The Strategy Unit.

The role of appointment systems and progress with high impact actions

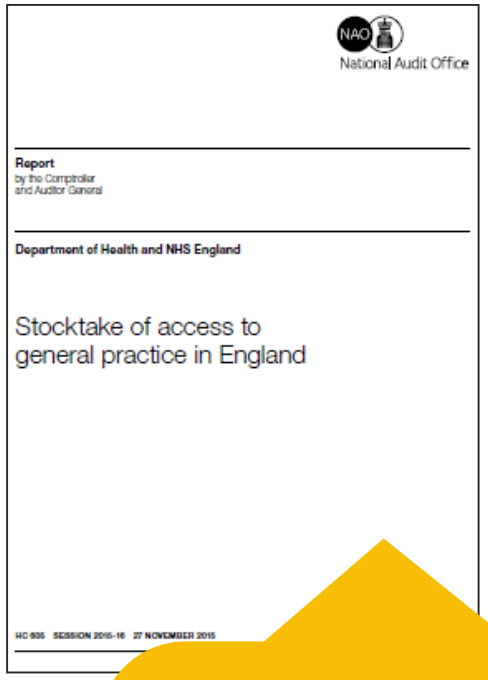
Project Slideset

November 2017

NHS
Midlands and Lancashire
Commissioning Support Unit

Background

Rapid research was commissioned.....


National Audit Office

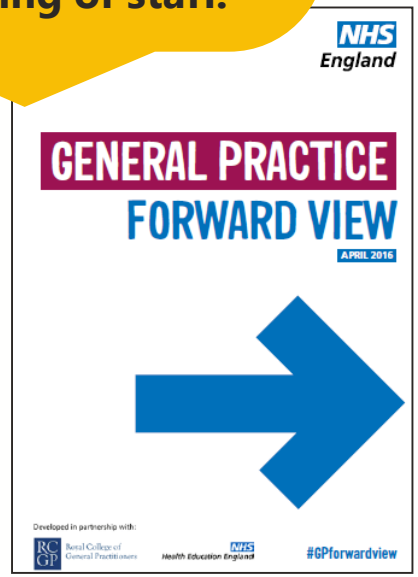
Report
by the Comptroller and Auditor General

Department of Health and NHS England

Stocktake of access to general practice in England

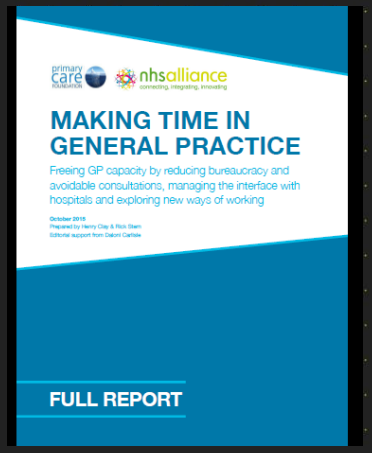
HC 606 SESSION 2015-16 27 NOVEMBER 2015

The General Practice Forward View cannot be delivered without sufficient recruitment and workforce expansion. Therefore NHS England and Health Education England (HEE) have set ambitious targets to expand the workforce, backed with an extra £206 million as part of the Sustainability and Transformation package. **We will also support the development of capability within the current workforce and support the health and wellbeing of staff.**



NHS England should research how different practices' appointment-booking and other working arrangements drive variations in access. Such insights would help NHS England and practices themselves to understand the effect of different approaches, such as same-day appointments, on key indicators of access.

.....to understand differences and assess progress



Aim and Objectives

Aim

Describe how differences in appointment systems and other working arrangements in general practice **drives variations in access**.

Objectives

1: To **understand** the **different appointment-booking** and **other working arrangements** in place at general practices to **meet demand for access** to general practice.

2: To **summarise the evidence** regarding the impact of each of the **Ten High Impact Actions** on **patients' access to care** in general practice.

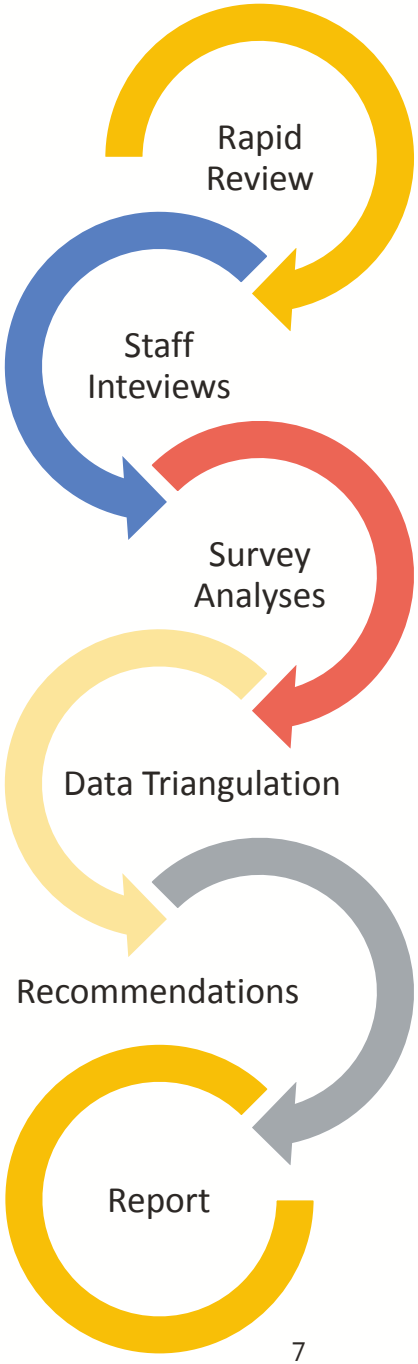
3: To **recommend** how general practices can **improve appointment systems and other working arrangements** for the access needs of their specific populations.

