

Improving access, responding to patients

A 'how-to' guide for GP practices



In partnership with



Supported by



Dear colleagues

People come into practice management from all walks of life, and our roles can differ significantly. However, we all strive to achieve the same goals – to deliver high quality, responsive and receptive services, reaching out to local communities to make a difference to patients' lives.

Society is changing and we now live in a consumer-led world with an emphasis on a more responsive culture from those providing primary care services, which necessitates the need for a cultural change.

Practice managers are leading advocates of new ways of working and are establishing truly patient-focused, efficient services. As we move into this changing culture, it is our job to ensure that we are able to utilise a full range of systems, tools and resources at the front line, which in turn will benefit our businesses.

This guide is a celebration of some of this good practice, sharing the successes and signposting to real examples of things that have proven to work, things that make a real difference for patients, and the working lives of our staff. It will not only be helpful for practice managers but all those involved in delivering primary care services.

Over the next 12 months, we will be creating a new national NHS Practice Management Network, to connect all practice managers across the country. If you would like to get involved or let us know what matters to you, sign up at: www.networks.nhs.uk/practicemanagement.

This network website will be officially launched in autumn 2009 and will host a range of practical resources, including an interactive version of this handbook, a database of organisations and suppliers of these different supportive systems and tools, and a forum for you to share your experiences.

We look forward to working with you so that we can help each other overcome the future challenges facing us as practice managers.

Best wishes

NHS Practice Management Network

In partnership with the British Medical Association, NHS Alliance, Royal College of General Practitioners, National Association of Primary Care, Family Doctor Association, Institute of Healthcare Management and Association of Medical Secretaries, Practice Managers, Administrators and Receptionists.

'Responding positively to patients' expectations is an essential part of providing quality NHS general practice. GPs and their staff already work hard in partnership with patients to develop and improve their services. Patients who feel welcome at their practice are more likely to remain loyal to it and so reinforce the vital doctor–patient relationship. The General Practitioners Committee knows that some practices will inevitably feel constrained by the financial and physical limitations of their surgeries, but most are still determined to find new ways to respond to their patients' needs. This guide will help practices thinking about potential changes they might make. It contains some useful examples and case studies across a broad range of topics, which practices can consider and discuss with their patients.'

Laurence Buckman

Chairman, General Practitioners Committee, British Medical Association

'Practice managers have a crucial role to play in primary care. This guide will help them to share knowledge, involve patients and develop better services. The goal of improving patient care is a worthy one and we are proud to support this guide.'

Steve Field

Chairman, Royal College of General Practitioners



'Until fairly recently, practice managers were the forgotten tribe of the NHS. Today, they are leading general practice alongside clinicians and are a force to be reckoned with. Many practice managers are among the most progressive and inspirational leaders in primary care and the establishment of an NHS Practice Management Network will enable them to support practice managers everywhere in their crucial work for the future.'

'Primary care, and general practice in particular, holds the keys to a sustainable NHS – especially at a time of economic decline. As leaders within general practice and primary care, practice managers are now the key to improving general practice locally and also the means of enabling integrated commissioning and primary care provision to flourish. In short, it is no exaggeration to say that the saving of the NHS as we know it will depend upon the skills, determination and inventiveness of its practice managers. That is why this guide is so important and why the development of an NHS Practice Management Network is so vital – indeed overdue.'

Dr Michael Dixon
Chairman, NHS Alliance



'NAPC fully supports the sharing of ideas between practices allowing them to continually develop and improve the services that they provide for their patients. This guide provides an excellent opportunity for practices to review their service delivery against other models and adopt new ways of working appropriate to their patients and practice.'

Dr Johnny Marshall
Chairman, National Association of Primary Care



'AMSPAR is delighted to welcome the publication of this guide. We particularly welcome the emphasis on Core Principles which will help motivate staff, enhance the working environment and lead to a better service for patients.'

Tom Brownlie
**Chief Executive, Association of Medical Secretaries,
Practice Managers, Administrators and Receptionists**



'The Family Doctor Association is committed to providing patients with a service that treats patients as people not numbers. This handbook helps to enable practices achieve that delicate balance of providing timely, personal care within the resources available to practices.'

Dr Michael Taylor
Chairman, Family Doctor Association



'This handbook offers practices a significant tool that has turned the anecdotal perspective of a working surgery into an actual and realistic perspective. It identifies the issues and challenges and offers solutions that are workable in the majority of surgeries. It will enable surgeries to improve systems and processes on an informed basis that will be of benefit to both patients and staff.'

Sue Hodgetts
Chief Executive, Institute of Healthcare Management



Core principles

Consult

Before implementing any new system or service:

- Check with patients to see what they think.
- Check with your primary care trust to see if they are considering supporting any such systems or have some valuable information.
- Check with staff to see whether they see a need.
- Check with nearby practices to see if they have done something similar.

Value for money

Is the solution you're considering the most cost-effective? Are there alternative options that you could try first?

Training

To get the most out of any new system or service, staff will need to be fully trained on its potential.

Communicate

It is crucial that patients know about the change or new system. They should be kept involved and informed throughout the process. Otherwise, they may never find out about your efforts.

Evaluate

You will want to monitor and evaluate the effectiveness of any change or new system.

- WHY? – to justify its cost and its effectiveness.
- WHAT? – the effect on internal processes and systems, and on patients' experience.
- WHEN? – during or after the change or both.
- HOW? – will depend on what has been implemented but one method might be to get feedback from staff and patients via surveys or groups.

Structure

Page

1.0 Do you understand your demand?

1.1 Access: back to basics	1
1.2 Demand versus capacity – a simple overview	8
1.3 How to check staff levels for answering telephones	13
1.4 Workload analysis tool	23

2.0 Managing and meeting demand

2.1 Skill mix	27
2.2 Internet appointment booking	29
2.3 Home visits: duty clinicians and collaboration with other practices	34
2.4 Appointment reminder systems	39
2.5 Telephone consultations	43

3.0 The practice environment

3.1 How to achieve a healthy and relaxed environment	51
3.2 Self-service Check-in screens	52
3.3 Electronic display systems	55
3.4 Waiting room health monitors and surgery pods	64

4.0 Telephony

4.1 Understanding your current telephone infrastructure	69
4.2 Making a decision	76
4.3 Wireless headsets	79
4.4 Answering machines	80
4.5 Centrex	81
4.6 IP Centrex	82
4.7 Interactive Voice Response	83
4.8 Overflow call handling	84
4.9 Computer Telephony Integration	85

5.0 Ensuring a patient-focused service

5.1 Achieving patient-friendly services	87
---	----

6.0 Understanding your community

6.1 Five steps to improve access for patients from black and minority ethnic groups	95
6.2 Improving the experience of people with hearing loss	100
6.3 Improving the experience of people with sight loss	108
6.4 Five top tips to support a person with learning disabilities	112
6.5 Auto alerts on GP systems	114

Structure continued

	Page
7.0 Communications	
7.1 Top tips for marketing your practice	117
7.2 Why and how to create a website	119
7.3 Taking control of your information on NHS Choices	126
8.0 Patient engagement	
8.1 Techniques for engaging with patients	129
8.2 Setting up a Patient Participation Group	133
8.3 Real-time patient feedback	137
9.0 Change	
9.1 Redesigning the process	145
9.2 Planning tips for successful change	150
Glossary	157

1.0 Do you understand your demand?



1.1 Access: back to basics

Every practice should have a vision of what good access is. This should be formed through engagement with your staff and patients and should be something that you are constantly working towards.

Good access is about:

- patients being able to book an appointment quickly, within a reasonable timeframe, and pre-book one if they wish;
- patients being able to see a preferred clinician if they wish to wait longer for an appointment;
- patient access to reliable information about the practice, so that they can make their own decisions about the access they require;
- patients not only being able to book an appointment on the telephone but by other means, such as through the internet, email, TV or by text message;
- patients contributing to good access through Patient Participation Groups and other forums; and
- patients being able to telephone the practice throughout the day.

Good access is not about:

- limiting patients' ability to pre-book an appointment x days or weeks in advance;
- telling patients to ring on the morning of the day to book an appointment, or at a specific time;
- closing at lunchtime so the patient can't get through on the telephone or visit the practice to book an appointment or pick up a repeat prescription;
- obstacles preventing disabled people and those in a wheelchair easy access; or
- poorly trained reception staff.

Tips

Don't operate a telephone lottery. Asking patients to call back in the morning or at specific times will double the demand on phone lines and receptionists. Have a look at chapter 4, Telephony, to read about some simple changes you can make to your telephone system.

Getting the facts straight

The 24/48 hour access target has had some inadvertent side effects and encouraged some practices to prevent patients booking too far ahead. This was never the intention, and now some patients find it difficult to book an appointment in advance. This is a particular problem for those with long-term conditions. The reality is that opening up your appointments can actually help to manage your demand.

1.1 Access: back to basics continued

Step-by-step guide

Five key principles of moving from restricted access to responsive access

1. Measure demand

Before you can start, you must understand demand and how your appointment system works. For example, do you know how many patients come through the door each week and when?

- Equip a receptionist with a tick sheet template and record when a patient requests an appointment, even if one isn't available. A template is enclosed at the end of this section.
- Separate 'book on the day' and pre-bookable requests.
- Collect on a weekly basis.

This will enable you to identify variations in demand for same-day and pre-bookable appointments, roughly how many appointments you might need each day and the general split, that is, how many appointments might need to be left for same-day and how many are for pre-bookable. This information will be important when comparing against your current capacity (covered in section 2.1, Demand versus capacity). A total tally sheet is also provided for you to compare demand to appointment supply.



2. Shape demand

Start looking at ways you can shape demand. Not everyone needs to be seen by a GP in a consulting room. Consider opportunities for:

- telephone consultations
- GP triage
- skill mix
- internet booking
- patient education
- group sessions (for example, smoking cessation)
- wider use of local pharmacies.

Continued overleaf...

1.1 Access: back to basics continued

Step-by-step guide continued

3. Match capacity to demand

There is more on this in the next section, but consider the following:

- Mondays are the busiest day, followed usually by Tuesdays, Fridays, Wednesdays, Thursdays.
- Two thirds of your day's workload will come in before midday.
- Generally, most of the unwell people will call before 10.30am.
- Measure your third available appointment to give you an indication of whether you are offering enough appointments.

4. Contingency planning

Always plan ahead for holidays and try to account for sickness, and the flu season.

- Try and calculate demand and capacity weekly to identify when and how many extra appointments are necessary when there are GP shortages.
- Pre-booked appointments could be suspended on Mondays and reintroduced when the pressure is reduced.
- Try increasing the number of telephone consultations.

5. Communicate

It is crucial that you always communicate change to staff and patients. Their feedback is crucial.

- Discuss at weekly team meetings.
- Use simple patient questionnaires or other methods to gain feedback.
- Test out small changes before implementing on large scale.
- Set up patient groups to help resolve access issues.

Tips

Change can be scary, so ask yourself:

- Is everyone in the practice on board?
- Do they recognise a need for change?

1.1 Access: back to basics

Case study

The Kakoty Practice, Barnsley

This is a Personal Medical Services (PMS) practice (since 1999) of around 6,100 patients. It is an urban location split evenly over two sites. The population is classified as high health need. There are four full-time doctors and three full-time-equivalent nurses. Additional substance misuse and services for asylum-seekers and refugees are provided – both are high attendance client groups.

Objectives

With this population, access to medical services has to be good, and below are our key objectives:

- to have adequate capacity in place to offer patients an appointment quickly;
- to have processes in place to predict where this may not be possible;
- to provide a variety of access routes;
- to educate patients in how to use our services effectively; and
- to reduce did not attends (DNAs).

How we succeeded

Our initial task was to gauge the problem of not being able to offer patients same or next-day appointments. The first stage was to introduce capacity and demand monitoring. We also began the process of monitoring the third available appointment measure. This only took a few minutes for an administrator to complete. The monthly findings supported whether our changes were working.

We used the PDSA (Plan, Do, Study, Act) cycle to evaluate and refine changes. For example, we changed times and length of surgeries on different days to minimise DNAs and unused appointments. We introduced internet appointment booking and auto-text patient reminders and found this greatly improved the level of DNAs. We published newsletters to inform patients of when we were making changes and how to get the best from the appointment system. Now we are aware of when our high demand occurs and plan for it.

Continued overleaf...

1.1 Access: back to basics

Case study

The Kakoty Practice, Barnsley continued

Tips

- Successful delivery depends on owner 'buy-in'. The whole team have to want to achieve it, and all have to be open to changing their working practices.
- Accept monitoring as a way of working, not a quick fix, then managing demand becomes an integral part the process.
- Involve everyone within the team and listen to them. The receptionist taking appointment requests will know about high demand and how patients perceive the service.

Tips

- Communicate your aims to patients – if they know how much it matters, then they will be more likely to engage.
- Stay with it – unexpected absences in small organisations can spoil the best of systems. By preparing staff in advance in how to deal with these situations you can alleviate service pressures later on.
- Share your successes – access monitoring is a standing item on our team meeting agenda. We discuss and share access issues, which promotes cohesive working across the team.

Contact

Marie Hoyle

marie.hoyle@nhs.net

1.1 Access: back to basics continued

Understanding demand for the same-day and pre-booked appointments – Template only

Instructions

Please tally ALL APPOINTMENT REQUESTS during the course of this week. These should include telephone requests, internet bookings, those made in person and follow-ups. REQUESTS for appointments on the day should be recorded in the left column regardless of whether an appointment could be made or not. Use the right columns (in blue) to tally requests for pre-booked appointments. If your current system does not allow a full week for pre-bookings, you will need to ask the patient when they would have liked the appointment. N.B. DO NOT record when the appointment was actually made. You want to find out the variation in demand for same day and pre-booked appointments and how many appointments you might need to provide for each day.

Appointment is requested for..								Total
Today is	Same-day appointment	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Monday →	eg 1 Sept	eg 8 Sept	eg 2 Sept	eg 3 Sept	eg 4 Sept	eg 5 Sept	eg 6 Sept	
Tuesday →	eg 2 Sept	eg 8 Sept	eg 9 Sept	eg 3 Sept	eg 4 Sept	eg 5 Sept	eg 6 Sept	
Wednesday →	eg 3 Sept	eg 8 Sept	eg 9 Sept	eg 10 Sept	eg 4 Sept	eg 5 Sept	eg 6 Sept	
Thursday →	eg 4 Sept	eg 8 Sept	eg 9 Sept	eg 10 Sept	eg 11 Sept	eg 5 Sept	eg 6 Sept	
Friday →	eg 5 Sept	eg 8 Sept	eg 9 Sept	eg 10 Sept	eg 11 Sept	eg 12 Sept	eg 6 Sept	
Saturday →	eg 6 Sept	eg 8 Sept	eg 9 Sept	eg 10 Sept	eg 11 Sept	eg 12 Sept	eg 13 Sept	
Total								

1.1 Access: back to basics continued

Total tally sheet

Instructions

- The figures for demand measurement should be inputted from the weekly demand measurement templates
- Actual capacity is the total number of appointments available, as described in the section on 'Assessing your capacity'
- This will enable you to make a quick comparison between your levels of demand vs your current appointment supply

		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
		Demand and measurement	Actual Capacity	Demand and measurement	Actual Capacity	Demand and measurement	Actual Capacity	Demand and measurement	Actual Capacity	Demand and measurement	Actual Capacity	Demand and measurement	Actual Capacity
Week 1 (eg 1-6 Sept)	Same-day requests												
	Pre-booked requests from previous 7 days including follow-ups												
	Total												
Week 2 (eg 8-13 Sept)	Same-day requests												
	Pre-booked requests from previous 7 days including follow-ups												
	Total												
Week 3 (eg 15-21 Sept)	Same-day requests												
	Pre-booked requests from previous 7 days including follow-ups												
	Total												
Week 4 (eg 23-29 Sept)	Same-day requests												
	Pre-booked requests from previous 7 days including follow-ups												
	Total												
Total (Demand vs Capacity) over 4 week period													

		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
		Demand and measurement	Actual Capacity	Demand and measurement	Actual Capacity	Demand and measurement	Actual Capacity	Demand and measurement	Actual Capacity	Demand and measurement	Actual Capacity	Demand and measurement	Actual Capacity
Week 1 (eg 1-6 Sept)	Same-day requests												
	Pre-booked requests from previous 7 days including follow-ups												
	Total												
Week 2 (eg 8-13 Sept)	Same-day requests												
	Pre-booked requests from previous 7 days including follow-ups												
	Total												
Week 3 (eg 15-21 Sept)	Same-day requests												
	Pre-booked requests from previous 7 days including follow-ups												
	Total												
Week 4 (eg 23-29 Sept)	Same-day requests												
	Pre-booked requests from previous 7 days including follow-ups												
	Total												

Total (Demand vs Capacity) over 4 week period

1.2 Demand versus capacity – a simple overview



Here is a simple process to analyse the number and type of consultations that you offer. You can then carry out a basic comparison between your capacity and your levels of demand (as discussed in the previous section).

This should help you to understand:

- whether you offer the right number of appointments, the right mix between same-day and pre-bookable and to check whether they are spread correctly across the week; and
- how you might compare against some national averages as a rough guide.

We provide a detailed practical example to help you learn from a practice that carried out in-depth analysis.

Important

It is recognised that practices simply cannot meet all their patients' expectations for appointments. In some practices the mix of telephone consultations, telephone triage, open access clinics etc may cause problems when assessing appointment supply. However, by following the simple demand versus capacity process described in this section and the previous section, practices should gain a basic understanding of the factors that might affect patients' experience of access.

Tips

You will usually be able to use the system to print out your appointment supply. It may be helpful to run two lists of appointments for each day – one run last thing at night looking at the next day, and then one at the end of that day so that you can take into account on an average day those same-day appointments that might be added to the overall list on the day.

Step-by-step guide

1. Count appointments for a typical week

What is it that needs counting?

The aim is to count all of the routine appointments available for the week, including same-day appointments, slots put aside for pre-bookable appointments and pre-planned telephone consultations (but not cases such as clinics).

You can split these by different health professionals, but to make quick, ball park comparisons with levels of demand, it may be easier to total only doctor appointments, or doctor and nurse.

1.2 Demand versus capacity – a simple overview continued

Step-by-step guide continued

Factors to consider

So far you have looked at the appointments you offer in a typical week. The chances are that this will be a time when few, if any, staff are on holiday or away. You will probably not have included a bank holiday, nor considered the impact of trainees and how they can contribute more over time, or looked at the impact of local support schemes.

By understanding the impact of these variations you may feel you need to adjust the average number of appointments offered over a given week.

