dr Sumners advised that the CCG was required to publish an updated outline communications plan each year, adding any significant changes that are proposed and the direction of travel. The Health and Wellbeing
Board is central to this process and plans will be produced over the next few months, focusing on
• Keeping Well, Keeping Independent
• Recovery Plan
• Procurement Pipeline;
• Reviewing where we are in these areas

It was agreed that Ms Adekoya will find out if In Health is still funded centrally and what the usage has been to date. It was agreed that there are concerns around quality and the prompts that are given on the system. Dr Sumners added that the CCG would need to review whether the service was working and whether it would need to be re-procured.

## 5.0 Items for discussion/updates

### 5.1 Medically unexplained symptoms

There are currently 8 practices who wish to participate in the training, and we are expecting a few more to sign up. Kings College have now withdrawn from delivering the training and Dr Chris Burton, Senior Clinical Lecturer from the University of Aberdeen will now undertake this training. It was noted that dates are now being finalised and Ms Adekoya will be finding out the spread of practices participating within the Borough.

### 5.1.1 Networks

Ms Adekoya advised that there had been one bid received so far. There is a drive to move forward in all areas with the Networks and momentum from CCG is required to facilitate this, whilst recognising the CCG should be using a light touch as it should be a bottom up approach.

Greg Cairns explained that there was a Barnet workshop taking place the following week which would be practically focused on helping practices to write plans. All practices would be encouraged to attend. It was noted that practices could put in standalone bids but that if the proposals were too small there may not be the scale of change that would be required. Dr Sumners noted that some CCGs had made the whole of the CCG a network, which would be her personal vision.

Dr Niamh White asked whether salaried GPs were being encouraged. Dr Sumners advised that information had been disseminated to practices but it had not meant to exclude salaried GPs. Greg Cairns confirmed that an email had gone to every GP, but would check that salaried GPs were included. It was agreed that Ms Adekoya would check that salaried GP’s are on the mailing lists.

It was agreed that Debbie Griver would find out who receives the GP Bulletin and ensure that the GP list is up to date. It was agreed that everyone aligned to a GP should receive a copy of the Bulletin.

### 5.2 Local Enhanced Services

Community Care LES have been withdrawn but new improvement schemes are going ahead. End of Life care is currently being reviewed and will be completed by the end of September.

Greg Cairns asked about ‘Co-ordinate my Care’ and agreed to discuss this further outside the meeting with Dr Sumners.
## 5.3 NHS England Directed Enhanced Services

Ms Adekoya advised that the Risk Profiling DES had been sent to the LMC and the document has been approved subject to defining patients opting out. The onus is on CCG to ensure that they communicate with patients through practice websites, leaflets and posters.

It was agreed that software is helping practices to contact patients but there is an issue about how to ensure all patients are consulted. Dr Uzoka stated that a piece around informed consent and data sharing was missing and although there is a clear benefit for patients to be consulted, in practice this would be difficult. There was a suggestion that all over 65’s would receive a letter to inform them but there was no guarantee others would read the website or view a poster. It was agreed that Ms Adekoya would email Greg Cairns the final paperwork so that he could confirm that LLMC were happy with it.

### 5.4 Data Sharing Agreement

Greg Cairns confirmed that the data sharing agreement documents had been reviewed and returned with comments.

Dr Lakhani stated that documents were written in a very legal way, and sweeping changes are being requested, but is not sure whether these are being replicated around the country. Dr Lakhani feels that the final document needs to be taken back to a full LMC meeting for discussion. It was felt that information within GP records could be misconstrued, especially in relation to minors, and could read very differently to outsiders. There was also the issue of who would deal with complaints, and adding to the workload of GPs.

Ms Adekoya confirmed that the agreement has been shared with all providers and revised a number of times and due to its content it does need to be written with legal terminology to mitigate any challenges.

Greg Cairns stated that a separate agreement needs to be produced as the current agreement is too specific and is concerned about a number of aspects within the document, including references to how Camden works.

Ms Adekoya and Greg Cairns confirmed that a schedule will be put into place for each item that is shared.

Dr Sumners stated that a timeline needs to be produced to ensure the final Agreement is correct and was conscious that the process for finalising needs to move forward.