Approach

Mixed Methods Approach

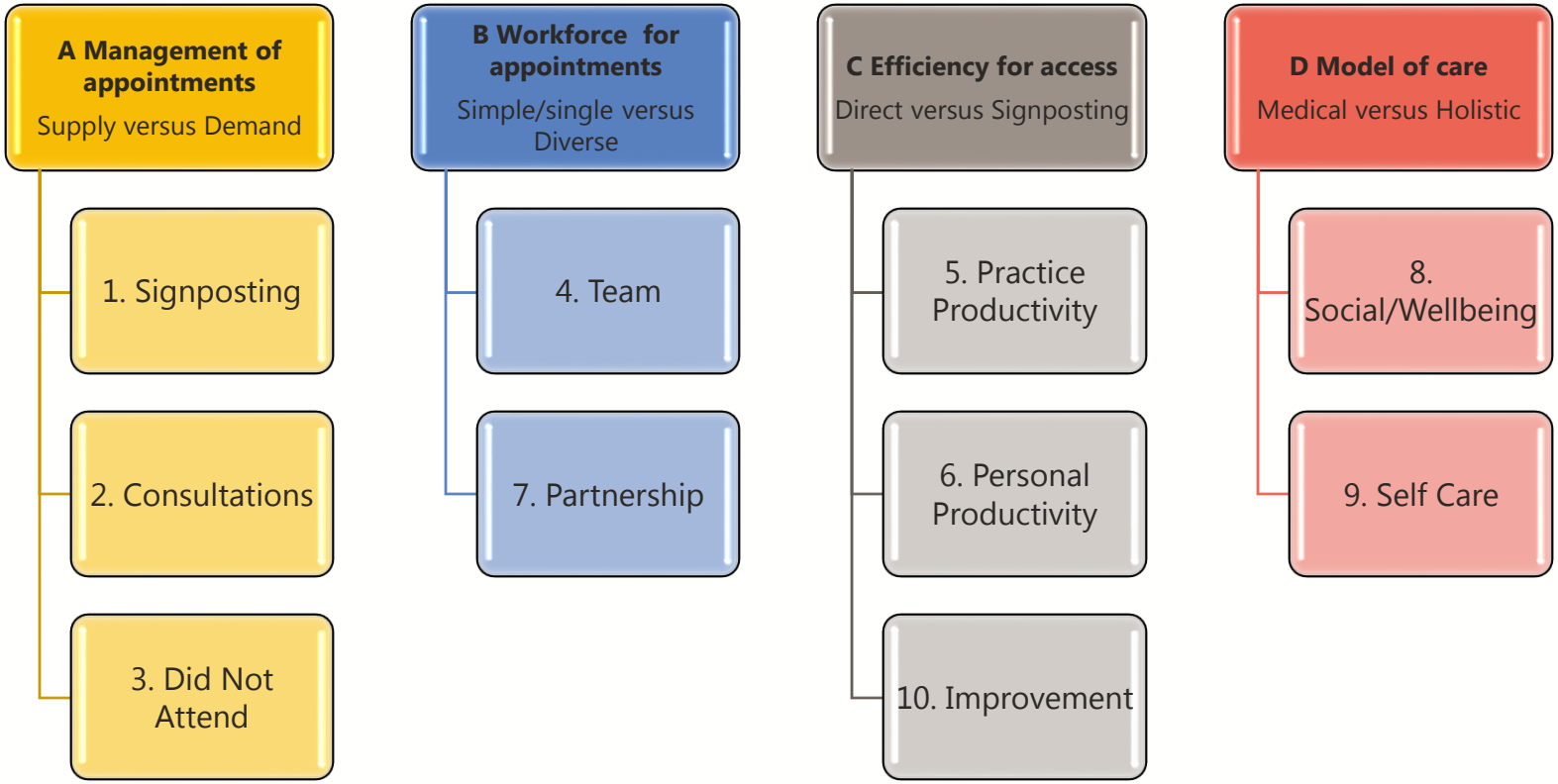
- Rapid review of the evidence
- Interviews with Practice Managers
- National survey data analysis
- National Advisory Group to provide guidance and context to the recommendations

Name	Organisation	Role
Robert Varnam (Dr)	NHS England	Head of General Practice Development
Mitchell Briggs	NHS England	Senior Programme Lead
Claire Oatway	Beacon Medical Group (Plymouth and South Hams)	Chief Operating Officer
Damian Hodgson (Prof)	Manchester Business School (University of Manchester)	Professor of Organisational Analysis
Jacintha Hodgson	Albion St & Withymoor (AW) Surgeries (Brierley Hill, Dudley)	Business Manager
Jayne Hunt	Modality Partnership (Sandwell and Birmingham)	Operations Director
Joanne Harding	Shropshire Doctors Cooperative Limited (Shropdoc, Shropshire, Telford and Wrekin and Powys)	Director of Transformation
Judith Smith (Prof)	Health Services Management Centre (HSMC, University of Birmingham)	Director
Sasha Karakusevic	NHS Horizons	Project Director
Simon Harlin (Dr)	Adult Community Services (Walsall Healthcare NHS Trust)	Clinical Lead



Aligning Frameworks

This analytical framework was developed using the Ten High Impact Actions and a steer from the projects Sponsor NHS England



Findings

Evidence Review

Analysts: Anam Malik and Sharon Stevens

Management of Appointments

1. Active Signposting	Receptionists operate under the influence of a number of pressures, prioritising timeliness over continuity (Alazri et al. 2007).
	Receptionists feel responsible for supporting vulnerable patients (Hammond et al. 2013).
	Care navigation has benefits of: receipt of timely care, reduction in unnecessary appointments, avoidance of hospital admissions, improved practice productivity and reduced workload (Health Education England 2016).
	Training for active signposting supports receptionists to confidently design, manage and deliver the care navigation role (NHS England undated, e).
2. New Consultation Types	Different types of consultations offer convenience, but raise concerns of increased demand, workload, privacy and confidentiality, (Ware and Mawby 2015).
	Telephone consultations not suitable for all patients (Paddison et al. 2015).
	E-consultations are dependent upon compatibility of IT systems (Farr et al. 2016).
	Video consultations can support management of chronic disease (Armfield et al. 2015) however increased computer proficiency required for patients (Leng et al. 2016).
	Shared medical appointments improve patient experience; care is perceived to be more accessible and sensitive to needs (Heyworth et al. 2014). NHS case study showed appointments avoided for frequent attenders (NHS England, undated, e).
3. Reduce DNAs	Reminder notifications help to improve attendance (Robotham et al. 2016). Reminders with details of timing and location of appointments are more effective (McLean et al. 2014).
	Encouraging patients to complete their own appointment card, asking patients to repeat appointment details and publicising attendance figures, result in reduced DNAs (Martin, Bassi and Dunbar-Rees 2012).
	Same-day telephone appointments to reduce 'just in-case' bookings associated with a 72% reduction in DNAs at one NHS case study (Rose et al. 2011).