- What happens when clinical staff are away on holiday? Are there occasions when some of the doctors or other staff have commitments which reduce their availability to see patients? Are fewer appointments available in those weeks? How many weeks in the year does this cover?
- What happens in a week with a bank holiday Monday? Are more appointments planned for the Tuesday after the bank holiday?
- What happens when GP trainees work in the practice (if they do)? Does this increase the capacity and free up doctor time or does it reduce the capacity at certain times?
- Do you have a 'duty doctor' and have you included the patients that are seen by him/her in the count of capacity?
- When a GP is on holiday, for small and personal list sizes, practices may experience greater demand on his/her return.
- Is there a local scheme to improve access that allows you to refer patients you can't see quickly elsewhere? Does this increase the capacity available?

Important: Does this mean that the capacity for a typical week should be adjusted? Once you have the total number of appointments, enter them into the relevant boxes of the 'total tally sheet' from the previous section. If you are unable to differentiate between those appointments you hold for same-day and pre-bookable, then simply enter the total figure.

		Monday	
		Demand and measurement	Actual Capacity
Week 1 (eg 1-6 Sept)	Same-day requests	89	75
	Pre-booked requests from previous 7 days including follow-ups	113	120
	Total	202	195

Continued overleaf...

1.2 Demand versus capacity – a simple overview continued

Step-by-step guide continued

2. Compare with demand from patients

This is about comparing available capacity in your practice (that is the total number of appointment slots) with the demand from patients (your analysis of same-day and pre-bookable requests). Each practice will differ but it is sometimes helpful to compare with a national average. Or you might compare yourself with another local practice.

Comparison with your demand measurement

Look at the analysis of your appointment requests against your analysis of current capacity (that is, available appointments).

- Are there days of the week where there is a much greater demand than the appointments you have available?
- Does the number of appointment requests significantly outnumber your total appointment supply?
- Are you holding too many same-day appointments back so that a lot of patients can't pre-book an appointment? Do you need to adjust the ratio between the same-day/pre-bookable split? Some practices find it easier to have two thirds of their appointments (including nursing capacity, telephone consultations) available to book in advance. That leaves one third for on-the-day cases, though the mix will vary to take into account the characteristics of different patients, or to reflect the greater demand for same-day requests on a Monday.

Crude comparisons with national averages

- Nationally, the median consultation rate is 5.3¹ (so, on average, each patient is seen just over five times in the year) for doctors, nurses and other healthcare professionals within general practice.
- A convenient rule of thumb is that the median level is approximately equivalent to 100 appointments per week for every 1,000 patients.
- However, significant numbers of practices have consultation rates lower than 4 or higher than 8 so there are very wide variations between practices – you may want to consider why the demands of your patients may be greater or less.

¹ *Trends in Consultation Rates in General Practice 1995 to 2007: Analysis of the Research Database*. September 2008; QRESEARCH and the Health and Social Care Information Centre

Tips

As a rule of thumb, for most practices, the patterns of demand are generally the same for each week.

1.2 Demand versus capacity – a simple overview continued

Practical example

One practice that carried out a more in-depth analysis of their capacity took into account a number of different factors such as:

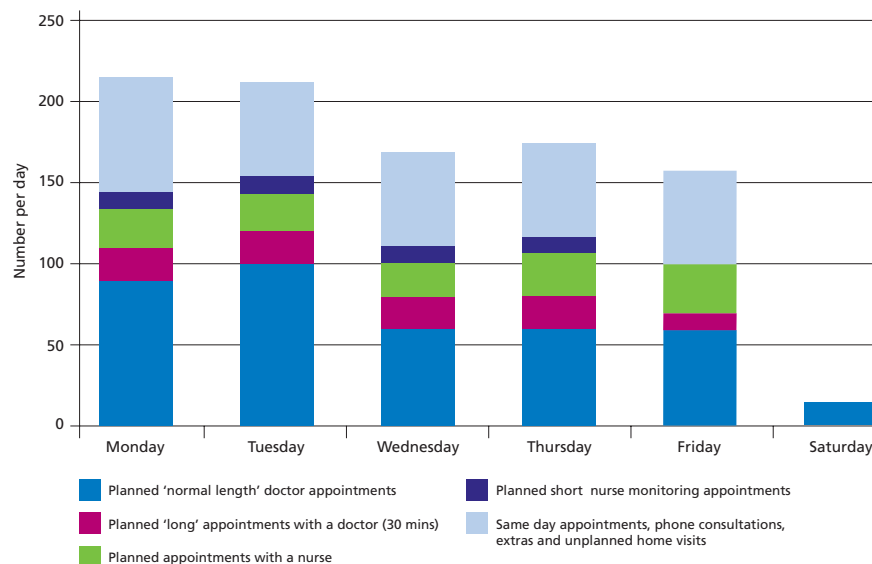
- Skill mix – many practices want to analyse the appointments to reflect the skill of the person whom the patient sees, so they will record separately appointments with a doctor, nurse, other health professional and healthcare assistant.
- Length of consultation – most practices find that they need to plan more time for some consultations, either by booking a 'double slot' or by planning a number of lengthier appointments, typically reserved for periodic reviews for those with complex conditions or multiple pathologies.
- Lead time – it is always necessary to handle a number of same-day cases – sometimes these can be completed through a telephone consultation. Sometimes they will result in a same-day appointment and sometimes in a home visit. Because these cases are often handled differently, and because it is necessary to reserve capacity for them, it is recommended that these are counted separately from appointments that were planned in advance.

Tips

To work out how many appointments you offer per 1000 patients, simply total all of your routine (same-day and pre-bookable) appointments in a given week (for example, for doctors and the practice nurse), divide the figure by your total list size and multiply it by a 1,000.

- Logical groupings of case types – in most practices there are logical groupings of case types for which the demand may be well understood and is sometimes highly predictable. These may include such things as baby clinic, minor illness, and routine monitoring appointments for those with long-term conditions etc.
- Type/location – another grouping that may be understood and useful for planning and capacity management in some practices is to categorise telephone consultations, home visits and face-to-face consultations in the surgery separately.

It used these to develop a range of categories in which appointments were divided:



1.2 Demand versus capacity – a simple overview continued

Some of the key lessons learnt

The example practice that has got a lot of things right

- Many of the appointments with doctors are planned at five consultations an hour, with those for nurses at two or three an hour.
- They had already defined some longer appointments. These are for planned periodic reviews of a group of patients with complex conditions. Also identified were some patients with long-term conditions who could be routinely monitored by nurses in relatively short slots.
- The practice already uses the duty doctor to monitor same-day requests, to steer some patients towards nurses and to complete some cases with a telephone consultation. The role also includes some degree of management of the resources of the practice to balance workload.
- The practice is also finding that around one third of the slots for same-day patients is about right overall.

But there are some lessons too

What is not obvious in the diagram, but was well known in the practice and obvious from comparison with the demand, is that, despite capacity being highest, Monday was still too busy. Clinical staff felt under constant pressure to keep up, while receptionists (from quite early in the day) were feeling that their job had become one of delaying patients to another day. Moving some of the 'long' appointments to later in the week freed up capacity, allowing the larger number of same-day patients on a Monday to be accommodated.

Tips

- Avoid distortion of the 'real' capacity and demand, because patients respond to the constraints applied in the past. Examples of this include apparently high levels of same-day appointments because it has become so difficult to book ahead that same-day slots are all that are available.
- Watch out for mistakenly flexing all types of appointments to suit the rotas of clinicians working part time. General practice can accommodate widely differing numbers of clinicians from one day to the next provided that it is the planned appointments that are flexed to suit staff availability. The capacity to deal with the predictable levels of same-day work (typically more after the weekend) must be reserved.
- Beware that simple changes to the rota or to increase the number of available slots on particular days can have a dramatic effect in addressing specific problems.

1.3 How to check staff levels for answering telephones



There are an estimated 300 million consultations taking place each year in practices across England. The vast majority will involve at least one telephone call to book the appointment – but many will involve a number of calls.

This results in a vast number of telephone calls that have to be handled by receptionists. Patients expect their calls to be answered and dealt with efficiently. For safety reasons, it is important that the small number of patients who ring with an urgent need are answered promptly and appropriately.

This section describes how to count the call demand in your practice and then to calculate how many people need to be allocated to answering the telephone to meet demand. It is based a standard formula devised by the Danish mathematician Agner Krarup Erlang (an expert in telephone systems).

Tips

To do the calculation you will need the following information:

- the number of incoming calls each hour;
- the average length of the incoming calls (including any 'wrap-up time' before being ready for the next call); and
- the service level to be delivered (expressed, for example, as 90% of calls to be answered in 30 seconds).

The formula assumes that the receptionist will be dedicated to answering the phone and will respond to the next call as soon as they are able.



1.3 How to check staff levels for answering telephones continued

Step-by-step guide

1. Choose a suitable period and prepare

It is important to make sure that the data collected is typical and represents the 'normal' level of demand. The points below suggest some of the things to look for when choosing a period to measure call length and demand.

Choose a period of 'normal' demand

This is simply a matter of avoiding obviously unrepresentative periods such as holiday periods when many of your patients may be away (or if you are in a holiday period when there may be unusual visitor demand). It is also worth avoiding any week that is close to or adjacent to a bank holiday because this too may affect demand patterns.

Capture everyone

You need to minimise the number of calls that cannot get through to the practice. So you should make sure that all of your normal receptionists are in. You might consider extra cover for particularly busy times in the week if you suspect that these are occasions on which patients have trouble in contacting the surgery.

Prepare for the data collection

If calls are to be counted by receptionists, then it will be necessary to be sure that they understand why you are looking at the process as well as exactly what they need to do to help. The work that you are doing is to help them to manage the difficult periods and make sure that they are in a position to carry out their job effectively. So they will welcome your interest. At the very least, it is courteous to explain to them what you are doing, but most practices will find that they are keen to get involved and help.



2. Count the existing demand and measure call length

In this step, we describe two alternative ways in which the key information can be collected. You may wish to vary the approach to collect some additional information at the same time. For example, you might wish to categorise the different types of call received, to understand what the proportion of calls are about. This may be useful when looking at the further options described in this handbook.

If you are doing this for the first time then try and keep it simple – receptionists will usually have at least part of their day that is so busy that additional tasks, especially those that do not address immediate patient needs, are sidelined. It is important that no calls are missed in the count and that the estimate of call length is reasonably accurate, so avoid asking for so much more that inaccuracies result.

Continued overleaf...

1.3 How to check staff levels for answering telephones continued

Step-by-step guide continued

Unless you have a phone system that includes a good and well understood telephone reporting system, we recommend that the counting of calls received in each hour of the day is recorded by the receptionists. Use a simple 'five bar gate' approach illustrated in the example below.

- Decide which calls are to be excluded (for example, direct dial calls that the receptionists do not answer) but count all calls that are answered by reception staff.
- Devise a simple tick sheet for counting the calls in each hour like that shown below. Tip – it is most important to make sure that every call is counted in the right time period, so keep any additional information that you want to collect very simple.
- Make sure that those filling in the sheet understand exactly what they have to do.
- Run a trial for a morning to make sure everyone is clear what to record – and make sure that you include any part-time staff.

Date: 5th November Day: Monday

Time period		Received by	Count of patients wanting an appointment		Count of all other calls	
Start	Finish					
08:00	08:30	dfh		9		6
08:30	09:00	jec		2		
09:00	09:30					
09:30	10:00					
10:00	10:30					
10:30	11:00					
11:00	11:30					
11:30	12:00					
12:00	12:30					
12:30	13:00					
13:00	13:30					
13:30	14:00					
14:00	14:30					
14:30	15:00					
15:00	15:30					
15:30	16:00					
16:00	16:30					
16:30	17:00					
17:00	17:30					
17:30	18:00					
18:00	18:30					

You may want one sheet per receptionist or one for each telephone

Keep the number of categories small for simplicity of use

Use of 'five bar gates' will make recording simple

Time periods can be varied – but you must record the number each hour

Continued overleaf...

1.3 How to check staff levels for answering telephones continued

Step-by-step guide continued

If you have adopted this approach, then you will also need to get a reasonable estimate of the average call length. It is not necessary to record this for all calls during the week.

In practice, we have found that asking someone else to sit and record the length of 100 calls received during representative times during the week gives a sufficiently accurate figure for applying Erlang's formula. We strongly recommend that you do not ask the reception staff to collect the start and end time of each call as they are receiving them. This takes time to record and adversely affects the performance that you are trying to measure.

Again, a simple form such as that shown below is easy to devise for the observer to record findings. You may choose either to list the start time and length of call (if a stop-watch is being used) or start and finish time (if a clock is to be used). Most people find it easiest to use a digital device rather than an analogue clock or watch to reduce the chance of errors in recording the various times.

Date: 5th November Day: Monday

Received by	Start time	Length of call	Type of call	
			Wanting an appointment	Other
dfh	9.02	3m 35s	Y	
jec	9.07	1m 10s		Y
dfh	9.16	2m 51s	Y	

You will want one sheet for the observer and will record calls coming in to different receptionists

If you are not using a stop-watch it will be easier to record start and finish times and then to calculate call length for each

Again any classification of call type or additional information should be kept simple

Continued overleaf...

1.3 How to check staff levels for answering telephones continued

Tips

A small number of practices will have telephone systems that produce reports on the number and length of calls. Where these systems and their reporting is well understood, they can provide much more robust data collected over a longer period of time. However, it is important to be sure of the following:

- That calls coming in to receptionists are identified, counted and measured – you do not want to include any calls where direct dialling means that they are handled by others.
- That you are measuring the length of the call excluding any message at the front of the call – we are interested in the time spent by the receptionist in answering each call.
- That we know the number of calls by hour of the day. Particular care needs to be taken to check whether the number of calls was distorted in some weeks. For example, if the practice closed for an afternoon for training, then this period may need to be discounted from the analysis.

Step-by-step guide continued

3. Calculate the required number for each hour

- Typically, most practices have greater number of incoming calls on a Monday (or after a bank holiday) and a reasonably consistent level of demand on the other days. But it may be higher following a half-day closure or on days when the practice is open for extended hours.
- Your first task is to examine the pattern of demand you've measured and decide which days are sufficiently similar so that they can be treated as following the same pattern, and which need to be considered separately. It may be useful to prepare a graph of the number of calls in each hour for each day to make this easier.

For simplicity, in the following example we have assumed that the demand was identified as higher on a Monday, but that on Tuesday to Friday it was sufficiently similar for the demand level to be averaged.

Continued overleaf...

1.3 How to check staff levels for answering telephones continued

Step-by-step guide continued

This includes the average call length and the desired service level

Assumed average call length 90 seconds
 Chosen Service level 90 %
 To be answered in 30 seconds

Hour commencing	Number of calls per hour	Number of agents required	Maximum capacity (calls per hour)	Planned number of receptionists
M o n d a y				
8	28	3	52	3
9	38	3	52	3
10	29	3	52	3
11	26	3	52	3
12	25	2	25	3
13	30	3	52	3
14	18	2	25	2
15	9	2	25	2
16	6	2	25	2
17	3	1	5	1
18	1	1	5	1
O t h e r d a y s				
8	20	2	25	3
9	22	2	25	3
10	21	2	25	3
11	18	2	25	2
12	15	2	25	2
13	16	2	25	2
14	12	2	25	2
15	6	2	25	2
16	4	1	5	2
17	2	1	5	1
18	1	1	5	1

This column comes from the look-up table and tells you the maximum capacity in calls per hour if you staff according to the Erlang formula

This column contains the number of calls per hour from your count over the week

This column comes from the look-up table included as an appendix

This is the planned number of reception staff that you believe will be needed based on the calculation but recognising that the demand will vary from the measured number

The above example is for a practice where the average incoming call length to reception staff was found to be 84 seconds. Using the look-up table (included in step 4) the next higher call length of 90 seconds was chosen and a service level of 90% of calls to be answered in 30 seconds was selected. The first and second columns show the times of day and the number of calls received (for Monday and then for the average of the other days). The third and fourth columns come from the look-up table, whilst the final column is the number of reception staff that the practice finally decided on.

There are slight variations in the third column. Because telephone demand varies significantly, the practice decided to go for a higher number of receptionists than the look-up table suggested at 12.00 till 13.00 on Monday, for the first three hours, and for 16.00 to 17.00 on other days. This judgement comes from comparing the second (number of incoming calls) and fourth column (maximum capacity) as well as by any 'local knowledge' such as how the week in which the count was made compared with the norm.

Continued overleaf...

1.3 How to check staff levels for answering telephones continued

Step-by-step guide continued

Important: It is very important that if service levels are to be met with the predicted call volumes, then reception staff must have answering the telephone as their primary responsibility.

Although even at the busy times in the example above, usage only just exceeds 30%, and at times is below 10%, any task given to the reception staff to do 'in between calls' must be one that doesn't compromise answering new calls. If staff are drawn away on to tasks that they cannot drop immediately, service levels will suffer.

4. Validate after implementation

The analysis was carried out based on a 'snapshot' of calls over one week. There are a number of reasons why it may be necessary to adjust the staffing levels:

- Demand has increased or decreased since the snapshot (perhaps because of seasonality, perhaps for many other reasons).
- The snapshot has been found not to be entirely representative of the norm.
- There appear to be times when the receptionists are not at all busy – or when patients seem to have difficulty in getting through to the practice.
- There are pressures from staff or the practice to modify the rotas, for example to release time for other necessary tasks.
- Since the time of the initial work the length of calls has changed (perhaps because of training of receptionists) to ensure more consistent, welcoming and effective answering of calls.

Two alternative approaches may be chosen to check that the staffing levels are appropriate.

Recalculate using Erlang. It is not necessary to repeat the full analysis that is described above. Based on the initial analysis, it will be apparent which times of the week might be closest to the tipping point, so these are the ones to look at. A simple exercise to repeat the count and re-measure the average call length focused on these borderline cases is likely to indicate if there is scope for adjusting the staffing levels.

Examine the record. For providers with telephone reporting systems, examining the reports for time to answer the phone reveals whether the targeted service level is being met. For those that do not have such systems it may be possible to ask your telephone service provider if they can set up call logging for a period for a modest cost. That will allow you to understand the numbers of calls, length, response time, and percentage of cases abandoned by hour of the day.

Continued overleaf...

1.3 How to check staff levels for answering telephones continued

Step-by-step guide continued

Look-up table for Erlang capacity

This table defines the maximum capacity of a given number of agents in calls per hour, given a service level and an average call length as shown. Should your values be outside this range the tool at this link (www.math.vu.nl/~koole/ccmath/ErlangCI/index.php) will calculate your own capacity for a given number of receptionists. In the example below, the service time (average length of call) was set to 90 seconds, the number of agents to 3 and the service level set at 90% of cases answered in 30 seconds. The engine has calculated the maximum capacity (52.63 calls per hour, rounded down to 52 in the table) and the average waiting time of 9.37 seconds.