It was agreed that Greg Cairns would meet with Ms Adekoya separately to discuss and Ms Adekoya would find out who the lawyers are. It was agreed that Greg Cairns would meet with the CCG and Dr Kambiz Boomla from Tower Hamlets to discuss further.

It was agreed to that Greg Cairns would invite Dr Boomla to the LMC meeting on 1st October.

---

### 5.5 Shift of work from secondary to primary care – to discuss proposed letter to acute trusts

Dr Sumners agreed to speak with Dr Saldhana to progress the matter but is supportive of delivering a joint letter.
5.6 **Shared information systems – London Borough of Barnet**

A business case is being developed to produce a similar platform to the one used by Hampshire and Camden. It was agreed that we need to put systems in place if we are sharing data. It was noted that the outline business case had gone to the Integrated Care Board and the full business case was now being worked up. It was agreed that the CCG would share the outline business case with the LMC. It was agreed to bring the full business case with costings to a future meeting.

<table>
<thead>
<tr>
<th>6.0 Public Health Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 It was agreed that Greg Cairns would speak to Mary Cleary about the necessity of sharing public health information and Ms Cleary attending meetings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.0 Date of the Next meeting</th>
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</thead>
<tbody>
<tr>
<td>7.1 The date of the next meeting was noted as 7 November 2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8.0 Any Other Business</th>
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</thead>
<tbody>
<tr>
<td>8.1 It was noted that Anthony Davies had replace Becky Kingsnorth and she would be invited to future LMC meetings.</td>
</tr>
</tbody>
</table>
The GP Appointment System
The Way Forward

Healthwatch Barnet
Written by Sue Blain, Stewart Block and Lisa Robbins
Design by Shereen Williams
## Contents

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Introduction

In 2012 Barnet Link published a Research Report on “Patient Access to Appointments and Use of Telephone Systems in London Borough of Barnet GP Practices”. The work leading to the report was undertaken in response to issues raised by members of the community.

The Report was presented in late 2012 at a public meeting hosted by Barnet LINk and the Barnet Clinical Commissioning Group (CCG). It raised a number of issues about difficulties with the GP appointment booking process and made a number of recommendations (please see Appendix A).

This earlier study was undertaken solely from the patient perspective. In order to clarify and understand the presenting problems and to investigate the issues from the GP practice point of view, it was decided to meet a limited number of Practice Managers. This enabled us to explore the issues from their perspective and to understand the management issues. From our previous research the major problems that we identified in the appointment process were both getting through to the receptionist and the allocation of the appointment. Having pinpointed the major symptoms we wanted to identify their underlying causes.

This report has, of necessity, focused only on access to GPs and the general appointment-making process. The issue of access to GPs and the appointment-making process applies to all groups in the community and we acknowledge that further work needs to be undertaken to support some minorities who meet problems on a daily basis when contacting their GP.

This work, undertaken in Dec 2012 –March 2013, was done under the aegis of Barnet Link and at the time it was not known into which organisation the Healthwatch contract would be awarded. It has now been confirmed that this work will be continued under Healthwatch Barnet as the successor to Barnet LINk. Owing to this there were very severe time restraints which the group were working to, and it was only possible to plan and visit seven practices. Many of our suggestions could possibly be implemented at low cost or no cost.
Methodology

Using the National GP Survey for year 2011/2012 we looked at Question 18 which reads ‘Overall, how would you describe your experience of making an appointment?’ and best covers the area that we wished to investigate. We extracted the responses for this question for all Barnet GP practices in order to look at the data, selecting the responses of “Good and Very Good”, and “Very Good” alone. We found the ranking of practices was very similar using these two categories so we chose to use the “Very Good” category alone. This is supported by ‘Overall experience of making an appointment’ from the PMS Contract review presentation by NCL NHS (NCLondon NHS “PMS Contract Review Patient & Public Representatives Meeting”, March 2013.)

It was apparent from this ranking that there were a significant number of single handed practices in both the top and bottom cohorts. We decided to discount this group as they may have issues unique to their structure as opposed to a multi-partner practice which is more representative of the GP services provided to the majority of the population in the London Borough of Barnet. We acknowledge that the next phase should include some single-handed practices.

From this ranking we then picked a limited number of practices which had two or more partners. These were 3 from the practices scoring highly; 3 from the lower end and one midpoint practice from this list.