Workforce for Appointments

4. Develop the team	GPs with specialist skills can achieve a reduction in referrals but raise concerns of increased GP workload (Pollard et al. 2014).
	Patients view care from health care assistants positively, considering it as less formal and offering prompt access and continuity of care (Bosley and Dale 2008).
	Patients display higher levels of satisfaction with nurses for tasks such as family planning (Martínez-González et al. 2014).
	Patients using clinical pharmacist services exhibit positive outcomes for medication adherence, resolution of medication-related problems and quality of life (Tan et al. 2014).
	Access to ANPs at care homes has avoided 417 unplanned admissions at a NHS case site (Prime Minister's Challenge Fund: Improving Access to General Practice 2015).
7. Partnership working	Practices choose to collaborate to 'achieve efficiencies' and to 'offer extended services in primary care' (Rosen et al. 2016).
	Multidisciplinary team working can improve patient-reported outcome measures in reported in COPD (Hernandez et al. 2015) and depression (Coventry et al. 2014).
	Collaboration of practices with community pharmacies to establish a minor ailments service reduces demand for GP appointment at a NHS case-study site (NHS England undated, e).

Efficiency for Access

5. Practice work flows	The improvement of flow across the system requires gaining an understanding of the patient/carer journey (Fillingham et al. 2016).
	Primary care staff value access to peer support when working in large practices (Rosen et al. 2016).
	Workflow can be improved by: proactive planned care, team functioning, sharing back-office functions, communication strategies and work flow mapping (Sinsky et al. 2013).
	Process mapping of a repeat prescription process and subsequent improvements to the process released 556 hours (NHS England e, undated).
6. Personal productivity	Staff value training and career development opportunities, as well as peer-support arrangements which reduce professional isolation (Rosen et al. 2016).
	Investment in training and skills development contribute to improved job satisfaction amongst staff (Rosen et al. 2016).
	Training across sites can be facilitated by web-based resources and saves time (Rosen et al. 2016).
10. Develop QI Expertise	Effective approaches to quality improvement include: audit and feedback; practice facilitation; educational outreach and processes for patient review and follow-up (Irwin et al. 2015).
	Specific training for quality improvement is required for general practice teams to ensure sustainability and continuous improvement (De Silva and Bamber 2014).
	Improvements in the quality of care given to patients needs to be support by relevant data and information (Goodwin et al. 2011).

Model of Care

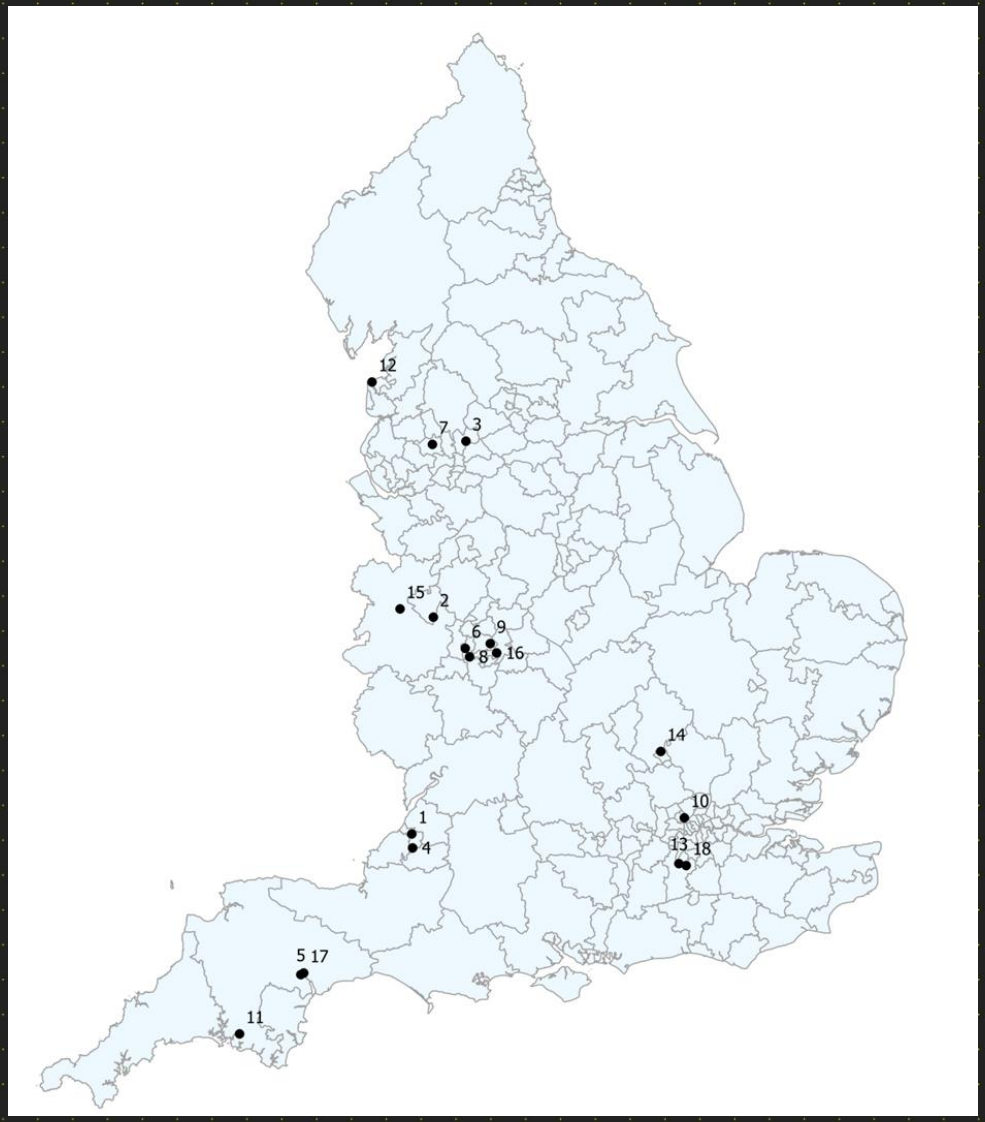
8. Social prescribing	Social prescribing is *"a way of linking patients in primary care with sources of support within the community…"* Bickerdike et al. (2017)
	May reduce frequent attendance to general practice by reducing social isolation and supporting those returning to work (Husk et al. 2016).
	Available evidence is insufficient to fully determine the success and cost effectiveness of social prescribing programmes (Wilson and Booth 2015).
	Communication, leadership and flexibility identified to be key strengths of a pilot intervention in the NHS (Whitelaw et al. 2016).
9. Supporting self-care	Multicomponent interventions are most effective for supporting self-management in people with long-term conditions (Taylor et al. 2014).
	Text-messaging interventions appear effective for diabetes self-management, weight loss, physical activity, smoking cessation, and medication adherence for antiretroviral therapy (Hall et al. 2015).
	Patient access to electronic health records imparts perception of control for the patient and time efficiencies for nurses (Jilka et al. 2015).
	Health Champions, who assist the practice in health promotion and outreach work re-directed patient concerns from general practices to the community at a case study site (NHS England undated, e).