Continued overleaf...

1.3 How to check staff levels for answering telephones continued

Step-by-step guide continued

Service level	Answered in (seconds)	Average call length (seconds)	Number of agents available					
			1	2	3	4	5	6
90%	30	60	9	43	86	134	185	237
90%	30	75	6	32	65	102	142	182
90%	30	90	5	25	52	82	114	147
90%	30	105	4	21	43	68	95	123
90%	30	120	3	18	37	59	82	106
90%	30	135	3	15	32	51	71	92
90%	30	150	2	14	28	45	63	82
90%	30	180	2	11	23	37	52	67
95%	30	60	4	30	68	112	159	209
95%	30	75	3	22	51	84	121	159
95%	30	90	2	18	41	67	97	128
95%	30	105	2	14	33	56	80	106
95%	30	120	1	12	28	48	69	91
95%	30	135	1	11	25	41	60	79
95%	30	150	1	9	22	37	53	70
95%	30	180	1	7	18	30	43	57
90%	45	60	11	49	97	148	202	257
90%	45	75	7	36	72	112	154	197
90%	45	90	6	28	57	89	123	158
90%	45	105	4	23	47	74	102	132
90%	45	120	4	19	40	63	87	113
90%	45	135	3	17	35	55	76	98
90%	45	150	3	15	30	48	67	87
90%	45	180	2	12	24	39	54	70
95%	45	60	5	36	79	127	178	231
95%	45	75	4	26	58	94	134	174
95%	45	90	3	20	45	75	106	139
95%	45	105	2	16	37	61	87	115
95%	45	120	2	14	31	52	74	98
95%	45	135	1	12	27	45	64	85
95%	45	150	1	10	24	39	57	75
95%	45	180	1	8	19	32	46	60
90%	60	60	13	55	106	160	215	272
90%	60	75	9	40	79	120	164	208
90%	60	90	6	31	62	96	131	167
90%	60	105	5	25	51	79	109	139
90%	60	120	4	21	43	67	92	118
90%	60	135	3	18	37	58	80	103
90%	60	150	3	16	32	51	71	91
90%	60	180	2	12	26	41	57	73
95%	60	60	7	42	88	139	193	248
95%	60	75	4	30	64	103	145	187
95%	60	90	3	23	50	81	114	149
95%	60	105	2	18	41	66	94	123
95%	60	120	2	15	34	56	79	104
95%	60	135	2	13	29	48	68	90
95%	60	150	1	11	25	42	60	79
95%	60	180	1	9	20	33	48	64

In the example within the text the call length was 90 seconds and the desired service level was 90% of calls answered within 30 seconds. This gives a maximum capacity of 5, 25 and 52 calls per hour for 1, 2 and 3 dedicated agents. The table is also used to calculate the number of agents required by looking for the number of agents that will give a capacity that is larger than the expected number of calls – so 28 calls in an hour requires three agents, given the same service level and average length of call.

1.3 How to check staff levels for answering telephones continued

The Erlang formula: background and information

What is the formula?

- Angmer Erlang was a Danish telecommunication engineer who developed the formula to assess how many switches/lines are required to be sure of meeting a particular service level.
- The Erlang C formula itself can be found on Wikipedia or in other reference works. For those who want to understand the detail a good description of the mathematics can be found at: www.mitan.co.uk/erlang/elgcmath.htm.
- Even this looks complicated! We have described a process that can be followed by any practice using simple tables drawn up on paper. For those that wish to be more sophisticated in their modelling, there are a number of modelling and calculation tools available. For those that have good Excel skills there is a free add-in available at: www.erlang.co.uk/excel.htm.

When should it be used and when might care be needed?

- The formula can be used to calculate a service level that can be achieved with a given number of 'agents' to answer the phone, or to calculate the number of agents needed to meet a particular level of demand.
- Caution should be exercised if calls that come in are of very widely varying lengths (for example, if a considerable number are completed in less than two minutes and an equivalent number take over 15 minutes). In these cases more sophisticated modelling may be required.
- Fortunately, incoming calls to a surgery typically average around 2 minutes or a little less and very few extend for longer than 8 minutes. So the Erlang formula is suitable for the purpose.
- Services using the formula should be aware that although the mathematics is sound, the smaller the practice the greater the chance that demand varies significantly from day to day or hour to hour. This is caused only by random variation in relatively small numbers. For this reason, it may be necessary to allow for a larger number of calls than average, if a given service level is to be reliably achieved.

1.4 Workload analysis tool

This is software that analyses primary care Read codes and presents the practice with visual information about their workload. This can be used to inform decision-making and capacity planning.

Benefits

- Live information about your clinical and administrative activity
- Can be used to develop plans for better use of skill mix within the practice
- Evidence-based data
- Data quality monitoring
- Identifies individual clinicians workload
- Offers the ability to benchmark data locally, regionally or nationally.

Drawbacks

- Training needs in order to understand and utilise the data
- Changing clinicians' recording habits
- The resource required to act on the information provided by the data to improve services
- Gaining agreement to share the data with other organisations.

Costs

Informatica Systems Ltd currently (at June 2009) offers the Workload Analysis Tool for a £150 initial set-up fee and £500 a year for the licence, maintenance and support. Other systems may be available and practices should carry out their own research before committing to a particular provider.

What questions could it help answer?

The practice manager

- Do you know how many patients presented last month with urinary tract infections or with musculo-skeletal problems?
- Are the patients seeing the most appropriate person?
- What is the impact of annual leave on individual's workload?

The nursing team

- Is the long-term condition workload rising or is this just a perception?
- How has my workload increased over the past few months?
- Do we need to put together a business case for more nursing hours?
- Are we seeing more older people since the community nursing team restricted their service?
- Is our nurse practitioner seeing the most appropriate patients?
- Can we train our healthcare support worker to take on other tasks?

1.4 Workload analysis tool continued

GPs

- How do my disease registers compare with our predicted prevalence?
- How are the registrars and F2 doctors managing their workload?
- Are they seeing the most appropriate patients?
- Can I delegate some of my workload to a different clinician?
- Could we use a community pharmacist to help with medication reviews?
- Would a physiotherapist provide a more cost-effective service for patients who present with musculo-skeletal problems?

Practice-based commissioners

- What is the level of demand for physiotherapy services within our cluster?
- How does this vary between the practices?
- How many of our patients are using the out-of-hours service? In what age range are these attendees?
- What percentage of the workload do long-term conditions represent? Could we manage this workload differently?
- We would like to consider and draw up a business case to commission our own district nursing service, what is the evidence to support this?

Step-by-step guide

1. Consider the following:

- How will the data be used and who will take the responsibility for this?
- Are you prepared to allow your data to be shared with other practices for benchmarking?
- Do you need any other audit tools, eg MMR audit?

2. Consult with suppliers

The Workload Analysis Tool (WAT) is available for use with all of the major clinical systems. For more information about the availability of the Workload Analysis Tool, please contact Informatica Systems on 0845 680 1347 or www.informatica-systems.co.uk. This might, of course, not be the only supplier of this particular software and practices may wish to undertake their own research.

3. Make an informed decision

What are the other sources of data available to you? Are they readily available and is the data recent and validated? Ask the supplier if you can speak to other users of the WAT before signing up to a year's licence. You might be able to have the WAT for a month's trial before committing to purchase.

Continued overleaf...

1.4 Workload analysis tool continued

Step-by-step guide continued

4. Change process

Agree an implementation date. Allow some time to read the user guide and have some questions that you would like to use the tool to explore. Start with some simple examples where you can validate the data. Arrange a staff meeting to discuss the data, or interpret the results with your Patient Participation Group.

5. Monitor, evaluate and audit

Consider how you might evaluate the effectiveness of the WAT for your practice. Before the licence is due for renewal spend some time evaluating the benefit and cost-effectiveness of the WAT.

What has changed within the practice as a result of the WAT? Have you shared your data with any other primary care organisation? Have you planned how you might use the tool in the coming year?

Tips

- A member of staff with good IT skills who can translate data into information is worth their weight in gold.
- Knowing the profile of the service users allows for appropriate provision and improved access.
- The clinical record is a legal document; how confident are you that your practice records are as accurate as possible?

Evidence of workload is a powerful tool for negotiation.

Practical example

The challenge

To increase capacity within the practice nursing team.

The role of the WAT

Identified workload activity for the nursing team.

The solution

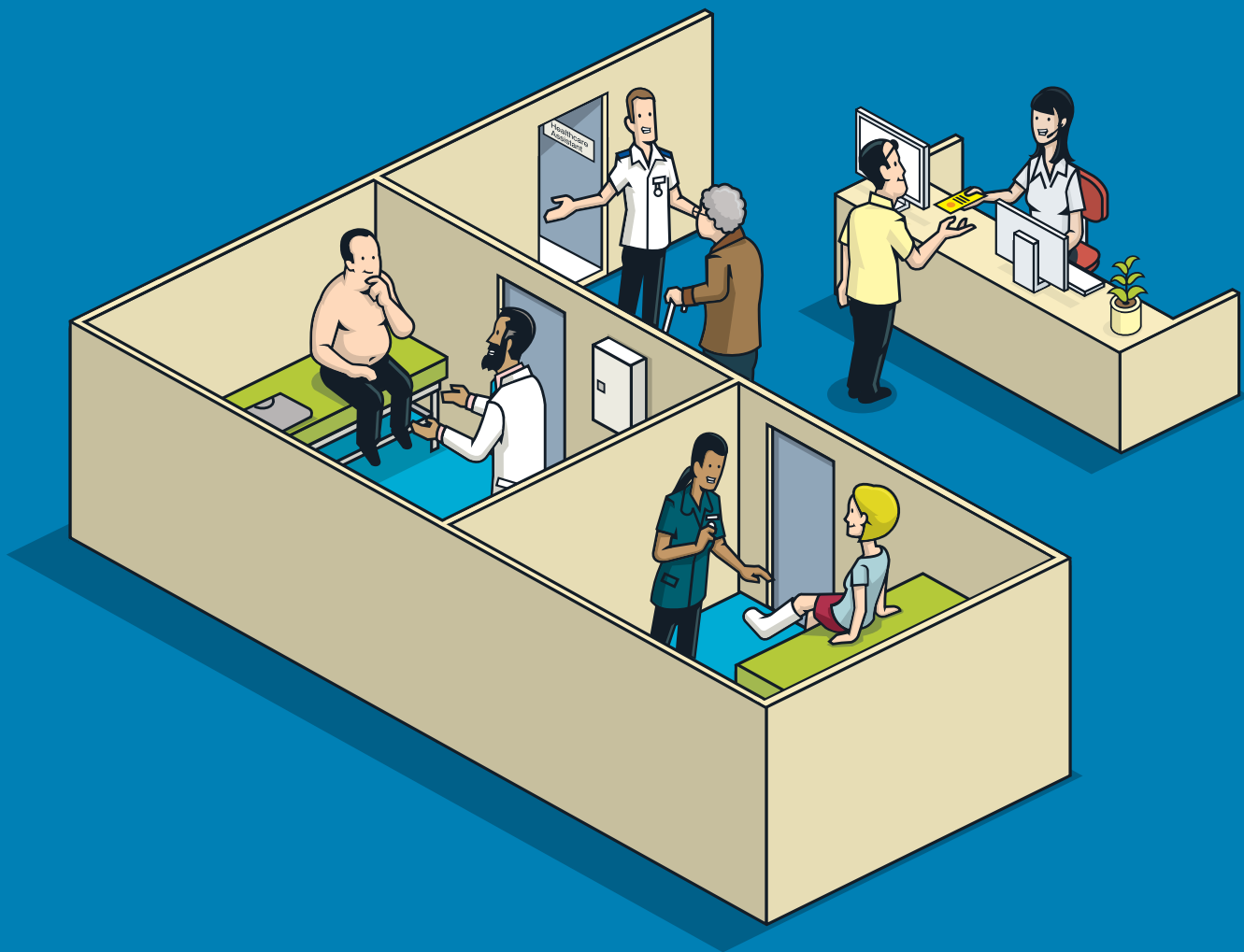
Two tasks currently carried out by the practice nurses could, with training, be done by healthcare support workers (HCSWs):

- assessment of foot pulses in diabetic patients; and
- first-line intervention in smoking cessation.

Result

Two HCSWs trained in foot pulse assessment. Freed up 23 hours of practice nurse time per month. New pathway implemented – HCSW first-line intervention for smoking cessation.

2.0 Managing and meeting demand



2.1 Skill mix

Demand for patient-led services is forcing practices to think carefully about the mixture of skills that their team possesses. The principle of employing staff who can provide the best, most effective care for patients, is set out in *A Health Service of All the Talents: Developing the NHS Workforce*, and emphasises the importance of:

- team working across professional organisations and boundaries;
- flexible working to make the best of the range of staff members' skills and knowledge;
- streamlining workforce planning and development, which stems from the needs of patients, not of professionals;
- maximising the contribution of all staff to patient care, doing away with the barriers that state that only doctors and nurses can provide particular types of care;
- modernising education and training to ensure that staff are equipped with the skills they need to work in a complex and changing NHS;
- developing new, more flexible, careers for all staff; and
- expanding the workforce to meet future demands.

Achieving a range of skills can help practices cope with an ageing population, address developments in the management of long-term conditions, meet contract requirements and help support practice-based commissioning.

Benefits

- Access to a healthcare professional may improve.
- Frees up higher grade staff's time to concentrate on therapeutic tasks.
- Improving access will lead to improved patient satisfaction, helping to achieve the targets set by the PCTs.
- Regular skill mix reviews can provide development opportunities for staff.

Drawbacks

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

Costs

These will vary depending on your need to employ additional staff or alter the contracted hours of your current staff.

2.1 Skill mix continued

Step-by-step guide

1. Firstly, **undertake a skill-mix review**. Use a diary to log the different tasks staff routinely do (see Workload Analysis Tool). Group the tasks into broad categories, such as 'administration'. Compare the tasks with the job descriptions of the staff to identify cross-over and duplications. Mapping this out with your team can help identify where skill gaps exist. Download the template at: www.rcn.org.uk/__data/assets/pdf_file/0019/176401/Tool7.5-Skills_audit_matrix.pdf.

2. Make **regular competency assessments** to identify development needs, and ensure staff can then be directed to work at the right level, making full use of their skills. Download an example at: www.rcn.org.uk/__data/assets/pdf_file/0005/176324/Tool3.1.pdf.

3. **Communicate with staff** – ensure a lead GP or practice manager discusses details of the skill mix and capacity plans with all the team at the practice.

4. **Communicate with patients** to understand their views about likely new roles and responsibilities (see chapter 8, Patient engagement).

5. **Support the integration of any new role**. A new role must be clearly understood. This is a key consideration for both the practice team and patients. Ensure patients understand the reason for the change, and what this means to them.

6. **Monitor and review any changes**. Set out what you hoped to achieve at the start, and gather feedback from staff and patients to assess the impact. Download a template at: www.rcn.org.uk/__data/assets/pdf_file/0007/176371/Tool6.10a-SkillMixAndIntegrationOfTeam.A.pdf.

The Wanless review suggested that up to 70% of the work done by a GP might be allocated to a general practice nurse (GPN). Healthcare assistants (HCAs) are also valuable posts being introduced in general practice, enabling nurses to take on more complex duties. For more information on how to safely and effectively introduce new roles, see the Working in Partnership Programme's (WiPP's) GPN and HCA Toolkits at: www.rcn.org.uk/development.

To get in touch with other practices that have made changes to their skill mix, see the WiPP Database of Good Practice at: www.wipp.nhs.uk.

2.2 Internet appointment booking

Allowing patients to create, amend and cancel their appointments online is becoming a popular alternative. It can be particularly convenient for patients when the practice is closed or telephone lines are busy.

Benefits

- Gives patients 24/7 access.
- Quick and easy to use, popular with patients who have busy lives.
- Can be popular with older people and those with hearing loss or a learning disability.
- Patients receive automated booking confirmations – no need to reconfirm by telephone.
- Reduces incoming calls and so relieves workload for reception staff.
- Appointments can be cancelled easily, reducing 'did not attends'.
- Some suppliers estimate there is a 67p saving from each appointment booked online.
- Practices can choose how many appointments they want displayed, and are therefore able to be booked online.
- Some systems allow patients to send a message with their booking to tell the clinician what their consultation is about. Many offer additional options such as repeat prescriptions.
- Log-in details can be revoked if a patient misuses the service.
- Many systems also allow patients to view and order repeat prescriptions online, providing additional convenience for patients and making practices more efficient.

Drawbacks

- Not everyone has access to a computer.
- Some patients may need a lot of training to use the system.
- Patients may be concerned about the security and confidentiality of the information.
- Requires some staff time.

Costs

Costs vary. This depends on whether it is an extension to your existing system or an update of an old system. Contact your GP system supplier to discuss your options.



2.2 Internet appointment booking continued

Step-by-step-guide

Consult

Have you checked with your Patient Participation Group to see whether there is an appetite for booking appointments online? What do your reception staff think about it? Are they happy to manage the system?

GP systems

There are a range of software solutions that work across many GP clinical operating systems. Many of the GP Systems of Choice (GPSoC) suppliers offer similar appointment booking services:

Egton Medical Information Systems Limited (EMIS) offer online appointment booking through EMIS Access. Around 1,500 practices are using this. An average of 45,000 appointments are being booked online each month.

Depending on the software, patients can also access the system using digital TV, or on their mobile. Practices using EMIS LV5.2 or EMIS PCS can use EMIS Access straight away – provided you have configured your software correctly. To do this, download one of the two easy-to-follow configuration guides from: www.emis-online.com/products/access/further. For more information or further support contact 0845 123 4455 or email fieldoperations@e-mis.com.

CSC Computer Sciences Limited offer online appointment booking through their SystemOnline service. It is an integral part of SystemOne. Practices can get started straight away by calling The Phoenix Partnership (TPP) on 0113 20 500 80. More information available at: www.tpp-uk.com/gp-systmonline.htm.

In Practice Systems (InPS) offer something slightly different. Vision Patient Partner is a 24-hour telephone appointment booking system that integrates with Vision's appointments. This allows patients to manage their appointments at any time. For more information contact 020 7501 7440, email sales@inps.co.uk or visit: www.inps4.co.uk/vision/extending-vision/vision-patient-partner/.

Continued overleaf...

2.2 Internet appointment booking continued

Step-by-step-guide continued

Practices using Practice Manager 2 from **Microtest** can make use of the e-Appointments facility. To place an order, or to request a demonstration, contact 0845 345 1606 or email sales@microtest.co.uk. For more information visit: www.microtest.co.uk.