The Practice Managers from these selected practices were then contacted by phone and the background to the research was given. In this first phase all 7 practices that we approached were willing to take part. A meeting was then arranged and practices were asked to provide some basic statistics regarding appointments in advance of the meeting (please see Appendix B). The meetings were arranged at the Practice Managers’ convenience, generally over a short working lunch at each practice, with a small team of volunteers from Barnet LINk asking a series of structured questions along the lines set out in Appendix B. For consistency, the same core team of volunteers participated in all seven visits, with additional volunteers from the GP Group as available.

The purpose of these meetings was to gather information and to hear the Managers’ views on the issues around ‘making appointments’. This included list size, clinical and non-clinical staff resources, number of telephone lines and patient non-attendances (DNAs).

This data was captured on a spreadsheet and subject to ratio analysis. This is shown below in Table 1 on an anonymised basis.
As a result of meeting the Practice Managers we realised that the appointment-making process is very complex and, to help understand this and the management issues involved, we produced a flow diagram (Appendix C). This highlights the complexity of the task that the Practice and the Practice Manager face on a daily basis. Please note that the flow chart is a draft and is subject to review.

**Summary of Findings**

Table 1 Data Analysis from GP Visits

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<tbody>
<tr>
<td></td>
<td>Practic e</td>
<td>List Size</td>
<td>Patient satisfaction % score</td>
<td>Ratio of Patients/WTE Doctor</td>
<td>Annual Number of Doctor + Nurse appts per patient</td>
<td>Patients/Phone line</td>
<td>DNAs as % appts</td>
<td>Depri vation Index</td>
<td>Long - standing Health Problem %</td>
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<td>5.62</td>
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<td>31.1 - 59.6</td>
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</table>
Data Analysis and Explanation

Column 1 - Practice Identification.

Column 2 - List Size - this is the list size for each practice, banded for anonymity, provided by the Practice Manager.

Column 3 – This relates to the “Very Good” % score from the National GP Survey 2011/2012 Question 18. To avoid practices being individually identified we have presented the analysis banded by increments of 5% points.

Column 4 - The Ratio of Patients per Whole Time Equivalent (WTE) Doctor – this is the number of patients per whole time doctor. To preserve anonymity the figures in this column, “Ratio of Patients/WTE Doctor” have been rounded to the nearest 100. Analysis was based on the unrounded figures.

Column 5 – Annual Number of Doctor + Nurse appts – this is the number of doctor and nurse appointments available per patient per year. In some practices patients are seen by a Nurse Practitioner rather than a GP. Similarly patients may be seen by a Healthcare Assistant for appropriate treatments, and these are included in this figure. This figure therefore gives a better picture of the availability of medical care. This data was provided by the Practice Managers.

Column 6 - This is the number of Patients per Telephone Line.

Column 7 - DNAs as % appts -this is the number of patients who did not attend their booked appointment as a % of the total number of appointments.

Column 8 - Deprivation Index (from NCLondon NHS “PMS Contract Review Patient & Public Representatives Meeting”, March 2013.) The higher the deprivation score, the higher the level of deprivation recorded amongst the practices’ patients.

Column 9 - Long Standing Health Problem Score (from NCLondon NHS “PMS Contract Review Patient & Public Representatives Meeting”, March 2013.) The higher the percentage recorded, shows the greater the number of patients with a long-standing health problem.

Observations

These observations are based on inspection rather than statistical analysis.

- Looking at these figures there appears to be no direct correlation between the number of patients per doctor (Column 4) and the patient satisfaction rating score (Column 3).
Apart from Practice A, it would appear that there is little correlation between the annual number of doctor and nurse appointments per patient (Column 5) and patient satisfaction.

The number of patients per telephone line (Column 6) does not appear to affect ranking. Analysis of these figures seems to suggest that adding telephone lines is not the simple answer to improving access to GPs. It must be remembered that patients also use the telephone for many other reasons than just making appointments (e.g. test results, information requests) and also make appointments by non-telephone means (walk-in, online).

DNAAs as % of appointments. The wide range merits further investigation.

Ranking does not correlate with "Deprivation Index". However Practice D illustrates that implementation of new policies and procedures can improve service to patients despite a high deprivation index.