Findings

Interviews

Analysts: Mahmoda Begum, Anam Malik, Shiona Aldridge and Abeda Mulla

Location of practices that were interviewed



Management of Appointments

Effective signposting requires trained receptionists	Receptionists engaged in non-clinical triage through care navigation training
	Training and support provided by clinicians
	Practice protocols and tools available
Preference for telephone consultations	Telephone consultations provide more convenient access and less rushed appointments
	Telephone consultation need to be tailored to patient population.
	Video consultations are still a future aspiration
Tackling DNA requires tailored approach	Specific services are more DNA prone
	Specific patient groups perceived to be more likely to DNA.
	Improved communication of appointment time and ability to cancel appointments.

Workforce for Appointments

Increased skill mix in practice team	Valued for quick access for patients and in providing better quality of care
	HCA releases nurse capacity; nurses release GP capacity
	Practice based pharmacist support release GP capacity and provides cost savings
Partnership working requires a community mindset	Provides patient centred care through a comprehensive and coordinated service offer
	Enabled by initial funding initiatives progressing to formal arrangements
	Facilitated by collaborative tools and a shared approach to access

Efficiency for Access

Productive work flows requires practice proactivity	Formal allocation of tasks to dedicated members of staff who are trained
	Practice manager develops, documents and coordinates processes
	Enabled by team culture of discussion and empowerment.
Personal productivity training improves practice efficiency	Diversity of approaches for personal resilience for patient interaction
	Practice culture of open door policy and breathing space improves staff morale and job satisfaction
	Challenges to accessing external training
Improvement initiatives require external support	Needs are recognised internally and championed by practice staff
	Supported (often funded) based on existing relationship with CCG
	Diversity of external suppliers for improvement support; access to these differs

Model of Care

Social prescribing dependent on community resource	Facilitates the development of community resilience
	Key role of practice based navigators /coordinators in bridging practice to other local services
	Concept of social prescribing not fully understood
Self-care support needs developing	Dependency on signposting to information resources and availability of education classes
	Coproduction of care plans especially in care home settings are valued
	Patient engagement a barrier to self care

Findings

National Datasets & Data Triangulation

Analyst: Jag Panesar

Triangulation

Analysts: Mahmoda Begum and Abeda Mulla

Patient experience of access at the practices that were interviewed

Range of Scores	Practices
Consistently above **the normal range**	5 and 7
Within the normal **range**	4 and 8
Consistently below **the normal range**	3,9,10 and 16

	Practice Identification																	
GP Patient Survey Question	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Ease of getting through to someone at GP surgery on the phone - % Easy	91%	47%	20%	66%	81%	74%	90%	65%	34%	45%	68%	73%	74%	38%	86%	50%	88%	28%
Helpfulness of receptionists at GP surgery - % Helpful	94%	79%	75%	86%	93%	91%	98%	86%	68%	65%	87%	90%	90%	92%	92%	69%	90%	70%
Frequency of seeing preferred GP - % Always, almost always, lot of the time	74%	64%	41%	68%	72%	65%	84%	60%	19%	38%	67%	65%	52%	64%	62%	29%	85%	43%
Able to get an appointment to see or speak to someone -% Yes	94%	55%	51%	67%	89%	82%	83%	70%	48%	47%	78%	68%	85%	58%	86%	54%	91%	50%
How long until actually saw or spoke to GP / nurse - % Same day, next day	30%	38%	22%	51%	42%	30%	61%	46%	72%	32%	47%	37%	68%	57%	50%	34%	48%	66%
Convenience of appointment - % Convenient	96%	89%	77%	82%	95%	92%	95%	91%	70%	85%	90%	91%	97%	96%	96%	73%	100%	79%
Overall experience of making an appointment -% Good	92%	59%	43%	65%	89%	74%	92%	68%	49%	46%	69%	70%	83%	55%	93%	46%	97%	47%
Satisfaction with opening hours - % Satisfied	87%	71%	67%	73%	84%	82%	94%	81%	67%	62%	78%	84%	74%	72%	86%	58%	79%	59%
Is GP surgery currently open at times that are convenient - % Yes	84%	67%	73%	75%	76%	84%	90%	89%	65%	60%	71%	85%	67%	79%	84%	52%	82%	69%
Overall experience of GP surgery - % Good	97%	81%	77%	78%	93%	81%	99%	88%	66%	69%	86%	91%	89%	88%	98%	67%	92%	76%
Recommending GP surgery to someone who has just moved to local area - % Yes	96%	74%	53%	71%	91%	66%	93%	82%	55%	54%	81%	80%	93%	74%	88%	50%	87%	60%