FrontDesk work across many GP systems including EMIS LV and PCS, InPS vision, iSoft Synergy and Premiere. They offer a range of modules such as online appointment booking, appointment reminders, check-in screens and patient call displays.

Training

Think about your staff receiving software training so that you can both make best use of the operating system. Training usually costs money, so contact your software supplier directly to check. Do make sure your patients know how to use the system. This may also require some training.

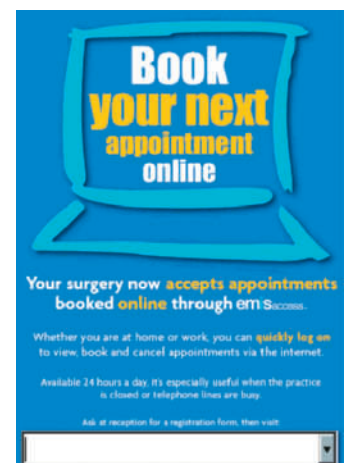
Communications

It is vital that you ensure all patients are made aware of the new system. Many suppliers offer promotional materials – such as posters and patient leaflets – that you can download from their websites.

Useful links

Read for yourself what patients are saying at: www.digitalspy.co.uk/forums/showthread.php?s=cbaa5b118ae06c268a2c22435eadbd6c&t=1032854.

Please note that this is not an exhaustive list of GP systems or software applications.



2.2 Internet appointment booking

Case study

Saltaire Medical Practice

This Bradford practice puts excellent patient access and choice first. Its online appointments booking system is a key part of this. Hundreds of Saltaire's 10,160 patients are happy to use this service, and numbers are growing.

Previously, patients could book appointments over the telephone, by post or in person. But this kept the surgery's phone lines busy and was often inconvenient for patients in full-time employment. The online system enables patients to book, view and cancel appointments 24/7. Patients see the same screen that receptionists see and can choose time slots that suit. They can also order repeat prescriptions through the same system.

New and existing patients can register for the service at the practice's reception. After showing identification, they are given unique log-on details that enable them to access the system, manage their appointments online and order repeat prescriptions. The facility is fully confidential and secure.

Saltaire had been offering online appointments via EMIS but the practice moved to the SystmOne clinical system in July 2008. The new system came with its own online appointment booking facility, called SystmOnline, which the practice began using as a pilot. As part of SystmOne, the booking facility is free of charge.

The system can't be used to book appointments at nurses' clinics, which require more specialised information on patients, but the practice hopes to include this feature in the future. 'We're always looking at new ways to improve patient access,' says Business Manager Catherine Darlington. 'We are a business in a competitive market and we want to offer a modern, responsive service.'

Benefits

- The online booking system offers patients greater access and choice, helping them to book appointments at their convenience and plan ahead.
- It reduces the morning rush of phone calls and frees up the phone lines for patients who don't use the internet.
- Being able to book an appointment online the night before reduces patient anxiety.
- Patients can order repeat prescriptions through the same system.

Tips

- Put a marketing strategy in place involving reception staff, leaflets, letters to patients and newsletters to raise patients' awareness.
- Make sure you have the capacity to cope with queries from those trying to use the system.
- Reception staff will need to invest time in registering patients and giving out log-on details, as well as helping them use it.
- Ensure you have a well designed practice website – the gateway to the online appointment booking service.
- Online booking is not for everyone. Reassure those who don't want to use the new system that the old one continues.

Contact

Catherine Darlington

catherine.darlington@bradford.nhs.uk

2.2 Internet appointment booking

Case study

Marple Cottage Surgery

Before an online system was introduced, patients at this surgery on the outskirts of Stockport, near Manchester, would have to try their luck with the busy telephone lines or visit the practice in person in order to make an appointment.

This was highly inconvenient for some, and often resulted in patients booking appointments 'just in case', to ensure a slot. So in 2001 the surgery introduced an online appointments booking service through its own in-house system. Then a few years later the EMIS system was introduced. Now, 15% of the practice's 6,000 patients are choosing to book online.

Patients who want to use the online system are issued with log-on details. They can then book, view and cancel appointments through the practice's website 24/7. Patients see the same bookings screen as the reception staff. The service is free of charge.

'People who know when they want to have an appointment, and which doctor they want to have it with, can make an appointment online without tying up the phone lines,' explains Practice Manager Johan Taylor. 'Patients have a choice about when they want to book and the early morning rush of calls is reduced.'

Benefits

- Patients have a choice about their appointment times, and can make them when the surgery is closed.
- The morning rush of phone calls is reduced.
- The phone lines are freer, making it easier for patients who don't have internet access to book their appointments by telephone.
- Lower call volumes free reception staff for other tasks.
- The number of speculative appointments made by patients is cut, increasing appointment availability.

Tips

- Be prepared for teething problems while patients get used to the system. Reception staff may have to spend time answering queries about making online appointments.
- Although receptionists may gain some time as the number of calls goes down, this saving may be cancelled out by the time needed to issue log-on details and help patients use the system.
- Promote the service widely, through front-line reception staff, leaflets, letters, flyers and word-of-mouth. Allow time to do this (patients won't just find out about it).
- Ensure you have a good practice website.

Contact

Johan Taylor

johan.taylor@gp-p88006.nhs.uk

2.3 Home visits: duty clinicians and collaborating with other practices

For some practices, a cost-effective solution could be a doctor dedicated, for example, to providing home visits or telephone consultations. This may be preferable to doctors both running regular surgeries and carrying out home visits. This can be taken forward by collaborating with other nearby practices.

Benefits

- Where there is a dedicated duty doctor to make home visits, emergency patients can be seen more quickly than they would at the surgery. And they can benefit from longer appointments.
- Practices can reduce the number of emergency walk-in patients. These cause congestion in the waiting room and extend doctors' working hours.
- By reducing visits to the surgery, home visits can also cut the risk of infection and local hospital admissions.

Costs

It can be expensive for practices to carry out home visits, because they take much longer than appointments at the surgery. Practices who have combined to provide an acute visiting service have found the service pays for itself (see above).

Large practices might think about making one of their doctors available every day for home visits. This does not add any extra cost, and is popular with patients and doctors.

Drawbacks

- Home visits can cost time and money if the practice doesn't have a dedicated duty doctor for home visits. A GP can see between two and four patients at the surgery in the time it takes to visit one patient at home.
- Better care can often be provided at the surgery. This is because there is specialist equipment and tests can be carried out more easily than at home.
- Home visits can be very disruptive for surgeries. This can lead to dissatisfaction among those patients making practice appointments, but subsequently kept waiting because of an emergency home visit.

2.3 Home visits: duty clinicians and collaborating with other practices continued

Step-by-step guide

1. Are your surgeries currently being disrupted by requests for acute home visits? Is this having a negative impact on patients, who are waiting longer for their appointments when their doctor is called away? What is the effect on the doctors, who are called away from their routine surgeries?

2. How long do patients who request home visits have to wait to see a doctor? If it's more than an hour or two, is this leading to higher rates of hospital admissions? Is it causing patients distress, or is it having an adverse effect on their health?

3. Think about the different options for providing a dedicated GP for home visits during each practice day. He or she can respond quickly to requests for acute home visits, without disrupting the practice or the patients in the waiting room. You could introduce a duty doctor system: one practice GP who has no booked appointments for the day, leaving him or her free to meet home visit requests quickly. Another option is to collaborate with other practices, by hiring an external doctor whose sole purpose is to make home visits.

4. Before going to patients' homes, talk to them on the phone to find out if visiting them is the best course.

5. Make sure all reception staff and practice managers are familiar with the practice's policy on home visits, so that requests are channelled effectively.

6. Are you introducing an acute visiting service or duty doctor system? Think about other activities the doctor could be doing while he or she is not making home visits. These might include visiting nursing homes or making follow-up calls.

2.3 Home visits: duty clinicians and collaborating with other practices Case study

Halton and St Helens PCT

St Helens borough in Merseyside had one of the highest emergency admission rates in the Strategic Health Authority area. There were 150 admissions per 1,000 population. This compared to the PCT target of 120 or fewer.

Patients would call their practice in the morning, hoping for a home visit, but find out that their doctor was fully booked for the entire surgery. In some cases, this resulted in a delay of over three hours from time of the request to the visit being made. If the condition deteriorated, or they thought it did, patients or their carers frequently called an ambulance or went to A&E.

There was therefore a need to reduce emergency admission rates. So, nine practices in a St Helens commissioning consortium devised a shared acute visiting service. This employed a GP dedicated to home visits.

Now, patients who request an urgent home visit call their practice and speak to their own doctor or a practice nurse. The medical professional assesses whether or not the patient needs to be seen. If so, the doctor from the acute visiting service will be sent. Three quarters of patients are seen within an hour, with the appointments lasting up to 20 minutes.

There are now 12 practices involved, and the results have been 'phenomenal', says lead GP Dr Shikha Pitalia. 'We launched this scheme in December 2006, and since then we've reduced emergency admissions by 30%. We had support from the PCT in the first year, but now the scheme is self-funding. It generates savings from the emergency admissions avoided.'

The benefits are significant, for the practice as well as the patient.

'Just one or two urgent requests for home visits can significantly reduce the availability of GP appointments. Sharing a home visit doctor gives us back three appointments a day, on average,' says Dr Pitalia.

The system borrows the infrastructure of the local out-of-hours provider, who recruited a doctor with knowledge of the local referral care pathways to provide an acute visiting service. Regular monitoring of the service ensures that clinical standards are maintained.

Continued overleaf...

2.3 Home visits: duty clinicians and collaborating with other practices Case study

Halton and St Helens PCT continued

Benefits

- Emergency admission rates have fallen by 30% for this consortium.
- Patients get a genuine choice to stay at home, if that's what they want, in line with NHS principles.
- Patients appreciate the quick response and longer consultations.
- With fewer admissions, there's a reduced risk of hospital-acquired infections.
- Carers don't need to take time off work to take a patient to hospital.
- Doctors are able to plan their work more effectively. They no longer need to drop everything when a request for an urgent home visit comes in.

Tips

- Good communication is essential. All GPs involved in the scheme must understand and support the concept.
- Get all reception staff and practice managers on board, so requests for home visits are channelled.
- Using existing out-of-hours infrastructure aids implementation.
- The system needs to be regularly monitored, so it is transparent and standards are maintained.
- Build a cold case load for the GP doing the home visits, so any down time can be put to good use doing follow-up visits, visiting nursing homes etc.

Contact

Shikha Pitalia

shikha@ssphealth.com

2.3 Home visits: duty clinicians and collaborating with other practices Case study

West Malling Group Practice

West Malling Group Practice in Kent found that it was getting a large number of acute home visit requests during surgery hours. Sometimes, all the GPs would make home visits on the same day, disrupting workloads and causing a backlog. Patients needing home visits would often have to wait several hours until the end of morning or evening surgery, potentially risking their health and postponing any tests or hospital admissions until late in the day.

The practice also struggled with the large number of patients wanting or needing to be seen without appointments. They would have to wait until the end of the surgery to be seen. This increased congestion in the waiting room and extended doctors' regular hours. In 2002 the practice responded by introducing a duty doctor system. This brought huge benefits for patients and doctors.

The assigned duty doctor has no booked appointments. He or she takes all requests for urgent home visits, gives advice over the phone in urgent cases and receives calls for doctors who are not present. He or she also sees patients at the practice who need urgent attention but don't have appointments. At West Malling, the record for a number of duty doctor contacts in a ten-hour day is 120, including phone calls, home visits and patients coming to the surgery for emergency appointments.

'I think we give patients a fantastic service,' says Dr Jonty West, a partner at the practice. 'I know very few other surgeries where a patient is always guaranteed a call back from a doctor. And if someone feels they need a visit immediately, the doctor is able to leave at once, and then get the tests and admissions organised early in the day.'

Benefits

- Doctors who are not on duty have a more predictable work day.
- Patients always get a call back from a doctor or a home visit within a short space of time.
- Seeing emergency cases sooner enables doctors to get tests and hospital admissions organised early in the day, which benefits patients and hospitals.
- The practice has fewer walk-in patients, as patients know they can call for an emergency home visit.
- The scheme reduces the risk of infection in a pandemic situation.

Tips

- The duty doctor scheme works best in large practices. Ensure your medical team has sufficient capacity to spare a doctor from the daily appointments rota.
- Your duty doctor should have nothing else booked for the day (which may not be efficient in a small practice).
- As the duty doctor, stay on top of phone calls and visit requests, because they can come in at a rapid rate.

Contact

Dr Jonty West
jonty.west@nhs.net

2.4 Appointment reminder systems

Millions of GP and nurse appointments are missed every year. This amounts to millions of pounds worth of wasted NHS resources. There are many ways in which you can reduce your 'did not attends' (DNAs) and help to educate patients on their responsibilities. One of the most effective is a simple system that sends the patient a text message, a day or two beforehand, to remind them of their appointment.



Costs

There are many suppliers, and costs vary. Some systems that use Connecting for Health's NHSmail system are free. Some GP system suppliers are also now beginning to offer such functionality within their software.

Benefits

- Systems have been shown to reduce DNAs by up to 50%.
- Most products are compatible with most GP systems.
- Messages can be personalised.
- Systems are secure and confidential.
- Can be used for targeted health campaigns, eg informing patients of flu jabs or smoking cessation clinics.
- Can be used to engage with hard-to-reach patients, including the young and socially excluded.
- Multi-lingual – most systems include language templates so that your messages reach non-English speaking audiences.
- Systems can send one-off messages to individuals or groups of patients.
- Reduces administration costs for printing and postage.

Drawbacks

- Relies on the practice keeping up-to-date patient mobile phone numbers.
- Some patients may not want to be contacted by the practice.
- Not a complete solution – this won't eradicate DNAs totally.
- Some patients don't know their mobile numbers, while others forget to tell the practice when they change their number.

2.4 Appointment reminder systems continued

Step-by-step guide

1. Consider value for money

Would the alternatives – posting information to patients or a marketing campaign to reduce DNAs – cost more?

2. Test with your patients

Would they be happy to receive text messages from their GP practice? Do the majority of your patients have mobile telephones? Do you have mobile telephone numbers for all your patients? Who will maintain the details?

3. GP systems

Check with your existing GP software supplier to see if:

- they already offer a system that can be easily added to yours; and
- the system you are considering is compatible with your software.

4. Training

Make sure your staff have the appropriate training to get the best out of the system.

5. Impact

Make sure you monitor and evaluate the impact of the system. Have DNAs been reduced?

Tips

- If you use delivery reports, this enables reception staff to check if a patient has received the message or whether their number might need updating.
- Allow patients to text back to cancel their appointment to free up the telephone line.

2.4 Appointment reminder systems

Case study

Brigstock Medical Practice

Croydon is the most heavily populated London borough. Many patients of the area's Brigstock Medical Practice were failing to turn up for medical appointments. The practice was logging 90 DNAs per week. This wasted surgery hours, cost the practice money and prevented other patients from getting appointments. Doctors therefore wanted to find a way to remind people politely when they were due at the surgery. This would save time and money and improve access for 1,500 registered patients. So in January 2008, Brigstock installed MJog, a fully automated appointments reminder system. This uses text messaging technology. It started as a pilot, and within a few months the number of missed appointments had reduced by a third.

The practice says that older patients, who may not have mobile phones, tend not to miss appointments. It's the mobile-phone-friendly generation of patients who tend not to show, which makes the text reminder system particularly effective in reducing DNAs. 'The number of DNAs per week fell to 60. So you're talking about 30 more appointments for doctors or nurses,' comments Dipti Gandhi, a partner at Brigstock. 'In terms of access, it's a huge thing for us. The feedback we've had shows that patients are very pleased with the service.'

MJog, manufactured by Soft Options Technologies and partnered with EMIS, looks through a practice's database for upcoming appointments. It can look up to seven days ahead, but the practice can tailor the notice period to 24, 48 hours or longer. MJog then sends a text to the patient's mobile phone. The practice now wants to take advantage of MJog's additional services. This includes a 'healthcare campaign manager' that allows the practice to send messages to mobile phones.

These highlight anti-smoking or flu jab campaigns, for example. The recipient lists can be customised for every message sent, as can the content. Patients, for example, can be reminded not to eat before clinical appointments if that is a requirement.

Benefits

- DNAs fell by a third within months.
- Patients are more likely to meet their appointments.
- The system saves surgery hours and therefore money.
- It increases patient satisfaction.
- The service encourages practices to keep their patients' details up to date.
- It can be used for health campaigns, targeting particular groups of patients who would be most likely to benefit.

Tips

- Ensure you have up-to-date records of patients or the system won't work. This requires an investment of administrative time, as patients' mobile phone numbers can change regularly.
- Put processes in place to keep patients' contact details up to date on an ongoing basis.
- Spread the word to your patients through publicity campaigns, so they volunteer their mobile phone numbers.

Contact

Dipti Gandhi

dipti.gandhi@gp-h83017.nhs.uk

2.4 Appointment reminder systems

Case study

Oldham PCT

Oldham PCT looked at several ways to increase access to primary care services and decided that a text messaging service has several benefits, including reducing DNAs.

A small number of practices joined the scheme in May 2008. The PCT introduced practice managers to staff from the text system provider, iPlato. They began working together to introduce the system.

iPlato's web-based text messaging system was chosen over others because it works with all the major clinical systems, including EMIS and InPS Vision. Once the system was installed in the practices, a text message was sent to all patients whose mobile phone number was already in the practice system. In practices that were IT-oriented, the first texts were going out within a week of system set-up.

The initial message asked patients if they wanted to receive appointment reminders and health messages. If they assented, they were enrolled in the service. In addition to that initial text message, patients who came to the practice were asked if they wanted to receive text messages.

With targeted health messages, the system can be used to send manual text messages to individuals or groups of patients. Automated appointment reminders are sent to patients by text message at a predefined time before each visit. Reply texts from patients are directed as emails to an email address.

Contact

Martin Weavers, 0161 622 4304
martin.weavers@nhs.net

The PCT paid for the initial set-up costs and software for the first year of the service. In the second year, there's an annual maintenance cost, for which the practices are responsible. The text messages themselves cost 6p each and are sold in bundles of 3,000. Staff time spent on this project was minimal.

The PCT is now actively trying to reach more patients who have mobile phones, to encourage them to give their surgeries their numbers. Mobile phones are used by 84% of the adult population, which suggests that there is huge potential for growth in penetration.

In September 2008, the PCT invited practices to an event to learn more about the text messaging system. Since then, many more practices have opted in, and the PCT expects interest to grow.

Tips

- Elderly patients were just as comfortable receiving text messages as young people.
- There may be confidentiality issues with younger patients – there was a risk that their parents might read their mobile phone messages. Consider setting an age limit of 16 for people enrolling in this service.
- If you are in the process of switching clinical systems, wait until the new system has been installed.