The number of patients with Chronic Health Problems (Column 9) may have some bearing on ranking, but this is not entirely borne out by cross-referencing the annual number of patient appointments per GP and nurse. Further analysis and feedback is required.

Having eliminated all of the above and based on our discussions with practices, we concluded that some of the essential elements contributing to high patient satisfaction are:

- Good management with a strong and engaged Practice Manager
- The Doctors, Practice Manager and the Reception staff working as a co-ordinated team
- On-going patient education and managing patient expectation
- Patients confident that they will be seen when they need an appointment. This is the key to eliminating the 8am pressures on the telephone lines.

We enlarge on these findings below:
Best Practice Findings and Suggestions

From the information that we gathered at our meetings with Practice Managers at the seven surgeries we visited we drew a number of conclusions and identified some excellent good practice. We have therefore documented here the trends and conclusions that we found and have identified some of the good practice that we feel may be of interest to other practices that we have not visited.

These issues may be grouped under a number of broad headings.

Issues, of course, may fall under more than one heading and are inter-related:

A - Managing patient expectations
B - Information to patients
C - Feedback & teamwork
D - Making an appointment

A. Managing Patient Expectations

i. Several Practices are attempting to ‘educate’ their patients on how to access and use the appointment system. For example, patients at one practice are asked only to phone at opening time for appointments required on that day. In one practice the guidelines for making appointments are set out in the practice leaflet. This sort of guidance seems to be helpful and instils confidence in patients that they will be able to get an appointment when really needed.

ii. One Practice we visited is trialling the NHS Minor Ailments Scheme. Patients are offered the opportunity to use this, when appropriate, for direct access to local pharmacies who can now directly prescribe medicine to patients who have a Minor Ailment and are eligible for free prescriptions. Those who are offered this scheme sign-up and are entitled to up to 10 prescriptions for minor illnesses which are dispensed directly from the pharmacist, without having to see a GP. Please see Appendix D, where examples of Minor Ailments can be seen.

iii. Some practices show a clear list of ailments / conditions that will be seen by the practice nurse so that it is clear which sort of appointment needs to be booked.
B. Information to Patients

i. Practice Leaflets and Patient Newsletters are becoming more popular and seem to be effective ways of informing and updating patients about the most effective ways of using the GP surgery, and keeping them up to date when changes occur.

ii. Some practices have developed clear, structured websites giving practical and useful information and links as well as the facility to book appointments online. These could be developed further, and patients encouraged to access these for information and guidance prior to making an appointment, and for general information. NHS England will be providing non-recurring annual rewards to GP practices for the successful preparation, establishment and adoption of electronic services to deliver online patient access during the period 2013/14 to at least 2014/15.

iii. Public health initiatives and advice need to be channelled more carefully to patients. Often these campaigns lead to the GPs being inundated with the worried well. Focused campaigns with further guidance would be more helpful.

C. Feedback and Teamwork

i. Several surgeries give feedback to their patients if they feel their request for an urgent appointment is not appropriate, and the matter could have been dealt with less urgently. This is fed back to the patient by the doctor they have seen, and information is passed back to the receptionist for monitoring.

ii. Patient Participation Groups (PPGs) are an effective way of engaging with patients and enabling them to have a voice in the practice. Two of the seven practices we visited have regular contact via their PPGs and both felt they benefited from good suggestions and constructive support through the groups.

iii. Practice Managers value the Practice Manager Network meetings, but often only the current administrative problems are discussed with no time for best practice ideas to be developed. Many also struggle to prioritise attending the meetings under the pressure of work.

iv. One practice was part of a small Hub Group who meet bi-monthly to discuss practical issues/solutions and give peer support and joint working wherever
possible. This has helped support Practice Managers, and alleviated the feeling of isolation.

v. One of the key aspects that we noticed across the practices we visited was the need for good doctor/manager/staff communication. The practices that appeared to be most successful were those with good communication and strong engaged practice managers. A long-standing, stable reception team is good for patients and for the practice.