The majority of practices scores across the eleven questions were variable with only 2 practices scoring consistently above the normal range and 4 below

Key features of the practices consistently above the normal range for patient experience

Practice 5

- Identified patient need and developed clinical team accordingly
- Tailored consultations to meet patient needs
- GPs and Practice Manager take a proactive role in partnership working
- Sought and received support for improvement

Practice 7

- Introduced new clinical roles and flexible skill base for non-clinicians
- Identified communication barriers with patients and implemented improvements
- Proactive partnership working with other practices
- Used support from CCG to improve appointment systems, streamline processes and enhance consultations offer

Key features of the practices consistently below the normal range for patient experience

Practice 3

- Local collaborative working with other practices in its 'infancy'
- Not proactive in enhancing patient access
- Implementation of improvements was difficult
- Futility for attempting patient behavioural change

Practice 9

- Transitioning to an ambitious partnership model with local practices
- Current focus on modernising general practice delivery not patient experience
- Staff development expected and initiated
- Practice not sufficiently engaged in patient education or empowerment

Practice 10

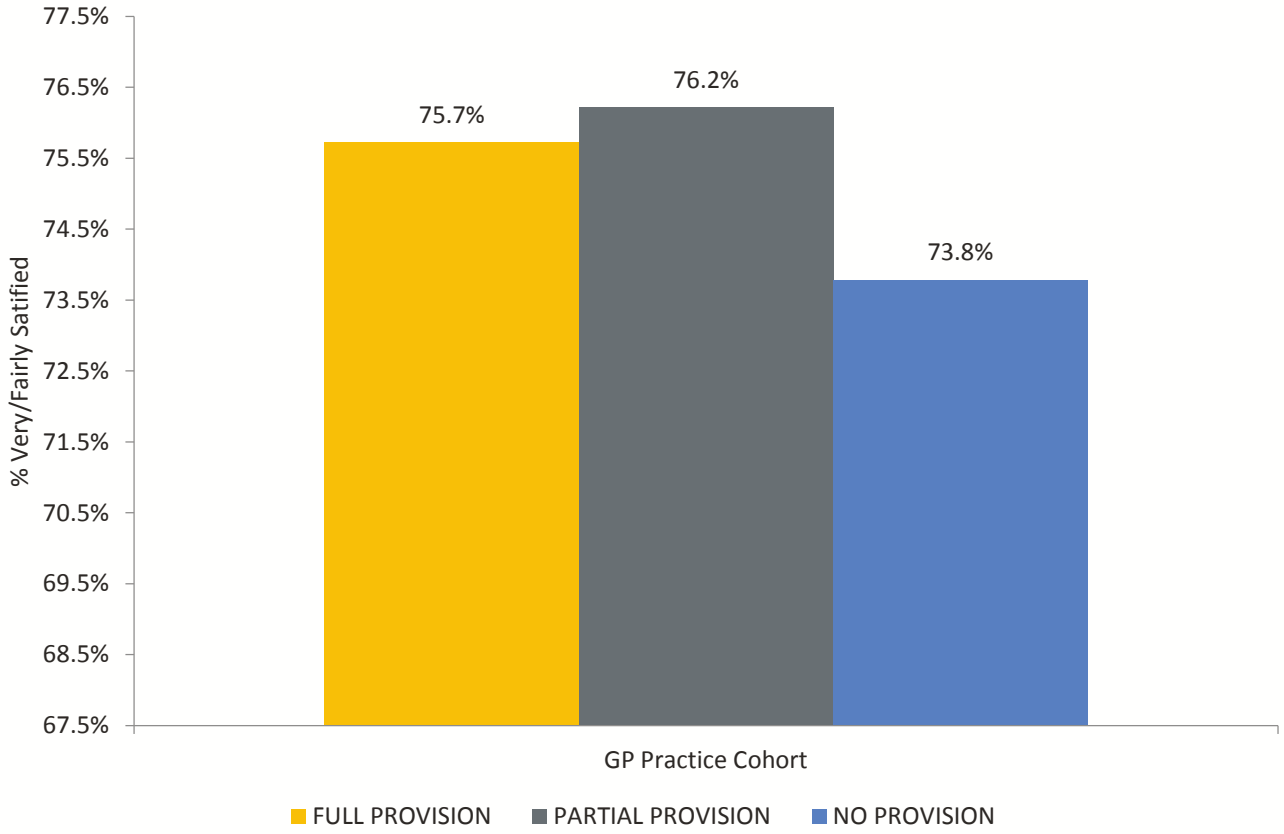
- Knowledge of alternatives was limited.
- The practice struggled with building relationships with patients
- Staff development opportunities limited to external offer
- Patient education was dependent on the secondary care provision

Practice 16

- Partnership working with other practices limited to formal arrangements for OOH
- Patients were viewed as demanding with unrealistic expectations
- Training at the practice was limited
- Challenged by the language barrier between staff and patients

Patient satisfaction rating for practices with or without extended opening hours

'How satisfied are you with the hours that your GP surgery is open?'
The following % responding very or fairly satisfied



Full provision - patients have access to pre-bookable appointments on Saturdays and on Sundays, and on each weekday for at least 1.5 hours