2.5 Telephone consultations

Telephone consultations can be cheaper and quicker than seeing patients face to face, but they carry risks. In the right circumstances, they can increase efficiency, improve access and boost patient satisfaction.

Benefits

- There is increased efficiency. By talking to patients before they make an appointment, doctors can ensure they only see people who would benefit from a face-to-face consultation.
- Waiting times and appointment systems can be better managed, leading to greater patient satisfaction and lower staff stress levels.
- Patients have another channel through which to access primary care. This is particularly useful for people with reduced mobility or very little spare time.
- Telephone consultations can increase the opportunity for a patient to consult their preferred doctor, reinforcing the relationship, to the benefit of both parties.

Drawbacks

- Doctors rely on visual cues for diagnosis and these are absent in phone consultations. This could lead to a greater risk of wrong diagnosis.
- Phone calls are dependent on the setting, with both parties influenced by their surroundings and mood. Patients won't necessarily share the full details of their health problem. Doctors won't always interpret what they say correctly.
- People who don't speak English as their first language are not always confident at self-expression. Decision-making is difficult for the GP. Involving interpreters is complicated and costly.
- While some patients appreciate telephone consultations, others regard it as a blocking tactic.
- Telephone consultations can result in higher phone bills – up to 25% higher.
- Not all conditions are suitable for phone management. Some will need a personal examination.

2.5 Telephone consultations continued

Telephone consultations by GPs in normal practice hours serve a variety of purposes:

In clinical management

- Assessing a new clinical problem and recommending appropriate action – such as a home visit, surgery appointment, hospital visit or self-care.
- Offering a second opinion or taking over management from a colleague.
- Giving advice – particularly when the patient is well known to the doctor.
- Multi-tasking, eg conducting a surgery while on call for emergencies.
- Following up a clinical problem.

In practice organisation

- Arranging repeat prescriptions or medical certificates.
- Giving the results of investigations.
- Fielding a complaint or other feedback.
- Speaking to third parties about a patient, eg relatives or social workers.



2.5 Telephone consultations

Case studies

Bolton

In 1987, a telephone consultation study was conducted in a Bolton practice of 14,000 patients. A dedicated telephone advice line staffed by doctors was set up. They took 277 calls in the five-month study period. Each call lasted about three minutes. In a post-study questionnaire:

- 75% of the patients who responded said they would have made an appointment if they hadn't been able to call.
- 13% would have requested a home visit.
- 91% of respondents were satisfied with the advice line.
- Doctors in the practice thought that 64% of the calls were useful.

New Hampshire (USA)

In New Hampshire between 1988 and 1990, follow-up calls initiated by doctors replaced face-to-face consultations in a primary care setting. Five hundred male veterans selected at random received three telephone consultations. Plus, the usual interval between face-to-face consultations was doubled. Over these two years:

- The telephone care patients used significantly fewer prescribed drugs and experienced fewer admissions, with shorter hospital stays, resulting in savings of \$1,656 per patient.
- There was no significant difference in mortality between the two groups.

Leicestershire

The Cottage Surgery at Woodhouse Eaves in Leicestershire has been running a telephone consultation system for six years. Doctors talk to nearly all patients before they make an appointment. Exceptions are patients with language issues or particular conditions automatically requiring face-to-face consultation.

- 34% of patients who call the surgery end up wanting to see a doctor face to face. A quarter want advice and another quarter want something that doesn't involve direct contact. The remainder see the practice nurse.
- DNAs and complaints fell to almost zero.
- Access figures went up to 98%.

East London

Three doctors at the Limehouse Practice in East London talk to all their patients on the telephone before they make an appointment. In nearly three years, they have found:

- Between 60% and 70% of people who call go on to make an appointment for a face-to-face consultation, usually the same day or the next day. The rest can be helped on the phone.
- In a patient survey, 91% of patients were in favour of the telephone consultation system.

(See the end of this section for full case study.)

2.5 Telephone consultations continued

Expert advice

Royal College of General Practitioners (RCGP) guidance on telephone consultations in primary care

- Practice teams should regard the telephone as a means of improving access and personal care, rather than as a barrier.
- Patients should be involved in any plans to develop or change the telephone-based services a practice provides.
- A practice should have one incoming telephone line per 2,500 registered patients, and the flexibility to open further lines at busy times.
- All incoming and outgoing telephone calls with patients and carers should be noted in medical records.
- Doctors should be flexible regarding consultations so as to meet the needs of patients who prefer the phone.
- Doctors might consider telephone follow-up as an alternative to some face-to-face consultations for common conditions such as depression and cancer.
- An article from the June 2009 issue of *The British Journal of General Practice* concluded that 'Used appropriately, telephone consulting enhances access to health care, aids continuity, and saves time and travelling for patients. The current emphasis for acute triage, however, worried clinicians and patients. Given these findings, and until the safe use of telephone triage is fully understood and agreed on by stakeholders, policy makers and clinicians should be using the telephone primarily for managing follow up appointments when diagnostic assessment has already been undertaken.' <http://rcgp.publisher.ingentaconnect.com/content/rcgp/bjgp/2009/00000059/00000563/art00004;jsessionid=iwetqq7ym10v.alice>

Costs

There are minimal costs involved in introducing a telephone consultation system. Phone systems need to be up to date, with increased capacity and more than one line into the practice. Computer systems should permit internal messaging and fast retrieval of patient records. Phone bills will rise in proportion to the increase in telephone consultations being made.

2.5 Telephone consultations continued

Tips

When to use the phone

Some health problems cannot be dealt with in a phone consultation – for example, those where the doctor needs to see or touch the patient. Some things that might be dealt with by telephone could include the following, though there may be circumstances where even these conditions are deemed too dangerous to diagnose or deal with over the phone:

- coughs and/or breathlessness
- earache
- sore and/or discharging eyes
- rashes and other skin problems
- spinal pain and injuries
- other musculoskeletal pain and injuries
- diarrhoea
- cystitis in women
- emergency contraception
- vaginal bleeding in early pregnancy
- anxiety and depression.

Tips

What to say

Although there needs to be flexibility in the structure of telephone consultations, several key stages can be identified:

- Identify yourself and the caller/person being called – the patient whenever possible.
- Gather information, including social context and clinical history.
- Address the biomedical aspects of the problem and the patient's perspective.
- Give a diagnosis or interpretation of the patient's problem, with an explanation.
- Signpost the point at which a triage or management decision must be made.
- Negotiate the outcome according to agreed guidelines.
- Make follow-up arrangements sharing thoughts on possible developments.
- Prepare for the next call and be professionally safe, keeping good records.

2.5 Telephone consultations continued

Other considerations

Knowing the patient

One thing that distinguishes GP phone consultations from the service provided by NHS Direct is the medical professional's familiarity with patients and access to their records. This reduces uncertainties in communication and diagnosis. When the doctor doesn't know the patient, for example, if a locum makes the call, it is less likely to be successful.

Structure and teamwork

So that patients are given consistent advice and treatment when they call, policies and boundaries need to be established within the primary care team. Practices should decide what proportion of clinical time should be set aside for telephone consultations, what conditions will be managed this way and what advice will be given for each condition.

Risks and warnings

A lack of training and confidence can limit the effectiveness of telephone consultations. Doctors tend to feel more confident when conducting telephone consultations with familiar patients during practice hours, than when making calls out of hours.

According to 38 doctors interviewed for a study in Cambridge in 1997, the factors most frequently associated with difficult calls are:

- a difference of opinion on the need for a visit;
- parental anxiety about children;
- chronic conditions; and
- mental health problems.

Telephone consultations are prone to errors in:

- information gathering, from inadequate knowledge of drug usage and allergy history;
- relationship building, usually through anger on one or other side;
- decision-making, for example premature decisions; and
- explanation and planning, due to poor communication.

The relative anonymity patients have when talking on the phone promotes clear communication, but it's just as likely to inhibit it. Doctors should keep this uncertainty in mind when conducting telephone consultations. Be prepared for any eventuality.

Credit and references

Some of the information here is adapted from *Telephone Consultations in Primary Care* by Tony Males (Royal College of General Practitioners, London, 2007, available to purchase from: www.rcgp.org.uk/bookshop/info_2_9780850843064.html).

2.5 Telephone consultations

Case study

The Limehouse Practice (full case study)

In 2006, the Limehouse Practice in East London found that patients were waiting a long time to be seen. All seven GPs were committed to their own lists of patients, but often saw each other's as they attempted to improve access.

Doctors believed that moving to a system of telephone consultations during practice hours would increase capacity, as fewer patients would need to visit the surgery. They also saw it as a way of reinforcing doctor/patient relationships.

When patients call with a health issue, a message is taken and their registered doctor calls them back, usually within 24 hours. After that conversation, the doctor decides if he or she needs to see the patient. If so, the doctor makes an appointment, usually for that day or the next.

'Using telephone consultations in this way makes us more efficient as a practice. But it also reaffirms the importance of primary care providers and the old-fashioned idea that GPs get to know their patients over a long time. That's part of the reward of it,' says Dr David Kirby, one of the GPs who uses this system.

Between 60% and 70% of callers make an appointment for a face-to-face consultation. The rest can be helped by phone, perhaps through advice, referrals, test results or repeat prescriptions. This system cuts waiting time and means that the doctors have already spoken to patients before they see them. This makes for more efficient consultations.

The doctors who use this system tend to make their calls in the early afternoon and evening, leaving the morning and later afternoon for face-to-face consultations.

Benefits

- This system allows doctors to manage conditions more easily and build individual relationships with patients.
- Fewer patients now need to attend in person, reducing pressure on appointments and waiting time, so the atmosphere in the practice is more relaxed.
- A patient survey in 2008 showed over 90% of patients were in favour of the telephone consultation system.

Tips

- It's better to see patients whose first language isn't English face to face. Communicating with these patients is often more difficult on the phone.
- It's not always easy to call people back, if they don't answer their mobile phones or are out a lot. If they can't be contacted within three days, the doctors at the Limehouse Practice send them a letter.
- Telephone consultations work best for patients who are articulate and are time-poor.

Contact

Dr David Kirby, 020 7515 2211
david.kirby@gp-f84054.nhs.uk

2.5 Telephone consultations

Case study

The Cottage Surgery (full case study)

The Cottage Surgery at Woodhouse Eaves in Leicestershire was set up by Dr Stephen Clay as a one-doctor practice in 2003. To increase capacity and cut waiting times, the doctor uses a system whereby all patients are put through to him when they call. Working together with the patient, he then determines whether or not a consultation is required.

Dr Clay uses variants of this system in two other practices managed by his team. The total number of patients in all three practices is around 10,500. When a patient calls the Cottage Surgery, the receptionist takes a brief note of their name and what the problem is, if they are happy to say so. They are either put straight through to Dr Clay or, if he's busy, he calls them back at the earliest opportunity.

When he talks to patients, the doctor decides if he needs to see them and if he does, he makes an appointment, usually for that day. If in doubt, he asks them to come in. Phone calls last, on average, between two and three minutes, considerably less time than a face-to-face consultation. This enables the practice to offer longer appointments to people who need them.

'I've found that 50% of patients don't need to see a medical professional and only 34% choose to come in and see me,' he reports. 'About a quarter just want advice and the other quarter want something that doesn't involve direct contact, such as a repeat prescription. The remainder see the practice nurse.' Some patients are not suited to phone consultations, for language or work reasons or because of their particular condition. These patients are identified to reception staff, who book an appointment for them when they call, rather than pass the call through to the doctor.

Benefits

- The waiting room is never full and wait times are minimal.
- Patients are happier because they don't waste a trip to the doctor when it's not necessary.
- Staff are more relaxed because the morning bottlenecks at reception have gone.
- DNA rates have plummeted to virtually zero, as have complaints from patients.
- Doctors have more time, even though they're dealing with more patients in a day than they would without the telephone consultations.

Tips

- When you start using telephone consultations for all patients, clear your books first so you have empty clinics to book people into.
- The system works best if the telephone consultations take place earlier in the day and face-to-face clinics take place later, attended by people who spoke to the doctor earlier.
- Demand is predictable, so match your resources with the demand. If more people call the practice on Mondays, design your system so you have extra capacity on that day.

Contact

Dr Stephen Clay
s.clay@thecottagesurgery.co.uk

3.0 The practice environment



3.1 How to achieve a healthy and relaxed environment

First impressions count. Your waiting room can leave a lasting impression. Using simple design principles and techniques can make the waiting room a more relaxed and calm environment, as well as provide educational opportunities for patients.

Suggestions

1. **Appearance.** The appearance of reception is key. You don't need to remove any existing fittings. Instead, update the area with a simple, cheap façade or panelling.
2. **Patient comfort.** Put yourself in the shoes of your patients. Why not sit for 5–10 minutes in your own waiting room and consider what might need updating. Make sure you ask staff before making any changes.
3. **Colour.** Use colour. Choose colours that are cheerful, natural and inviting. Use colour therapy techniques – warmer tones can be a good choice whilst violet gives a calming effect and red is energising.
4. **Plants.** Place green plants around the room to make the space feel more comfortable.
5. **Lighting.** Improve the lighting. Make sure walkways are clearly lit, particularly if you have patients with sight loss.
6. **Music.** Think about playing music. This can help people relax before seeing the doctor. Request feedback about music preferences via a questionnaire.
7. **Poems.** Think about having poems in the waiting room. Evidence suggests they can help patients relax.
8. **Reading material.** Consider a range of newspapers and magazines. Make a named person within the practice (or Patient Participation Group (PPG)) responsible for checking the condition and relevance of magazines.
9. **Cleaning.** Think about giving the carpet a fresh look or a steam clean.
10. **Water cooler.** Consider installing a water cooler/dispenser with recyclable cups.
11. **Pushchairs.** Have an area for pushchairs.
12. **Toys.** Consider installing a 'fixed toy' and remove all individual toys.
13. **Access.** Organise and theme health information to help patients access the information they require.
14. **Noticeboards.** Revamp noticeboards and liaise with patients about what they think is needed.
15. **Seating.** Consider rearranging the seating, and separating the office from the reception area to improve confidentiality.
16. **TV.** Remove clutter and think about using patient information portals or installing flat-panel TVs.

Costs

Many changes can be done cheaply. Practices should speak to their PCT to see if they qualify for any grants or schemes.

3.2 Self-service check-in screens

Time is precious for receptionist staff. At busy times, patients can sometimes queue for several minutes to let staff know they have arrived. Automated touch-screens allow patients to check themselves in for an appointment quickly.

Some considerations

- Is there a need for this technology?
- How do receptionists feel about it? Do they often see queues forming, particularly at peak times?
- Have you tested this with your PPG to see how patients feel about these systems?
- Have you checked with your PCT to see if they are thinking about supporting such products or have any learning they can share?
- What kind of check-in system would work best in your practice – freestanding, desktop or wireless clipboard?
- If you choose the wireless clipboard or desktop version, make sure it is far enough away from the reception area, but within viewing distance of reception staff and patients walking through the door.
- Consult your GP system supplier to check whether they offer their own systems, or that the systems you are considering are compatible with your software.
- Is this the most cost-effective solution?
- Agree an installation date with the supplier. Ensure you have an agreed communications plan for both staff (you may need a member of staff manning the system for the first couple of weeks to train patients) and patients (ensuring patients are made fully aware of the system through newsletters etc).
- Ensure you assess the impact of the new system through patient and staff reaction. Have reception staff seen queues reduce?

Tip

Get volunteers from your PPG to assist patients with the machines until they get used to them.

Benefits

- Patients spend less time queuing, relieving frustrations.
- Can free up receptionist time so that they can work in other areas.
- Manages patient expectations by informing them of waiting times.
- Option to have multiple screens for different waiting rooms or across different sites.
- Patients may feel more comfortable checking in on a screen rather than speaking to a receptionist.
- Text can be made multi-lingual.

Drawbacks

- They may not be suitable for patients with sight problems or elderly patients.
- Patients may prefer face-to-face contact rather than new technology.
- Think about privacy and confidentiality. Some patients may feel like their private information is available to all.
- There may be space issues in smaller surgeries.
- Think about maintenance costs.
- You may need to provide hand gel.

Costs

Up to £3,000 for initial set-up for kiosk-based solution. Maintenance charges of around £340 a year. (Speak to your PCT.)

3.2 Self-service check-in screens

Case study

St Lawrence Surgery

The St Lawrence surgery in Worthing, West Sussex looks after 12,000 patients and has always been innovative in responding to feedback from its PPG. So, when the queues at the reception desk became a real problem, both for patients and the practice team, the surgery acted.

While investigating an automated check-in system to address this problem the practice also aimed to:

- improve patient confidentiality;
- speed up the arrival systems for nurses and GPs;
- reduce the spread of infection to reception staff;
- give patients an idea of the waiting time; and
- provide a choice of check-in facilities.

The practice put forward a business case to their PCT for a grant to cover the initial £3,000 installation cost. This identified the current problems for the practice:

- Queues were resulting in late arrivals and late registrations.
- Therefore patients were late for their appointments.
- This had a very negative impact on GP and nurse running time and appointment schedules.

There was a strong body of support for the introduction of the new system, but a number of potential risks were identified including:

- ongoing maintenance costs (£340 per year) and issues;
- lack of personal contact;
- learning how to use the system; and
- resistance from older patients.

These risk factors were monitored during the introduction and the evaluation of the project. One of the keys to the project's success with patients is that automated check-in is not mandatory.

Patients have a choice, so can opt to book in with the receptionist. This project also highlighted the need for more privacy around the reception desk. New railings and signage were added to encourage patients to stand back slightly from patients ahead of them. The new system is fully integrated with the practice's existing computer software (supplied by EMIS). Despite one or two hiccups during the first few weeks, it is working very efficiently.

Benefits

- Improved access for patients
- No complaints about queuing
- Appointments now run to time
- Better patient confidentiality
- A sound investment.

Tips

- Site the check-in machine away from the reception area but near enough for staff to keep an eye on it.
- Install a hand gel dispenser at the side of the check-in screen with a sign asking patients to use the gel to reduce infectivity.
- Give patients a choice – not everyone will want to use this check-in system.

Contact

Josiane Wadey, 01903 222902

jowadey@nhs.net

3.2 Self-service check-in screens

Case study

Dawlish Medical Group

This is a large practice in Devon with over 12,000 patients. On a Monday morning the check-in queue for appointments was getting out of hand. Many patients arrived late which had an impact on appointment schedules.

According to Practice Manager Janine Payne, the reception desk just couldn't cope with the volume of patients during peak times – 550 patients coming through the door in one day.