vi. All of the practices we visited train their reception staff in house. This varied from 2 to 3 weeks’ shadowing a senior member of the reception team, to a more structured induction and trial period lasting three months— involving IT training, knowledge of protocols and procedures and signing off competencies as they are achieved. One practice had developed a training booklet for new staff. Having been involved in a Mystery Shopping project and heard how intensively the reception staff in Community Healthcare Reception desks are trained in all aspects of customer care, we were surprised that this seemed to be absent for GP reception staff who appeared to be largely trained on the job with little formal external training undertaken. We felt that reception staff would benefit from bespoke training looking at attitudinal aspects and conflict resolution techniques as well as the technical aspects covered in house.

vii. Two practices undertake their own Patient Surveys (in addition to the National one) each year which is found to be a very useful monitoring tool, enabling the practices to promptly respond to particular local issues.

viii. Where regular locums are used or surgery time is covered by other doctors from the practice during doctor absences, then the patient satisfaction rate is noted to be higher than where a range of different locums are used. Not all practices have cover for absent doctors.

ix. One practice noticed that the absence of Health Visitors attached to their practice had increased the workload as they used to advise families with young children.

D. Managing the Appointment Process

i. Telephone appointments with the doctor were perceived by the Practice Managers to be popular with patients where a given time was allocated for this form of consultation. This was a very useful facility for patients, saving a visit to the practice where reassurance may be all that is needed.
ii. Some practices have installed systems where appointments are confirmed by text to mobile phones and appointments can be cancelled if no longer required. This has cut DNAs in some practices, but not eliminated them. It is important that practices take advantage of modern communication channels within the context of a Communication Plan.

iii. DNAs are actively monitored and acted on in some practices, which helps to reduce the waste of resources. This is done by telephone calls and letters to the patients and, in extremis, removal from the list. Some practices displayed the numbers of DNAs during the previous month to raise awareness of the problem.

iv. Only one practice that we visited had an 0844 telephone number which generated a lot of complaints and was unpopular with the patients. The practice recognised this as an issue.

v. It has become clear during our visits that where patients are confident that they will be able to access an appointment urgently when required, the '8am scrum' disappears.

vi. The interpreter service was reported as good but needs to be booked in advance. This saves members of the family attending and performing this function, and maintains confidentiality and the dignity of the patient. Interpreters can also help convey medical terms and information, which family members may not be aware of. However some practices are able to use their ethnically diverse staff for this function.

vii. The practices varied considerably with the time over which advance appointment bookings could be made varying from one week to twelve months. Taking the ratings from the national Patients Satisfaction Survey, those practices with the long advanced booking period received more positive responses on the survey.

viii. Good use is being made by receptionists of screens which flash up patients’ information when an appointment is being made – thus helping to ensure that appropriate priority is being given to vulnerable and terminally ill patients. Some surgeries use cards which are issued to patients to highlight where priority is needed. This was being used as an “Aide Memoire” for the receptionists when booking appointments at the desk.

ix. One surgery said demand for appointments had trebled in the last year. Another said patient attendances had gone up from 3 to 6 per year. Our
figures ranged from 3.45 to 6.64 available appointments per patient per annum.

x. Over half of the practices reported that patients valued having blood testing facilities at the surgeries. This is usually done by Healthcare Assistants.
Next Steps

Recognising the small sample size of this study, we are keen to visit more surgeries, gathering further data and information on good practice.

We will consider academic involvement in our further work.

NHS England leads on primary care commissioning. We are in discussion with the CCG, which has been able to provide the GP Group with guidance on how these findings and best practice can be disseminated to GP surgeries and PPGs.

This report has been circulated to the Practice Managers so that they can check factual accuracy and make any comments.

Other Areas of Research

During this project a number of issues arose which we were not able to investigate further due to constraints both of our brief and of time.

However, we would like to note that further phases of this work will consider:

- Support for people with Learning Disabilities. Barnet LINk gave a presentation on this GP Project to the Barnet Council Learning Disability Partnership Board. Participants made a number of recommendations which will be included in future work. Molly Rayment, Primary Care Learning Disabilities Health Facilitator Nurse, is in contact with the Healthwatch Barnet GP group and hopes to work with them on issues at GP practices in order to improve outcomes for people with learning disabilities. Mencap has also been updated on this area and we will liaise with staff and members on taking this aspect forward.