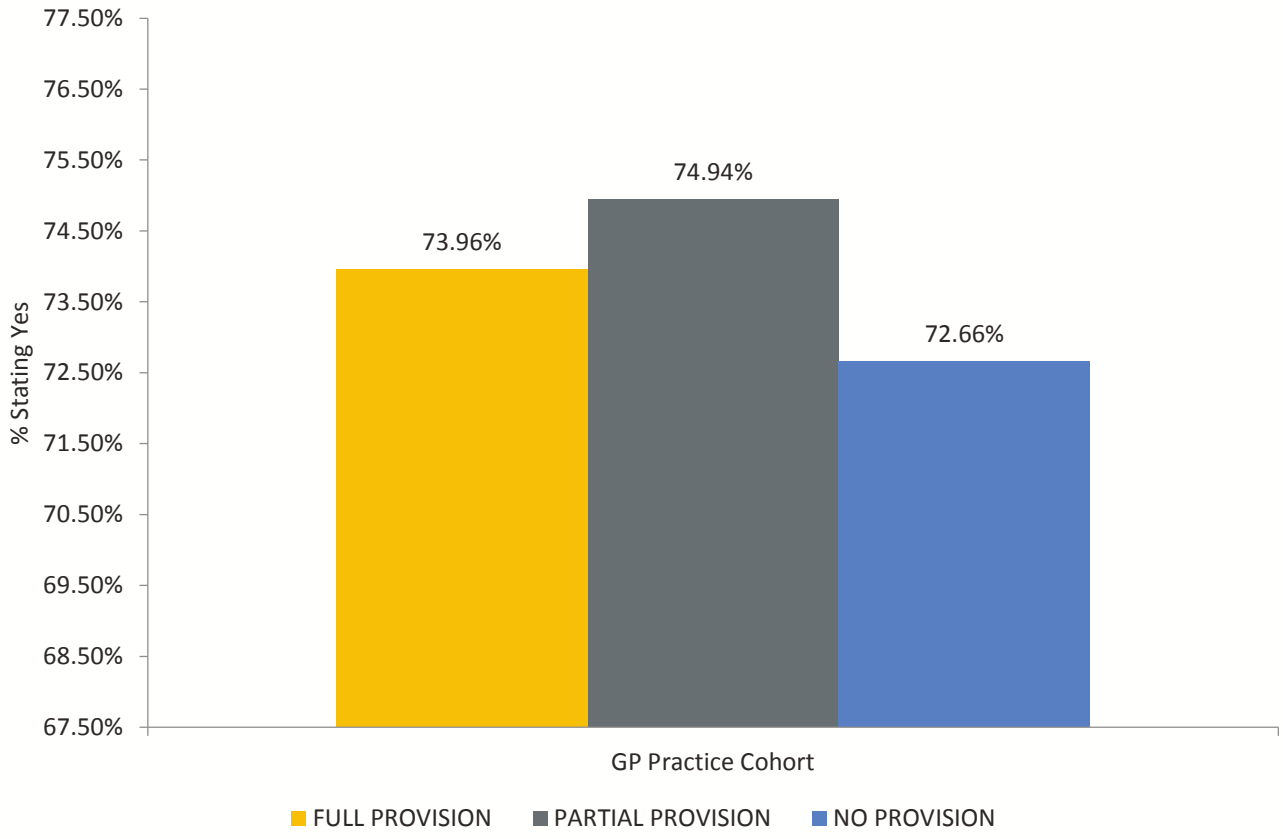
Partial provision - patients have access to pre-bookable appointments on at least one day of the week

No provision - practices have no extended access arrangements in place on any day

There is very little difference in patient satisfaction between partial and full provision

Patient convenience rating for practices with/without extended opening hours

'Is your GP surgery currently open at times that are convenient for you?'
The following % stating yes



Full provision - patients have access to pre-bookable appointments on Saturdays and on Sundays, and on each weekday for at least 1.5 hours

Partial provision - patients have access to pre-bookable appointments on at least one day of the week

No provision - practices have no extended access arrangements in place on any day

There is very little difference in perceived convenience between partial and full provision

A Management of appointments Supply versus Demand	The size of the practice did not appear to be linked to a practice's ability to innovate for consultation types. However larger practices were in a better position to offer a wider range of consultation types.
	The different consultations offered in larger practices were driven by a desire to provide patients a choice of access to clinicians. Whilst in smaller practices the different type of access to a preferred clinician provided continuity of care.
	A broader clinical team offering meant that GPs saw more complex patients requiring more time; practices reported the need to offer flexibility within it to suit the clinician.
B Workforce for appointments Simple/single versus Diverse	The diversity of nurse roles in general practice offered a perceptible improvement in GP workload and was valued by patients over time to the extent that nurse appointments were subsequently specifically requested.
	There was a difference in how practice managers took care of the personal and professional needs of all the practice staff and this was linked to reports of morale and ability to manage patient demand at the practice.
	Partnership working promoted the sharing of resources and skills and enhanced a practice's capability for improvement.
	Where practices recognised the need to work in partnership (for improved services) they did so even in the absence of a formal arrangement and leveraged any commissioning relationship to fund or support collaboration.
C Efficiency for access	Clinicians and non-clinicians supported one another to evolve and improve appointment and consultation processes to improve patient access.
	Practices with experience, capability and confidence to provide effective training in-house for their operational processes are also proactive in seeking support for external training.
	Standardised, good quality training for service improvement was not accessible by all practices that required it.
	There can be fatigue with improvement processes for meeting patient demand as it is often felt to be unsurmountable.
D Model of care Medical versus Holistic	More evidence of progress with a patient centred care coordination model of care where there was a higher elderly population with inherent chronic care or frail elderly needs.
	A holistic approach to care was perceived to be more relevant at practices with specific frail elderly or long term/complex conditions.
	Practice-based care navigators are the much appreciated mechanism through which patients are connected to appropriate community services (in an effort to reduce emergency admissions).
	The physical space to offer a one stop shop was likely to become a limiting factor for delivery of a holistic model of care.

Conclusion

The evidence

The peer-review evidence underpinning the High Impact Actions varies for the individual Actions by:-

- status of the evidence base (established, emerging or under-researched)
- the quality or comparability of what is studied
- the generalisability to UK or primary care settings

As it stands the following have the strongest evidence-base

- ***telephone consultations as an alternative type of consultation***
- ***enhanced nursing roles as part of team development***
- ***self-management for long term conditions***

The experience of Practices

A careful balance is required to manage the supply of and demand for appointments:

- ‘Hard’ features: the different types of consultations offered, the diversity of clinical and non-clinical staff; the size of the practice; and the partnership working
- ‘Soft’ features: staff engagement, interest for improvement; autonomy through training and personal resilience; leaders or champions of access and team working.
- Patient need based on health status: access needs differ for self-limiting versus chronic conditions whereas access for holistic care requires different professionals
- Patient preference for continuity or timeliness for access; preferences differ between patient groups with some having very high expectations.