'We visited a neighbouring practice that had installed an electronic check-in system and saw first hand just how well it worked. Financially, our practice was lucky enough to have a pot of money from some private fundraising which we decided to use. The cost of the hardware, software and licence was around £1,500 and of course there is an annual maintenance fee.'

One of the surgery's key issues was the location of the equipment, as at the time it had to be within ten feet of the server. This means that it is quite close to the reception desk. Other risks included:

- possible abuse of the equipment;
- a reluctance among over 65s to use the system;
- ensuring that the signposting to the new system and the instructions on how to use it were clearly visible;
- identifying a member of the practice team to take responsibility for updates and training; and
- annual maintenance costs.

The surgery addressed all these issues during the planning and implementation phase. Key to the success of the project has been clear communication with patients during the introduction of the new system.

As Janine explains, 'Using the electronic check-in system is easy when you know how. But if you have problems the first time you use it you will be less inclined to use it next time. That's why we often have informal training sessions going on and volunteers at peak times to help – we find this works very well indeed.'

Benefits

- Queuing is significantly reduced.
- Over 50% of patients use the system and this figure is increasing every month.
- Feedback from the surgery's patient support group is very positive.
- It's a good example of how technology can improve the patient experience.

Tips

- Install your equipment so that it can be supervised from a distance but offers confidentiality and takes patients away from the reception desk.
- Offer patients a choice – many older patients are happier to queue up and receive a personal service.
- Check with your PCT to see if funding is available.

Contact

Janine Payne, 01626 884112
janine.payne@nhs.net

3.3 Electronic display systems

These are large screens that can be used as information gateways, promoting health improvement messages for patients as they wait for their appointments. The screens can also be used to publicise services and call patients for their consultation.

Benefits

- **Flexibility:** Practices can choose the message content, and specify the times, the length of each message and sometimes colour schemes.
- **Range of messages:** Systems often come with a vast selection of messages that are regularly updated, for example healthy eating and smoking cessation advice. New messages can usually be created using simple software such as Microsoft PowerPoint.
- **Targeting:** Messages can target specific groups, for example new baby clinics. By displaying text in different languages, they could be used to engage a diverse patient population.
- **Free up time for reception staff:** The patient call function can relieve pressure on receptionists, freeing them for other duties.
- **Free up time for GPs:** Doctors save the time between appointments previously spent phoning reception or going in search of patients. This allows them to read patients' notes or catch up on paperwork.

Drawbacks

- **Accessibility:** The system might not be appropriate for groups such as visually impaired patients. You should not rely solely on a screen to call patients for their appointments.
- **Patient resistance:** Think about whether to include sound. Some patients may feel frustrated being bombarded with lots of health messages.
- **Training:** Staff may need intensive software training.
- **Cost:** The initial investment is high. You will also want to think about maintenance costs and annual support.

Resources

There are numerous suppliers of screens but few that mesh with standard GP software. Practices can choose between sophisticated liquid crystal display (LCD)/plasma flat screens and the simpler, more cost-effective light emitting diode (LED) screens.

3.3 Electronic display systems continued

Some considerations

1. Is there a need for this technology?
 - Do staff often handle enquiries about opening times, clinic availability, vaccinations etc?
 - Are patients likely to watch the screen?
 - Have you checked with your Patient Participation Group (PPG)?
 - Do you have a particularly diverse practice population?
 - If so, do the screens offer a multi-lingual option?
 - Have any local practices implemented something similar? If so, talk to them and see what their patients think.
 - Speak to your PCT – have they looked at any similar systems for other local services?
2. Before you choose a system or screen, check whether your current GP system supplier offers any compatible products. Or whether the product you are considering will work with your system. Consider what features and functionality you require. For example, do you want the patient call facility or just a health information portal?
3. Think value for money. Is this the most cost-effective solution? Are there other mechanisms and other techniques, for example leaflets or other communications tools, that you should use?
4. Set aside time to train staff on how to use the system and get the most out of it. Ensure patients are made fully aware of the system too.
5. Ensure you monitor and evaluate. Do receptionists feel the system is working well? Do waiting patients pay attention to the screen? Has there been an increase in clinic attendances?
6. Think carefully about patient messaging. It could be a good opportunity to make people aware of recent did not attend (DNA) rates, a new appointment booking system or future dates for PPG meetings.

3.3 Electronic display systems

Case study

Victoria Medical Centre

When the Victoria Medical Centre in London moved to a new state-of-the-art building two years ago, the practice wanted to introduce technology to match.

With premises spread over two floors and fifteen consulting rooms, the practice needed an efficient patient calling system. Previously, doctors would come out of their rooms to call patients or reception staff would shout their names. This wasted valuable minutes between consultations and there was sometimes confusion over where patients should go.

To resolve this, the practice decided to install LCD/plasma screens, manufactured by Jayex Technology Ltd. Three 32-inch screens were placed in its large main waiting area and one in a smaller waiting area upstairs. The LCD/plasma screens combine a patient calling system with a health information display facility for patients – displayed in colour and using pictures.

Using a computer interface, doctors can call patients directly from their rooms. The patient's name flashes up on the screens in the waiting rooms. The practice also makes use of the screens to communicate health messages to patients while they are waiting.

That includes information about flu vaccine or screening campaigns. Once they have received minimal training, reception staff can update the health information that goes on the screens.

Says IT Manager Steve Barlow: 'The more time the doctors spend on reading notes, writing letters or doing paperwork the better. This system saves them a lot of time. As well as being beneficial, the screens look professional and modern.'

Steve says patients and staff are overwhelmingly pleased with the screens.

Continued overleaf...

3.3 Electronic display systems

Case study

Victoria Medical Centre continued

Benefits

- LCD/plasma screens are more sophisticated than the cheaper LED variety, displaying information in colour and using pictures.
- Doctors can call patients electronically from their consulting room, allowing them to spend the minutes in between appointments preparing for the consultation or catching up on paperwork.
- Receptionists no longer have to struggle to pronounce difficult names or to be heard in a busy waiting room.
- The hard-of-hearing patients particularly benefit.
- There is no confusion about where patients need to be. This puts patients at ease and also reduces questions to receptionists.
- The practice can communicate key messages through the screens (see above).
- The screens give the surgery a more professional and modern feel.

Tips

- The initial investment is high, much greater than for an LED patient call system.
- Be prepared for some teething problems with the new technology.
- Note that reception staff and doctors will need some training in how to use the screens and the patient calling system.
- Older patients may initially be confused by the new patient calling system, so some prompting and promotion may be needed.
- Some patients may have concerns about confidentiality and may object to their names flashing across a screen. They can be called via the old system.
- Make sure you update the health information on a reasonably regular basis.

Contact

Steve Barlow
steve.barlow@nhs.net

3.3 Electronic display systems

Case study

Fernley Medical Centre

Fernley Medical Centre in Sparkhill, Birmingham, found that its 6,500 registered patients, particularly the hard-of-hearing, would often struggle to hear their names being called out for appointments in a busy waiting room.

The practice also wanted a more efficient way of communicating health information, promoting health campaigns and advertising specific clinics.

The practice installed Envisage, an advanced visual information system, in January 2007 under a pilot scheme and hasn't looked back. Envisage, manufactured by Egton and Numed, combines a patient calling system and an information service using modern LCD screens. Fernley installed two 32-inch screens, one at each end of its waiting room.

Doctors now call patients directly by pressing a button on their computers in their consulting rooms. The patient's name flashes up on the screens in the waiting room, along with the consulting room number. The message is repeated within a few seconds in case the patient misses it.

'Patients can see their names clearly,' says Practice Manager Nora Grosvenor. 'Deaf patients have benefited the most, as they no longer feel singled out – we used to have to go over and speak to them.'

Envisage comes with a media pack containing a selection of health messages that the practice can choose to broadcast. These range from smoking warnings and 5-A-DAY promotional adverts to messages about flu jabs and child vaccination campaigns. Practices can tailor these to their needs. They can also create their own messages using HTML, jpeg images or Microsoft PowerPoint slides.

In addition, the screens can display practical information about the surgery.

'When we extended our notice hours we could immediately let the patients know via the screens. We can also feed back our patients' survey results or if someone is blocking the doctors' car park in an emergency, we can put an urgent message on the screen,' explains Nora.

Envisage produces media pack updates every two months, ensuring practices have a fresh assortment of the latest national health topics and promotions.

Continued overleaf...

3.3 Electronic display systems

Case study

Fernley Medical Centre continued

Benefits

- The electronic patient calling system saves time for doctors and receptionists, allowing them to catch up on other duties.
- It spares embarrassment for deaf patients.
- The practice can broadcast key health messages, publicise practice information or advertise health campaigns.
- Patients are better informed about the practice's services.

Tips

- Be prepared for potential technological glitches, but remember that good support is available from Egton.
- The initial investment is high, so consider whether the screens will benefit your practice before installation.
- Visually-impaired patients will need to be called by traditional methods.
- The screens are not a substitute for producing written information for patients.

Contact

Nora Grosvenor, 0844 815 1135
nora.grosvenor@hobtpct.nhs.uk

3.3 Electronic display systems

Case study

Hamilton Practice

The Hamilton Practice in Harlow, Essex has some 9,500 patients. It found that it was losing valuable surgery time, adding up to hours over the week, because patients failed to hear their names being called out by the receptionist in a busy waiting room, or they couldn't find their way to the consulting room. Hard-of-hearing patients struggled in particular.

To deal with these issues, the practice decided to introduce an electronic patient calling system in 2003. Hamilton chose an LED screen manufactured by Jayex Technology Ltd. LED screens are cheaper than the more sophisticated LCD/plasma screens. They use red dot lettering on a black background and additional health alerts and messages can be programmed to flash across the bottom of the screen. Doctors, nurses and other health professionals control the screen from their consulting rooms, calling patients through their computers. The patient's name and the consulting room then flash across the LED screen, which is visible to all patients.

Receptionists no longer have to call out patients' names and are free to carry on with other duties, while the doctors save time between consultations. 'It was quite a big investment to consider at the time but we felt, on balance, that it would pay for itself in a few years. With the time it has saved – and time is money – it has obviously proved to be excellent value, and patient satisfaction has improved beyond measure,' says Practice Manager George Shields.

'A few minutes saved here or there makes an hour or two during the week for each doctor,' George adds. Only a small amount of initial training is required.

Benefits

- LED screens are more cost-effective than LCD/plasma screens.
- The system avoids problems of patients mishearing or not hearing their names or consulting room numbers.
- Receptionists do not have to struggle to pronounce difficult names.
- The system saves valuable minutes between consultations, adding up to several hours over the week, and therefore saves money.
- It frees up receptionists for other duties.
- The screen can be used to communicate important healthcare messages.
- It improves patient satisfaction.

Tips

- The initial investment is high.
- Practices may want to consider whether it would be more effective for them over the long term to install the more sophisticated LCD/plasma flat screens.
- The screens cannot carry coloured or complex messages like their LCD counterparts.
- Be prepared for a small amount of initial training for staff.
- A small number of patients may object to the screens because of confidentiality concerns and these patients may want to be called using the traditional method.

Contact

George Shields, 01279 645094
george.shields@nhs.net

3.3 Electronic display systems

Case study

Norbury Health Centre

Norbury Health Centre, a practice of some 9,000 patients in south east London, found that its old method of calling patients for appointments put pressure on reception staff. They had to call out the names of patients in a busy waiting room. It also wasted valuable surgery minutes, as doctors often had to go looking for their patients.

Practice Manager Rasikal Shah said some patients would accuse reception staff of favouritism, because of the order in which they called patients, sometimes leading to arguments.

That changed in 1999, when the practice decided to install an electronic patient calling system. This was an LED screen, manufactured by Jayex Technology Ltd.

The screen links to all the practice's computers and enables doctors to call in patients from their consulting room. The screen in the waiting room beeps, and the patient's name and allocated consulting room appear on it.

Mr Shah says the system has been well received by patients and staff.

'Calling patients directly saves a lot of time for the reception staff. This also gives doctors a bit of time to finish off paperwork or read through a patient's notes in between consultations. They know the patient will turn up at their door and that they don't need to go out and look for them,' he says.

The system also gives the surgery a much more professional feel and avoids problems of patients not hearing their name being called.

Norbury also uses the LED screens to publicise health campaigns or alerts, which scroll across the bottom of the screen. All of the practice's doctors, nurses and healthcare assistants and its midwife use the system.

Continued overleaf...

3.3 Electronic display systems

Case study

Norbury Health Centre continued

Benefits

- Doctors call patients directly from their consulting room, avoiding arguments between reception staff and patients.
- Doctors save time in between consultations, which they can spend on paperwork or reading a patient's history.
- Doctors, reception staff and patients have the peace of mind that patients will know when the doctor is ready to see them and will go to the correct consulting room.
- Reception staff can spend the time they would have spent calling patients on other tasks.
- The screens can be used for health alerts or to advise patients of specialist clinics or campaigns.

Tips

- Note that the initial cost is high.
- Allow a short period of time for staff to get used to operating the technology.
- Some patients may initially be concerned about their names appearing on a screen.
- Make sure the reception team and doctors have a drill and can immediately revert back to the old system, in case the screen breaks down during a busy surgery.

Contact

Rasikal Shah, 020 8679 6591

3.4 Waiting room health monitors and surgery pods

The time available during a clinical consultation must be divided between a number of tasks. Some can be delegated to members of the practice team other than GPs, for example collecting routine clinical information, conducting simple tests and updating patient records.

Many GP practices now share these tasks across practice nurses, healthcare assistants (HCAs) and administrative staff. This optimises GP time. This principle of delegation can be taken one logical step further – can patients be asked to complete some of these tasks for themselves?

Making a difference

Before investing in waiting room monitors, each practice should consider how it might integrate the system into their existing patient management processes.

In a sense it is no different from taking on an extra member of staff. It needs a room or space in which to operate, a private area with a desk where patients would feel comfortable taking clinical tests. The practice needs to work out which information, tests and data it will be set up to collect.

Both the practice clinical and administrative staff need to understand how using the 'pod' fits into the patient journey. Questions to consider include 'what type of patient and when?', followed by 'how many times might this happen?'

The answers will help to assess the likely benefit and return compared to the effort and investment required. At the end of this section there is an account of a practice that has realised significant and tangible benefits from using the technology.

How to make it happen

This section describes a series of practical steps for practices and discusses what is involved in each step:

- Agree the need.
- Assess practice compatibility.
- Obtain a quote.
- Make an investment decision.
- Design new processes.
- Install system.
- Embed new processes.
- Measure benefits.



3.4 Waiting room health monitors and surgery pods continued

Step-by-step guide

1. Agree the need

Practices will need to judge, or better still measure, how much consultation time might be saved by the system generating and collecting data. Similarly, they need to describe accurately its use in a screening or health management programme context. System manufacturers list a number of variables it can be used for: weight and body mass index (BMI), oxygen saturation, pulse, blood pressure, clinical questionnaires etc.

2. Assess practice compatibility

Practices should assess compatibility using three criteria: patients, staff and technical. The practice's existing clinical software system may not allow the 'pod' to write data directly into the electronic patient record. Practices should check this with the surgery pod manufacturer. Practices will know immediately if space can be found for such a system to work.

The practice team will sense whether their patients would find this acceptable and usable. If only a limited number of patients use the system or large numbers of patients need extensive help from staff, then potential benefits are reduced. In order to realise these benefits, an assessment also should be made of the staff's ability to change processes and working practices where necessary.

3. Obtain a quote

Contact a manufacturer and get a quote for providing the system and maintenance.

4. Make an investment decision

On the basis of the previous three steps the practice should make their investment decision.

Continued overleaf...

3.4 Waiting room health monitors and surgery pods continued

Step-by-step guide continued

5. Design new processes

Once the purchasing decision is made, work should start immediately (before delivery and installation), to design new practice processes. Staff should work out where and how the system will be used, the training which will be delivered that allows all staff to understand the system, and how to help patients use it. The practice will need to ensure that the system is checked regularly and that testing materials are disposed of. You might wish to consider writing these duties into a role or job description.

A key point in this design step is to ensure the system can completely replace current ways of working. Without 'complete replacement' a practice may run the risk of running multiple and potentially inefficient processes.

6. Install system

The system is delivered, installed and tested in accordance with the manufacturer's policy.

7. Embed new processes

Following staff training, the practice must maintain momentum. When staff are busy and under time pressure in a practice, there is a risk of reverting to 'the old system'. Extra effort will be needed to support staff so this does not happen and the new investment pays off.

8. Measure benefits

Revisit the original thinking in step 1 'Agree the need' and collect data with the system in place and operating steadily. Assess any effects on consultation time, the number of patients that have used the system, the amount of data that has been collected and the degree to which staff may have had to help the patients use the system. Review successes and plan any adjustment or extension to the system.

3.4 Waiting room health monitors and surgery pods Case study

Parkfield Medical Centre

The patient group at Parkfield Medical Centre in Potters Bar bought a stand-alone automatic blood pressure monitor with a tunnel cuff, made by PMS (Instruments) Ltd.

Installed in the waiting room behind a screen, its simple design makes it very easy for patients to use without supervision. Patients sit in a chair, put their arm into a hole in the machine and press a button. There's no need to put a cuff on, as the cuff is incorporated. The machine produces a printed reading, which can be added to the patient's records.

The practice has a higher-than-average elderly population and many patients have chronic health concerns. The blood pressure monitor is used regularly by patients seeking reassurance while they're making an appointment, collecting prescriptions or passing by. It's also used by those whose blood pressure is being monitored by doctors or nurses.

After patients have been shown how to use the machine once, they are able to do it again without help. The margin for error in the readings is minimal because if a patient uses the machine incorrectly, the blood pressure reading is noticeably inaccurate, and apparent to the medical professional adding it to the file.

The popularity of the monitor surprised practice staff. 'I thought it would sit in the corner unused, but people love it and it's used all the time,' says Practice Manager Brian Eastwood. 'I think people like the idea of doing something for themselves and no one has any problems using it, not even elderly people. It saves nursing time too, as we no longer have to dedicate resources to taking blood pressure.'

We are saving over four hours a week of healthcare assistant time, which can be used for other health promotion work.'

Benefits

- The automatic blood pressure monitor is convenient for patients who don't need to make an appointment to have their blood pressure checked.
- It saves nursing hours and appointment time.
- It encourages a spirit of self-care within the patient population, empowering people to take responsibility for their own health.

Tips

- Don't assume elderly patients will be put off by high-tech machines. They are just as likely to be confident using an automatic blood pressure monitor as younger people are.
- It's a good idea to draw up user protocols and advice for patients. Explain what the numbers in the readings mean for them.
- All practice staff, including receptionists, should be trained in how the machine works, so they can help patients using it for the first time.