- Support for people with physical and sensory impairments. In October 2011 Middlesex Association for the Blind, in partnership with other organisations presented a report to the Physical and Sensory Impairment (PSI) Partnership Board, ‘Access Project for Deaf and Hard of Hearing People in Barnet’ that covered key recommendations for Health Services in Barnet. We are working with the PSI Partnership Board, Barnet Vision Strategy Group on this, and it is hoped that Alison Asafu-Adjaye from Sense, will be working with the GP Group regarding accessing GP services.

- Different methods of patient triage when they first contact the surgery.
- Helping practices to be supportive for people with Mental Health conditions. Healthwatch will talk to the Mental Health Partnership Board and Mental Health Network to follow this up. The GP Group will also link with Healthwatch Barnet’s work with the Gypsy, Roma, Traveller community and Lesbian, Gay, Bisexual and Transgender community to be aware of and support any projects they carry out in on primary care.
References


National GP Patient Survey (www.gp-patient.co.uk)

Acknowledgements

Thank you to the volunteers of the Barnet LINk/Healthwatch Barnet GP Group for their hard work and support in the compiling of this report. In particular to Melvin Gamp and Ranil Jayasinghe for their assistance in completing the Practice Managers meetings.

Thank you to the 7 Practice Managers who very generously and constructively gave their time and expertise enabling us to complete this piece of work. They were a very dedicated and inspiring group of managers and we thank them very much for their contributions.

Our grateful thanks are also due to John Morton, Chief Officer NHS Barnet CCG, and Becky Kingsnorth, Head of Primary Care Strategy, Barnet CCG, who have reviewed the report and supported the Healthwatch GP Group in taking the work forward.

Finally, we would like to thank Selina Rodrigues, Head of Healthwatch Barnet, and to say how much we appreciated her support and advice during the researching and writing of this report.
Appendix A: Previous Report Recommendations


I. GP access systems need to be revised to ensure the system is patient-centered, logical, friendly and helpful. From the evidence gathered we have learned that a significant number of the patients taking part in this research felt that the booking system in their surgery was not patient-friendly.

II. The quality of communication between patients and their surgeries should be improved, through Patient Participation Groups. We recommend practices to talk to their patients about adjusting their systems to make it easier for them to access GP services when needed.

III. Regarding booking by phone specifically, GP practices are strongly encouraged to look at creative ways to increase patient satisfaction in this area, for example allowing patients to ring in the day before for the next day’s appointments.

IV. Standardisation of telephone numbers across Barnet’s GP practices is needed. We are concerned to see that around 10% of GP surgeries are using 0844 numbers, or other premium numbers, which create barriers to the service for those who cannot afford the charges incurred.

V. Clearer information about appropriate use of NHS services is needed to raise patient awareness about when to go to GPs, Chemists, Walk-In-Clinics and A&E.

VI. A cost effective balance between demand and capacity is important and we recommend identification and circulation of “best practice” and current demand/capacity analysis and local benchmarking.

VII. Serious consideration should be given to technology-based systems to ease the pressure on the telephone booking system. Alternatives would be needed for those that are unable to use the internet or other technology.

VIII. Overall patients disliked divulging their symptoms to a receptionist as it was perceived to be breach of confidentiality. Decisions about whether an appointment is an emergency matter or not should be made by a clinical member of the team (i.e. a nurse or a doctor).

IX. GP appointment systems should be patient-oriented based on the evidence gathered so that those who are vulnerable, disadvantaged, too ill or in need of special support are more sympathetically looked after. Perhaps an alternative telephone line or protected calling times could be considered.
X. From the survey responses, there is the possibility that some surgeries may not have an adequate number of telephone lines or staff to serve all the patients on their lists and we recommend that “mystery shoppers” test the surgery telephone systems and report their findings.

XI. Best-practice procedures should be shared across GP practices in Barnet, so that those rated highly by patients can serve as models to encourage change and improved patient satisfaction.

XII. We are concerned to see Edgware having consistently higher negative feedback than East Finchley. We recommend future exploration by CQC is focused on this geographical area to improve quality of services.

XIII. We would like to see patients being able to see a named doctor as far as the appointments allow, and similarly for emergency appointments.

XIV. Dignity and respect of patients should be observed at all times, in particular regarding requests to see a male or female doctor.