The impact of which can be limited by two factors

- ***Lack of skill***
- ***Lack of funding***

Recommendations

The findings from the research were presented to the advisory group alongside draft recommendations. The advisors with their policy, strategic, academic, clinical and general practice experience expertise refined and added to the original list to generate the following recommendations

NHS England

1. A national strategy, with patient behavioural change components, should be considered to manage expectations of general practice and for patients to take more accountability of their own health and wellbeing particularly for self-limiting conditions. This will support the inherent tension of 'We're getting healthier, but we're using the NHS more.' (Page 7; Next Steps FYFV, 2017).
2. More guidance and standardisation for career development, both clinical and non-clinical is required to professionalise the primary care workforce as new roles emerge. As a starting point we would suggest templates for job descriptions for the key roles in general practice, for both traditional roles such as (practice managers and nurses) and new roles (such as care navigators and pharmacists).

NHS England (2)

3. Telephone consultations can be promoted as an alternative type of consultation that offers more convenience for clinicians and patients. Video consultations could be a logical next step to account for patient and clinical preference for real-time and face-to-face consultations but require consistent technical infrastructure support. Independent of the mode of consultation, guidance and training should be provided to staff and awareness of patients for the different consultations should be enhanced.
4. A consistent approach to data management and utilisation in primary care for national quality improvement purposes is needed. A minimum dataset that is relevant to the supply and demand of appointments is required for practices to extract comparable data from electronic patient record systems. The reporting burden on practices should be balanced for timelines and the relevance of the data being collected.

Clinical Commissioning Groups

5. Compatible information systems that 'talk' to one another are required in a healthcare economy and should be future-proofed to allow for efficiency across primary care and multi-disciplinary partnership working. This is especially vital in enabling practices to work together and book appointments across practices in order to meet extended access objectives.
6. The continuous cycle of non-recurring pots of national and local funding make change initiatives for general practices difficult to embed, replicate and sustain. The longevity of pilot schemes and their funding should be considered by a commissioners; a pilot should not be commissioned without a clear plan to either stop or roll out with decision rules specified up front.
7. Practices should be supported to broaden access to specialist primary care clinicians through the provision of a commissioner managed pooled resource. The needs of the practice should be matched to the expertise of the clinician and allow patients direct access to the clinicians.

Clinical Commissioning Groups (2)

8. A consistent definition of social prescribing in primary care is required for delivery and evaluation purposes to allow for equity in coverage and a comparison of 'what works'. Dedicated health and social care navigators, equipped with a good knowledge of community resources, and working within practice based multidisciplinary teams can then be appropriately mobilised for social prescribing purposes.
9. The willingness by general practices to work in partnership with other agencies in their health and social care economies to provide holistic care should be encouraged through the development of accountable local GP leaders with an interest in general practice access.

General Practice

10. Active signposting by receptionists to internal and external services includes non-clinical triage and requires training and clinical support for receptionists. Confident signposting by receptionists can overcome patient reservations and ultimately result in a better patient experience and reduced GP workload.
11. Champions from within the practice should be empowered to take on specific initiatives; these could be clinicians, non-clinicians or even patient representatives. They need to be provided with 'breathing space' or protected time to develop efficient processes for the management of access. Introduction of an efficient process to self-care has the potential to reduce general practice demand.
12. Patient demand can begin to be addressed with a willingness to proactively identify and seek solutions for patient needs. This could involve an initial investment in resource such as IT tools or training of staff; or embracing new ways of working in partnerships with health, social and voluntary care professionals to reduce GP workload burden.

General Practice (2)

13. The efficient and effective tackling of Did Not Attends (DNAs) requires as a first step, an audit of rates, an awareness of the capacity of clinicians and an understanding of specific reasons that patients DNA at individual practices. This should be followed by the use of evidence-based strategies.
14. Practice managers should be proactive in developing productive work flows within their practice by working across staff groups and clearly delegating responsibilities and accountabilities. Proactivity by practice managers for team working will improve personal resilience of individual members of staff, morale of the practice and engender a culture of learning and efficiency.

Bibliography

Bibliography

- Alazri M et al. (2007) How do receptionists view continuity of care and access in general practice? European Journal of General Practice, 13(2):75-82. Available from: http://www.tandfonline.com/doi/full/10.1080/13814780701379048
- Bickerdike L et al. (2017) Social prescribing: less rhetoric and more reality. A systematic review of the evidence. BMJ Open, 7:e013384. Available from: http://bmjopen.bmj.com/content/bmjopen/7/4/e013384.full.pdf
- Bosley S and Dale J (2008) Healthcare assistants in general practice: practical and conceptual issues of skill-mix change. The British journal of general practice, 58(547); 118-124. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2233962/
- Coventry PA et al. (2014) Characteristics of effective collaborative care for treatment of depression: a systematic review and meta-regression of 74 randomised controlled trials. PLoS One, 9(9):e108114. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4180075/
- De Silva and Bamber (2014) Improving Quality in General Practice. Health Foundation. Available from: http://www.health.org.uk/sites/health/files/ImprovingQualityInGeneralPractice.pdf
- Farr M et al. (2016) Improving Access to Primary Care: eConsult Evaluation Report. The National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care West (NIHR CLAHRC West).
- Fillingham D et al. (2016) The challenge and potential of whole system flow. Health Foundation. Available from: http://www.health.org.uk/sites/health/files/ChallengeAndPotentialOfWholeSystemFlow.pdf
- Goodwin N et al. (2011) Improving the quality of care in general practice: Report of an independent inquiry commissioned by the King's Fund. King's Fund. Available from: https://www.kingsfund.org.uk/publications/improving-quality-care-general-practice