Contact

Brian Eastwood, 0844 477 8640
brian.eastwood@gp-E82027.nhs.uk

3.4 Waiting room health monitors and surgery pods Case study

Dawlish Medical Group

The focus is on helping patients to keep well and look after themselves. Therefore, Dawlish Medical Group in Devon decided to install a freestanding machine for patients to test their blood pressure. This service is freely available. Patients who are passing can 'pop in' as part of their own self-care, or blood pressure readings can be taken before a consultation and the results reviewed.

The cost of the machine is around £2,000, but Dawlish's very active League of Friends funded the purchase. The machine is simple to use. It asks patients for their name, date of birth and information on whether they smoke or not.

The reading is immediate, and arrives on a slip of paper, but is also recorded so patient notes can be updated and GPs can be alerted to any problems.

The drawbacks of installing the machine included:

- abuse of the machine as it is housed in a public area;
- children keen to play around with it;
- high cost of maintenance;
- hygiene – there is a risk of cross-infection; and
- expense – the machine is an expensive item that must be used carefully to provide accurate readings.

Feedback from our patients is very positive, particularly as we have a high proportion of over 65s in our practice population. It's not an alternative to seeing a health professional, but it is a really effective add-on service. It underpins the Government's call to help individuals take responsibility for their own health.

Explains Practice Manager Janine Payne: 'It's a great service to offer our patients. It has very wide application from the 'worried well' who just want to check up on themselves, to people with known high blood pressure conditions. Equally, we have young women running out of the contraceptive pill who can take their blood pressure, and if they are within normal limits, we can give them a prescription for a month.'

Benefits

- Patients enjoy being able to take their own blood pressure.
- Results are fed into patient records.
- We can use it to provide emergency contraceptive pills.
- We are proactively promoting blood pressure monitoring.

Tips

- Look for a model with a wipe-clean arm band.
- Encourage patients to pop in and check their blood pressure regularly.
- Make sure the machine is sited where it can be supervised to reduce possible abuse by children and patients.

Contact

Janine Payne, 01626 884112

janine.payne@nhs.net

4.0 Telephony



4.1 Understanding your current telephone infrastructure

Your telephone system is often the first point of contact that a patient has with your practice. This system can enhance the patient journey or disrupt it.

Negative phone experiences include:

- getting an engaged tone frequently;
- a ringing phone that no one answers;
- going through to an answering machine rather than to practice staff; and
- a telephone system that has a complex variety of options (eg press 1 for X and press 2 for Y etc).

Your telephone system should be driven by your patients' needs. This section will enable you to:

- understand your current telephone system and help you to make a decision to invest in a new system or upgrade your existing one;
- research and identify the options and solutions that are available using your current set-up; and
- use all this knowledge to invest in the most appropriate system for your practice.

The majority of solutions in this section will be dependent upon your financial resources, which may limit your options.

There is a glossary at the end of the guide to help explain any technical terms there are used in this section.

By understanding how your current telephone infrastructure operates, you will be able to decide whether to upgrade or replace it.

Your current telephone infrastructure will include the following parts:

- the physical telephone system itself;
- equipment such as switchboard, telephone switch, private branch exchange (see glossary);
- the telephone and fax lines (analogue and digital); and
- advanced telephone infrastructures such as an internet broadband connection.

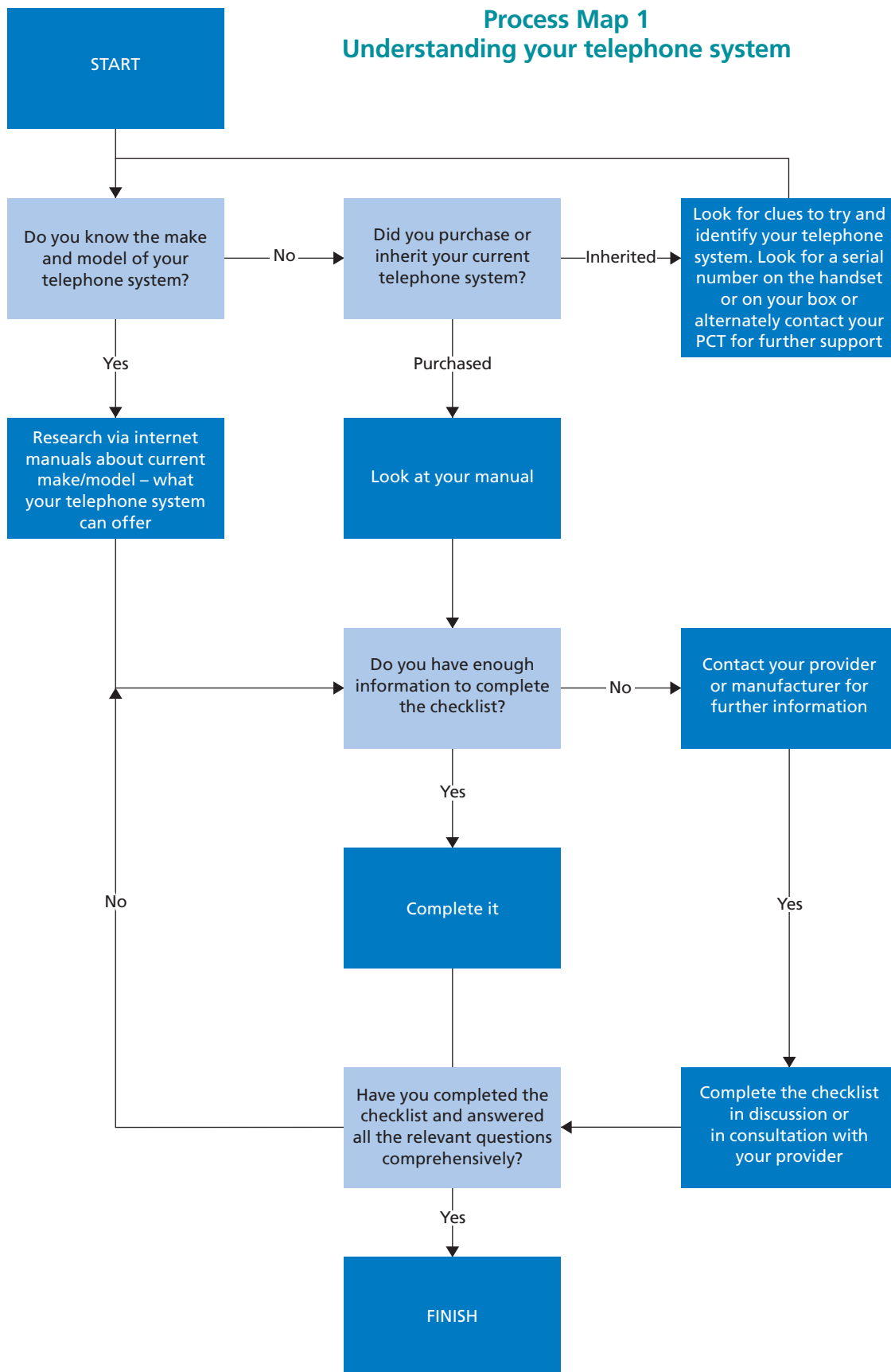
How to gain an understanding of your current telephone infrastructure

It's useful to break this task up into three parts:

- telephone system
- telephone and fax lines
- broadband.

On the following pages, you will find three process maps and corresponding checklists to work through. You may find it helpful to talk through some of the checklists with your current telephone supplier.

4.1 Understanding your current telephone infrastructure continued



4.1 Understanding your current telephone infrastructure continued

Checklist

Section 1 – Understanding your telephone system

The basics

YES / NO

1. Does your system have the capability to offer call transfers?
2. Does your system allow you to put callers on hold?
(a) If Yes, can you record information about the practice?
3. Does your system offer call waiting?
4. Does your system have the capability to store numbers in an internal phone directory?
5. Does your system offer voicemail answering machine?
(a) If Yes, can you record your own generic outgoing message as a practice?
(b) If Yes, can you record your own individual messages on separate extensions?
6. Can you purchase an add-on answering machine if your system does not offer this as an internal feature?
7. Does your system have the capability to provide an IVR (interactive voice response) as an add-on module or do you already have IVR?
8. Does your system have the capability to offer a variety of numbers/extensions that external callers can call directly (direct dialling inwards)?
9. Can you purchase Headsets (wired or wireless) for your current system?
10. Does your practice have a switchboard phone or master phone to transfer calls to others in the practice?
11. Do you have a current maintenance contract?
12. Have you considered adding an additional line to your telephone system?
(a) If Yes, then have you got enough members of staff to man the additional line(s)?

If you have answered NO to most of these, then you may need to consider investing in a new telephone system.

More advanced features

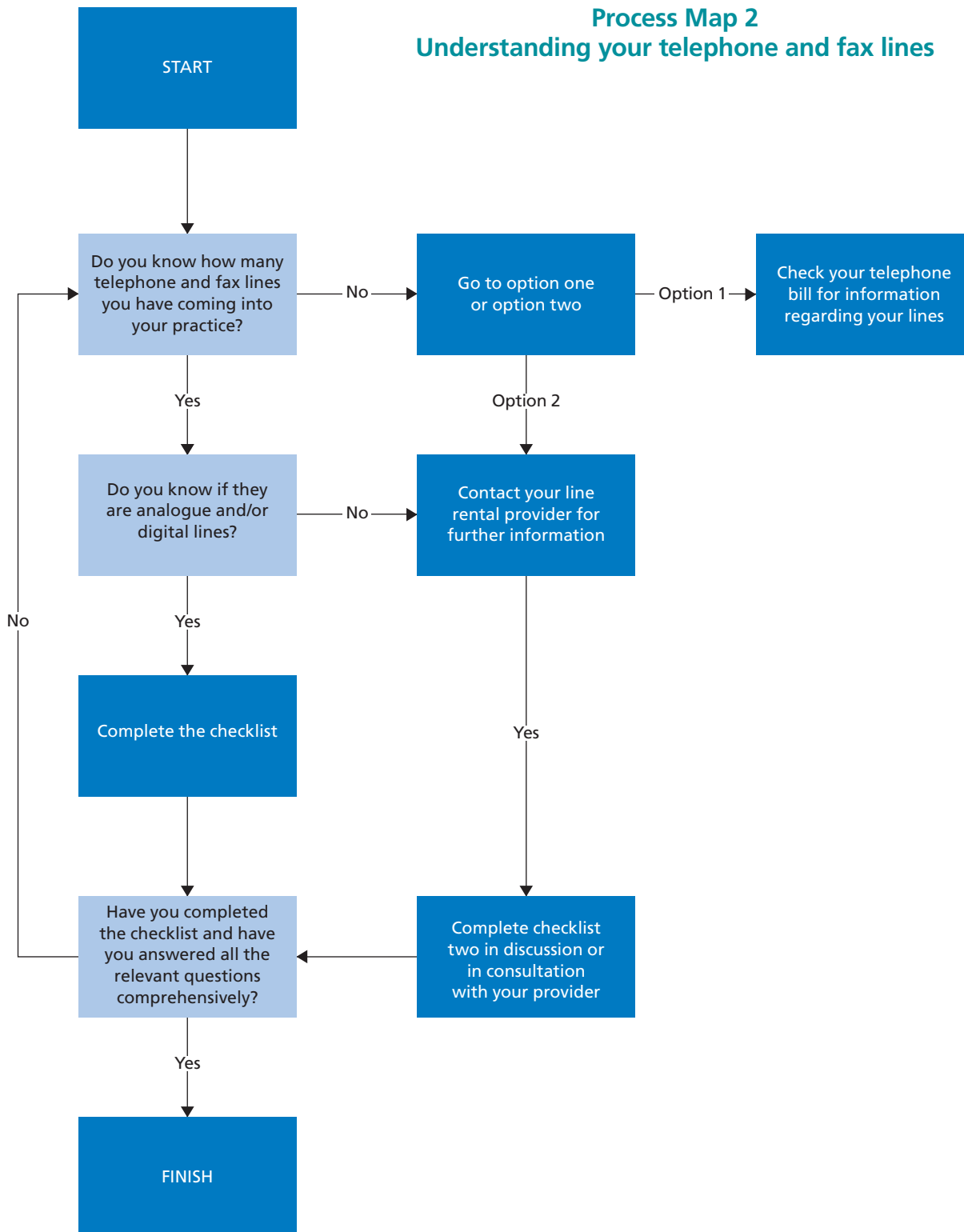
You may not need to answer the following to understand your current telephone system but answers to these questions could help you if you are looking at future innovative solutions.

13. Does your current system have the facility to offer caller line ID?
14. Does your current system have the capability to integrate data and voice?
15. Do you have several locations that will be using the same phone system?
16. Does your system have the capability to use Voice over IP as an overflow option?

(Please note: This means that your phone system can allow calls to come through via broadband at peak times when all telephone lines are being used – this will avoid engaged tones.)

4.1 Understanding your current telephone infrastructure continued

Process Map 2
Understanding your telephone and fax lines



4.1 Understanding your current telephone infrastructure continued

Checklist

Section 2 – Number of telephone lines

The facts

YES / NO

1. How many telephone lines do you have? _____

2. How many are analogue lines and how many are digital? _____

3. Do you have dedicated fax lines and how many do you have? _____

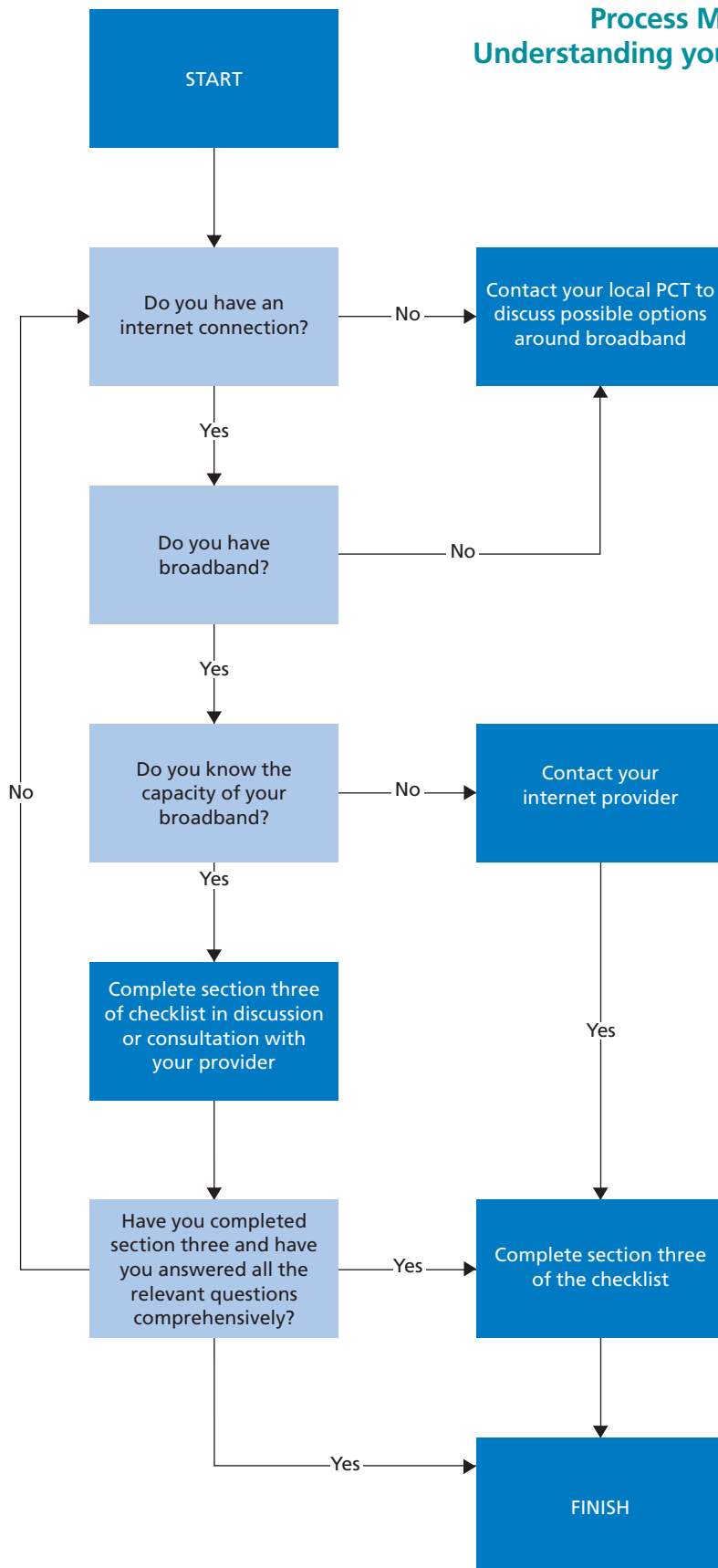
Future and demand proofing

4. Do staff ever have to wait to make an outgoing call because of the limited number of telephone lines (excluding dedicated fax lines) available to the practice?

5. Do you have enough staff to manage the number of telephones in your practice?

4.1 Understanding your current telephone infrastructure continued

Process Map 3
Understanding your broadband



4.1 Understanding your current telephone infrastructure continued

Checklist

Section 3 – Your internet connection for more advanced solutions

The facts

YES / NO

1. Do you have an internet connection?
2. What is the bandwidth for your internet connection? _____

Optional questions for more advanced innovative options or your practice

1. What is your IT Infrastructure and how is it managed? _____

2. Do you have a Wireless PC environment?
3. Do you have all the necessary wiring in place?
4. How difficult would it be to install additional wiring? _____

5. Do you have wire/ethernet and phone points in the desired locations?

4.2 Making a decision

Finances may determine whether you have the resources to invest in a new telephone system or upgrade your existing one.

If you're unsure, then consider the following:

- How much funding or capital investment do you have?
- Have you consulted your PCT on the financial resources available?
- Do you see yourself changing your telephone system in the next 12 months?

If you are considering replacing your telephone system within 12–24 months, you may want to consider small, cost-effective upgrades to your existing system.

Investing in the right system for your practice, now and in the future

If you decide to invest in a new telephone system, then consider your options before buying. Your PCT may be able to provide financial help. You will also need to consider staff training and possible disruptions to day-to-day operations during installation. Before making a purchase, you must consider patients' current and future needs. (See chapter 8, 'Patient engagement'.) A change management strategy may need to be developed and various consultations may be required. (See chapter 9, 'Change'.)

Your options

Choosing a new telephone system is a long-term investment. You will need to ensure that the system has spare capability, so it can expand with your practice. Find a supplier who can help you, but be aware of technical language and jargon. Don't be fooled into buying an overpriced, older system. Make sure that your supplier gives objective advice. Some may only describe a limited range of systems that are offered by their own companies.