XV. Regarding test results, we strongly recommend that each practice has a clear and consistent policy regarding test results.
### Appendix B: Questions and Data Gathered for GP Visits

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<td>Total number of telephone consultations with doctors per day:</td>
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<td>Number of receptionists answering phones:</td>
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<td>Number of receptionists for face to face contacts (or do they do both?):</td>
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<td>Is there on-line booking:</td>
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<td>Is there computerised check-in at the surgery:</td>
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<td>DNAs:</td>
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</table>
Appendix C: Draft Flow Chart showing GP Appointments System

GP Appointments System Process Chart
DRAFT - Subject to Review

Err on safety when to call, time what about patient info, feedback to patient

Appointment

Walk-in Online Phone “111”

Normal tariff Premium rate

Information nodes Decision points Actions

Redial Direct Queue

No Answer Q/Info No How long waiting

Yes Receptionist

Patient info

Yes Implicit Explicit

No Patient database

Training

Patient info

Triage

Yes

No
Appendix D: An Introduction to Barnet Community Pharmacy Minor Ailments Scheme

How do I join the scheme?

If you have any of the minor ailments listed in this leaflet and are registered with a participating Barnet GP practice, you are eligible to join this scheme.

Please follow the steps below to obtain your Minor Ailments passport, which you can use up to 10 times.

1. Take this leaflet to your GP receptionist and ask for a Minor Ailments passport (one per patient). The receptionist can give you more information about how the scheme works and which pharmacies are taking part.

2. Take the passport to your chosen pharmacy.

3. The pharmacist will ask you a few questions and give you the appropriate advice and treatment.

What minor ailments can be treated under this scheme?

- Athletes Foot
- Constipation
- Cough
- Cystitis
- Diarrhoea
- Earache
- Fever
- Hay Fever/allergic rhinitis/allergies
- Head lice
- Indigestion
- Insect bites/stings
- Mouth ulcers
- Sore throat
- Sprains/strains
- Teething
- Threadworm
- Vaginal Thrush
- Verrucas
- Upper respiratory tract infections
- Warts

**IMPORTANT INFORMATION**

Do not share your medication with others even if they have similar symptoms.

Advice may also be obtained from NHS Direct on 0845 4647 or nhsdirect.nhs.uk

Patient Information Leaflet – page 1
What is the Minor Ailment Scheme?

Everyone can go to their pharmacist for free advice or to buy a medicine for a minor illness or ailment. The scheme allows you to use a passport, given by your GP, to get medication (free, if eligible) straight from your pharmacy for conditions listed in this leaflet.

The Minor Ailment Scheme allows you easy access to the same advice, treatment and medications from your pharmacist as you would get from your GP, without having to wait for a GP appointment.

Who can use the service?

People who are registered with a GP practice in Burnet that is taking part in the scheme. Currently...

Why visit the pharmacy?

- Pharmacists are trained to treat minor ailments such as head lice or sore throat.
- You will not have to visit your GP for a prescription or wait for an appointment.
- Your GP will be able to spend more time treating patients with more serious illnesses.
- This is a confidential and high-quality service, designed to meet the needs of patients.

Where will the pharmacist ask me?

The pharmacist will ask you a range of questions about:
- your symptoms
- how long you have had symptoms
- your current medication
- history or ailment
- any other illness you have.

The answers will help the pharmacist to make a diagnosis and offer you advice.

Will I always get treatment for my ailment?

You will definitely be given advice and treatment if necessary. The pharmacist may decide that you need to see a GP and refer you back without giving you any medicine.

Will I still be able to see a GP?

Yes, if you want to you can still have an appointment to see the GP or nurse. This is just another way that you can get advice and treatment without waiting for an appointment with your GP.

Which pharmacy can I go to?

Please ask your GP practice for a list of participating pharmacies.

Please be aware that the service may only operate when the named pharmacist taking part in the scheme is on duty.

**IMPORTANT INFORMATION**

Your pharmacist is providing treatment and/or advice under the minor ailment scheme in line with the symptoms you have described.
Contact Healthwatch Barnet:

Tel: 0208 364 8400 ext 213
Email: info@healthwatchbarnet.co.uk

www.healthwatchbarnet.co.uk
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Like us on Facebook/healthwatchbarnet