Bibliography

- Hall AK et al. (2015) Mobile text messaging for health: a systematic review of reviews. Annual Reviews in Public Health, 36:393-415. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4406229/pdf/nihms677931.pdf
- Hammond J et al. (2013) Slaying the dragon myth: an ethnographic study of receptionists in UK general practice. British Journal of General Practice. 63(608):e177-84. Available from: http://bjgp.org/content/63/608/e177.long
- Health Education England (2016) Care Navigation: A Competency Framework. Health Education England. Available from: https://hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf
- Hernandez C et al. (2015) Effectiveness of community-based integrated care in frail COPD patients: a randomised controlled trial. Primary Care Respiratory Medicine, 6(4). Available from: http://www.nature.com/articles/npjpcrm201522
- Heyworth L et al. (2014) Influence of shared medical appointments on patient satisfaction: a retrospective 3-year study. Annals of Family Medicine, 12(4):324-30. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4096469/
- Husk K (2016) What approaches to social prescribing work, for whom, and in what circumstances? Systematic Reviews, 3;5:93. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4891904/
- Irwin R et al. (2015) Practice-level quality improvement interventions in primary care: a review of systematic reviews. Primary Health care Research & Development, 16 (6):556-577. Available from: https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/div-classtitlepractice-level-quality-improvement-interventions-in-primary-care-a-review-of-systematic-reviewsa-hreffn1-ref-typefnadiv/C8858233016E5B4963FC78B30F920490

Bibliography

- Jilka SR et al. (2015) “Nothing about me without me”: An interpretive review of patient accessible electronic health records. J Med Internet Res, 17(6),:e161. Available from: http://www.jmir.org/2015/6/e161/
- Leng S et al. (2016) The acceptability to patients of video-consulting in general practice: semi-structured interviews in three diverse general practices. Journal of innovation in health informatics, 23 (2); 141. Available from: https://hijournal.bcs.org/index.php/jhi/article/view/141/921
- Martin SJ, Bassi S and Dunbar-Rees R et al. (2012) Commitments, norms and custard creams – a social influence approach to reducing did not attends (DNAs). Journal of the royal society of medicine, 105(3) 101-104. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3308641/
- Martínez-González NA et al. (2014) Substitution of physicians by nurses in primary care: a systematic review and meta-analysis. BMC Health Services Research. 14(214). Available from: https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-214
- McLean S et al. (2014) Targeting the Use of Reminders and Notifications for Uptake by Populations (TURNUP): a systematic review and evidence synthesis. NIHR Journals Library; Health Services and Delivery Research. Available from: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0081323/
- National Audit Office (2015) Stocktake of access to general practice in England HC 605. Available from: https://www.nao.org.uk/wp-content/uploads/2015/11/Stocktake-of-access-to-general-practice-in-England.
- NHS England (2015) Prime Minister’s Challenge Fund: Improving Access to General Practice, Second Evaluation Report to September 2015. Available from: https://www.england.nhs.uk/wp-content/uploads/2016/10/gp-access-fund-nat-eval-wave1-sml.pdf

Bibliography

- NHS England (2016) General Practice Forward View. Available from: https://www.england.nhs.uk/gp/gpfv/
- NHS England (2017) Next steps on the NHS Five Year Forward View. Available from: https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/
- NHSEe (undated) Over 55 million patients in England set to benefit from accessing their GP record online. NHS England. Available from: https://www.england.nhs.uk/2016/07/gp-records-online/
- Paddison CA et al. (2015) Why do patients with multimorbidity in England report worse experiences in primary care? Evidence from the General Practice Patient Survey. BMJ Open, 24;5(3):e006172. Available from: http://bmjopen.bmj.com/content/5/3/e006172.full
- Pollard L et al. (2014) A study of role expansion: a new GP role in cardiology care. BMC Health Services Research. 14(205). Available from: https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-205
- Primary care foundation and NHS Alliance (2015) Making time in general practice. Available from: http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf
- Robotham D (2016) Using digital notifications to improve attendance in clinic: systematic review and meta-analysis. BMJ Open. 6(10):e012116. Available from: http://bmjopen.bmj.com/content/6/10/e012116.full
- Rose K et al. (2011) Advanced access scheduling outcomes: A systematic review. Archives of Internet Medicine, 171(13): 1150-1159. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3154021/

Bibliography

- Rosen R et al. (2016) Is bigger better? Lessons for large-scale general practice. Nuffield Trust. Available from: http://www.nuffieldtrust.org.uk/publications/bigger-better-lessons-large-scale-general-practice
- Tan EC et al. (2014) Pharmacist services provided in general practice clinics: A systematic review and meta-analysis. Research in social and administrative pharmacy, 10(4):608-622. https://www.ncbi.nlm.nih.gov/pubmed/24161491
- Taylor SJC et al. (2014) A rapid synthesis of the evidence on interventions supporting self-management for people with long-term conditions: PRISMS – Practical systematic Review of Self-Management Support for long-term conditions. Health Services and Delivery Research, 2(53). Available from: https://www.ncbi.nlm.nih.gov/books/NBK263840/ doi: 10.3310/hsdr02530
- Ware and Mawby (2015) Patient access to general practice: ideas and challenges from the front line. Royal College of General Practitioners. Available from: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/Patient-access-to-general-practice-2015.ashx.
- Whitelaw S et al. (2016) Developing and implementing a social prescribing initiative in primary care: insights into the possibility of normalisation and sustainability from a UK case study. Prim Health Care Res Dev, 18(2): 112-121. Available from: https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/div-classtitledeveloping-and-implementing-a-social-prescribing-initiative-in-primary-care-insights-into-the-possibility-of-normalisation-and-sustainability-from-a-uk-case-studydiv/12CD6886E4FF6E4248CBEB1E750AD26D/core-reader
- Wilson and Booth (2015) Social prescribing: A systematic review of the evidence. PROSPERO international register of systematic reviews. Available from: http://www.crd.york.ac.uk/PROSPERO/display_record.asp?ID=CRD42015023501

Karen Bradley
Abeda Mulla

Strategy Unit

Tel: 0121 612 1538

Email: strategy.unit@nhs.net