Hosted telephone solutions

Hosted solutions work in a similar way to a telephone system that is based at your practice. However, the switch sits at a central location. In most cases, the telephone company owns and manages the equipment and then sell services to customers. A hosted solution comes with extremely flexible features. However, certain features may come with a minimum contract length. Lines will be provided as part of the package and you will be provided with telephones that suit your needs. In some cases, you can hire them as part of the ongoing monthly costs or buy them outright. For more information, look at the IP Centrex telephone solution further on in this chapter.

03 systems

Ofcom, the UK telecommunications regulator, has issued the 030 number ranges, eg 0300 and 0303, for public sector and not-for-profit organisations requiring a presence, but without callers incurring the additional charges associated with calling 08 numbers. Charges for calling 03 numbers are the same as for calling standard 01 and 02 numbers, even from a mobile where they are included in call plans and bundled minutes.

More and more suppliers are developing 03 systems. So do your research – look on the internet or contact your PCT. The Department of Health is currently considering the results of its consultation on the use of 084 numbers in the NHS. For more information check www.dh.gov.uk/en/Consultations/Liveconsultations/DH_091879

4.2 Making a decision continued

Tip

Invest the time and resources to get it right. Do your homework and understand exactly what you need. Understand the features that your telephone system needs to improve the patients' experience.

Tip

Take advantage of your existing assets. Consider what assets you already have. For example, telephones can be very expensive. You may want to buy a new system that uses your existing telephones.

Tip

Ask other practices. If you like the way a telephone system works at another practice, ask them what system they use and, if possible, how much it costs. Talk to other practices or contact your PCT to get a feel for pricing, suppliers and options.

Tip

Prioritise features. List what you want and create a checklist. This will help you to make the best decision. For example, do you need an auto attendant feature? Do you want to provide information when patients are on hold? Do you need to monitor telephone usage? What are your voicemail needs?

Tip

Don't under invest. You have decided to invest in a telephone system to improve your practice and your patients' experience. If the new telephone system is unfit for purpose, patients may get an inferior service.

Tip

Find a good supplier. You will usually need to consult and hire experts to install and program a telephone system, so finding a good telephone dealer is key. Always ask for references, and contact the supplier's other customers.

Tip

Beware of over-zealous sales people. Most salespeople will sell you the benefits of the system without fully explaining the cost of add-on modules. Make sure that you know what's included in the base price and agree terms before signing any agreement. (You may want to consult other practices or your PCT before signing.)

4.2 Making a decision continued

Tip

Consider VoIP telephone systems. Voice over Internet Protocol (VoIP) technology allows practices to place and receive calls using the internet. You shouldn't rely solely on VoIP solutions, because internet connections are not as reliable as telephone lines. However, VoIP solutions can be a perfect solution to managing peak demand, when your practice may require an extra line to deal with calls.

Tip

Consider voicemail compatibility. Ensure your telephone system can work with a wide range of third-party voicemail systems. This keeps your options open and minimises the chance of you getting stuck with an inferior or overpriced voicemail system.

Tip

More wires than needed. Telephone experts recommend doubling the number of wires for future proofing. If you need to install wires for the telephone system, consider adding more than you need. This will up the initial cost of installation, but may offer a huge future saving.

Tip

Consider financing options. Ask your supplier whether you can pay for your system over time. This can be a big benefit if cash is limited. But be warned that leasing costs can drastically increase the final price of your telephone system.



4.3 Wireless headsets

Wireless headsets are easy-to-use, hands-free accessories. They allow the user, for example the receptionist, to carry out a range of other duties without missing incoming phone calls.

Benefits

- Allows more calls to be answered over the course of the day.
- Compatible with most desk phones.
- Cost effective – increases productivity and allows receptionists to multitask.
- Reception staff are freed up while answering calls, and can move around the practice if necessary.
- Some models can also act as an intercom between staff at reception and clinicians in the consultation room.

Drawbacks

- Can cause discomfort if worn over long periods.
- Possible interference with other wireless systems.
- Staff may need training.

Costs

Costs vary depending on the quality of the unit. Some systems can cost around £200 for a cordless unit, remote handset lifter and compatible telephone.

Is this equipment right for my practice?

Consult first

Check with staff to see whether they would be happy to wear headsets. Contact your PCT to see if they are using similar systems or have funded their installation at another practice.

Check your telephone system

Check with your existing supplier whether:

- they offer any products; and
- the product you are considering is compatible with your telephone system.

Ensure value for money

Is this the most cost-effective solution for you? It could be cheaper to employ a member of staff to support the reception desk at peak times.

Monitor and evaluate

What do your staff think about their headsets? Have they been able to take more incoming calls?

Tip

A good quality unit incorporating noise cancelling can minimise background interference and is a sound investment.



4.4 Answering machines

Allowing callers to leave a message may relieve some of their frustration if they are unable to get through to the practice. It's no substitute for answering calls, but may help during peak periods.

Is this right for my practice?

Consult first

Before installing an answering machine, consider the following:

- What do your staff think of the idea?
- Do they understand the risks involved?
- Do they feel that the benefits outweigh the risks or vice versa?
- How would your patients feel about leaving messages? Why not discuss the idea with your Patient Participation Group?
- Are there other practices with answering machines that you could learn from?

Check your telephone system

Check with your existing supplier if you can add a voicemail service easily. If not, stand-alone units work with most telephone systems and may be easier to manage.

Set guidelines

Ensure that staff and patients are aware of the new system and understand the usage guidelines. You might want to encourage patients to leave messages only for things like repeat prescriptions, advance appointments or general enquiries. Messages should be checked frequently and dealt with quickly.

Benefits

- Missed calls are recorded during peak times.
- Patients don't have to keep redialling the practice.
- It can be a cost-effective, quick-fix solution.

Drawbacks

- Not suitable for all telephone systems or situations.
- Expense of voicemail cards for some telephone systems.
- Additional cabling may be required.
- Significant clinical risks if messages are not picked up and dealt with systematically.

Costs

Answering machines usually cost very little. You can run one through your existing system or buy a stand-alone unit.

4.5 Centrex

Centrex is a 'virtual' phone system providing a number of extensions. It is a 'hosted' service, which means that the physical equipment and technology is provided, run and maintained by a supplier company. If your practice is looking for a new system but cannot afford an initial outlay on services and hardware, Centrex is often a good solution.

Benefits

- Offers integrated facilities such as voicemail and call forwarding.
- No financial outlay is required for hardware such as telephones.
- As equipment is provided by a supplier, it can be easily updated as technology advances.
- Enhancements may be available to improve access for hard-to-reach groups.
- Enables extra lines to be added easily.

Drawbacks

- Managed by a third-party supplier – you have less control and there may be issues with service level agreements.
- Monthly fees are payable over a contracted period.
- New telephone handsets are required for the best use of the system (a supplier may hire these to you or they can be bought outright).
- There is a limitation on using alternative suppliers for lower call charges.

Costs

Line rental fees and one-off charges are applicable. Some start at around £17 a month with a connection charge of £25 (current prices for a five-year contract as at March 2009). Telephone handsets providing full functionality cost around £80 each.

4.6 IP Centrex

IP Centrex is a hosted 'virtual' telephone system service that is similar to a private branch exchange. Unlike traditional Centrex, this system uses a broadband internet connection. Before considering an IP Centrex system, it's advisable to conduct an audit of current and potential broadband availability together with your existing IT hardware.

Benefits

- Uses sophisticated telephone system facilities controlled locally via a PC interface.
- No financial outlay is required for telephone system hardware.
- As equipment is provided by a supplier, it can be easily updated as technology advances.
- Enhancements may be available to improve access for hard-to-reach groups.
- Potential reduction in call outgoing charges.
- Move/add/change costs for extra extensions may be reduced.

Drawbacks

- Monthly fees payable over a contracted period.
- Managed by a third-party supplier – you have less control and there may be issues with service level agreements.
- New telephone handsets are required for full functionality (a supplier may hire these to you or they can be bought outright).
- Monthly charges for diverted calls may become expensive.
- Relies on a broadband connection and reliable local IT hardware.
- Local area network cabling is required.

Costs

Some systems start at around £15 a month. There are no long-term contracts to sign and no capital investment in hardware is required. As incoming calls are diverted, extra charges may become expensive. 0800 or 0844 numbers may be required and consideration should be given to the potential extra cost to patients, as covered earlier on in the chapter.

4.7 Interactive Voice Response

Interactive Voice Response (IVR) allows callers to interact with the telephone system using the keypad or voice commands. This can help to direct the caller to the most appropriate person or department quickly and easily.

Benefits

- Can streamline receptionist function.
- May reduce staff costs.
- Allows patients to access or request information (such as repeat prescriptions) without speaking to staff.
- No financial outlay is required for telephone system hardware.
- Can provide patients with 24/7 access to information by using recorded messages.
- Can make focused announcements targeting hard-to-reach groups.

Drawbacks

- A change of telephone number will be required for hosted systems.
- Requires significant testing and piloting with patients – older people and people whose first language isn't English may experience difficulties.
- Some patients may prefer to speak to a receptionist.
- Careful planning of available options and continual monitoring of effectiveness are required.

IVR systems are ideal for busy surgeries, enabling staff to deal with patients while the telephone system takes care of incoming calls, directing them as necessary.

Your current telephone system may be capable of supporting IVR. In addition, some newer telephone systems already have an auto attendant option available where simple keypad presses can access system options, information and particular people or services. Ensure that a full audit of your system is carried out before entering into any agreement.

4.8 Overflow call handling

INNOVATION

This service activates when a patient can't get through to the practice and it is particularly useful during busy periods. It diverts calls to an answering service or call centre where call handlers identify which practice the call is coming from and handle it appropriately.

Benefits

- Incoming calls are always answered.
- Messages can be taken and forwarded to a nominated individual at the practice.
- Messages can be relayed verbally, via email or SMS. This enables the practice to take immediate action.
- Call handlers could be given access to the practice appointment system and book the patient in themselves. However, this would require strict guidelines and may undermine the role of the receptionist.

Drawbacks

- Monthly service charges based on price per call could be expensive.
- Patients who are sensitive about privacy may prefer to speak with someone at the practice.
- It is unknown whether call handling is being used by practices so many risks and issues cannot be identified.

Costs

Monthly service charges can be around £25, with each call handled costing around 85p. There may be additional costs for diverting calls.

4.9 Computer Telephony Integration

INNOVATION

Computer Telephony Integration (CTI) allows interactions on a telephone and computer to be integrated or co-ordinated. For example, when a patient calls, the computer system recognises the number and automatically brings up the patient's details.

Benefits

- Personalisation – receptionists can answer the telephone using the patient's name.
- Can save time accessing records and reduce telephone call time.

Drawbacks

- Telephone and GP systems may not currently be offering such services.
- Requires electronic patient details or records.

Further information

You will need to contact your GP system or telephone provider to see whether this functionality is being considered.

5.0 Ensuring a patient-focused service



5.1 Achieving patient-friendly services

Practices should respond to both the clinical and non-clinical needs of their patients. If you are welcoming and helpful, your patients will feel valued and your staff will experience greater job satisfaction. In addition, the general atmosphere in the practice will improve, making it a more appealing place to work and visit.

Benefits

- Friendly reception staff can help patients to maintain a positive frame of mind in a potentially stressful situation, thus improving their visit.
- By delivering a more personalised service, reception staff gain greater job satisfaction; this may help with staff retention.
- Good care also helps to retain patients. If your patients experience poor service, they may go elsewhere.

Drawbacks

- Reception staff are often overloaded with work: juggling the phones with checking people in, finding prescriptions and answering queries. Providing a personalised service may not seem like a priority.
- Some staff may resist efforts to update their skills or work in a different way.

Value for money

Improved, patient-focused services can be achieved without incurring any costs. However, some optional costs could include:

- training. Will external training be required?
- front-desk cover. If receptionists undertake training during practice hours, extra cover may be needed.

5.1 Achieving patient-friendly services

continued

Things to consider

Employ patient-focused staff

Staff in patient-facing positions should have certain key skills. Look for people who are proactive, patient and friendly. Employing staff that are reflective of the local community may also help in providing a more personalised patient experience.

Establish high standards of patient care

Identify examples of good service behaviour and include them in your protocols and policies. Set targets for your staff, monitor their performance and hold yourself and your team accountable. Winning staff support for any changes in advance will help with motivation.

Listen to patient feedback

Invite feedback from your patients and share it with staff in a positive and supportive manner. Encourage your team to remember the patients' perspective and take it into account when making decisions that will affect them.

Remove barriers to good service

The practice environment should always be as comfortable and attractive as possible. Your staff procedures and policies should be clear and any rules well explained. In a large practice, removing the incoming calls from the front desk will enable receptionists to focus on face-to-face contacts.

Reduce patient anxiety to increase satisfaction

Minimise your patients' anxiety by creating a welcoming and supportive environment. Ensure that all relevant information is clearly available and regularly look for ways to improve and personalise your services.

Help staff cope better with stress

If your staff are stressed, they will find it more difficult to be friendly and welcoming. Try to establish policies that enable them to recognise and deal with stress. Regular occupational health assessments may also help.

Always maintain the focus on service

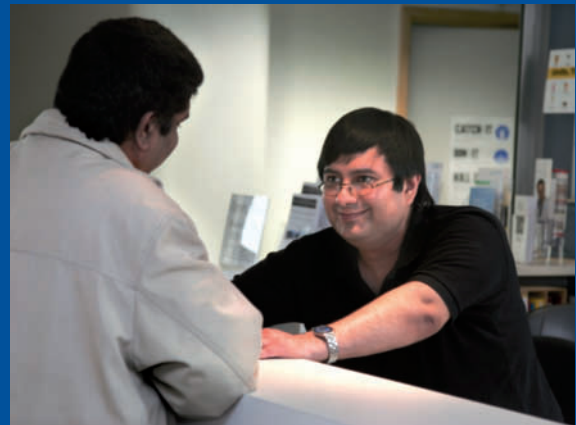
Staff meetings are a good opportunity to talk about the importance of providing personalised and patient-focused services. Encouraging members of staff to be service 'champions' or changing the title of some jobs to be more patient focused may help reinforce the message.

5.1 Achieving patient-friendly services

continued

Tips for customer-facing staff

- **Smile.** Remember to smile when dealing with patients, both in person and on the phone.
- **Be personal and proactive.** Try to use age-appropriate greetings when possible and always ask how you can help.
- **Stay visible.** Try to remain available at all times.
- **Be helpful.** Never say, 'I don't know' without adding, 'but I can find out for you'.
- **Prioritise.** A patient standing in front of you takes precedence over someone on the phone.
- **Be firm but fair.** Don't let patients monopolise your time if others are waiting.
- **Use the support available.** Call for back-up support if long queues are forming.
- **Stay alert.** Try to read body language so you can see if someone needs help.
- **Respect privacy.** Don't discuss patients or their treatment in front of other people.
- **Stay motivated.** Wherever possible, try to give people more than they expect.
- **Always be respectful.** All patients deserve attention, regardless of their age or appearance.



5.1 Achieving patient-friendly services

Case study

Chessel Practice

Patient surveys by the practice manager at Chessel Practice in Southampton revealed that some patients were unhappy with the level of service they were receiving from receptionists.

Practice Manager Vanessa Young wanted to offer reception staff external customer service training and decided that the National Vocational Qualification (NVQ) Level 2 in Customer Service would be a good starting point.

The training was delivered free of charge through the Government's Train to Gain programme. The participants were required to complete several modules, on topics such as 'giving a positive impression' and 'dealing with customers face to face'.

The workload consisted of independent study, carried out in the participants' own time, plus appraisal by a visiting assessor, who came to the practice to observe the participants and provide feedback on their assignments. The first three receptionists to complete the qualification were the longest serving and, initially, were extremely resistant to the idea. They even threatened to leave.

'We made a deal with them,' Vanessa explains. 'We said they had to start the course and if they then wanted to drop out, the practice would pay the £100 penalty fee for doing so. We also stressed that the practice would support them fully throughout the course, in whatever way it could.'

Once the first three participants had embarked on the qualification, resistance evaporated. The tasks were manageable and there were some unexpected positive experiences.

For instance, doctors and the practice manager were required to write 'witness statements' about the trainees, and the affirmative messages these contained made the receptionists feel valued. The first participants took three to four months to gain their NVQs. The remaining reception staff are being put through the programme in groups of two.

Benefits

- The attitude of the reception staff has improved.
- There have been no complaints from patients since the training started.
- The receptionists seem happier, which has had a knock-on, positive effect throughout the practice.

Tips

- Don't put more than two receptionists through the course at any one time, because you'll need to provide cover for them while they're training.
- Avoid starting the training at busy times of year, such as Christmas.
- Be sensitive about how you introduce the idea of taking this qualification, particularly with long-serving receptionists. To minimise resistance, gain support for the training before imposing it as mandatory.

Contact

Vanessa Young
vanessa.young@nhs.net

5.1 Achieving patient-friendly services

Case study

The Lighthouse Medical Practice

The Lighthouse Medical Practice in Eastbourne saw that entrenched cultural issues were getting in the way of customer service. Many patients expected to get what they wanted when they wanted it, whereas staff viewed patients as problems, rather than as customers who deserved good service.

Practice Manager Amanda Sayer, with her background in the retail sector, believed that truly engaging patients in managing the surgery would improve understanding on both sides. This would lead to a better customer experience. Setting up and then supporting a patient forum seemed a logical move.

Many patient forums are recruited somewhat haphazardly, through a poster on the waiting room notice board. By contrast, the recruitment of the Lighthouse patient forum members came after a painstaking planning process. Amanda used a 'service improvement grid' to outline the aims of the forum and the best way to recruit people, which included getting nominations from GPs and nurses.

From the beginning, the forum has embraced many of the projects designed to improve customer care. One of its first projects was to improve the waiting room environment. So far, it has changed the music, notice board, leaflet rack, magazines and chairs, with more changes on the way. The forum has been given a budget of £30,000, from freed-up commissioning resources, to spend on such improvements and on health promotion events.

'Working with the patients themselves makes a huge difference to customer service. We are dependent on each other for making the surgery tick over and we share everything with them,' says Amanda.

Another key improvement has been the forum's involvement in meeting and greeting in the surgery. Once a week, one member of the patient forum spends a day in the practice, helping patients with the touch screens and generally being helpful and welcoming. This makes the experience of visiting the surgery less stressful for many people.

Continued overleaf...

5.1 Achieving patient-friendly services

Case study

The Lighthouse Medical Practice continued

Benefits

- Members of the patient group are a presence in the surgery during the day, not just during evening meetings – which means that they are seen by other patients. This creates a sense of collaboration and promotes understanding between staff and patients.
- The patient group also provides front-line feedback to the practice on a formal and informal basis.

Tips

- When recruiting people for your patient group, plan the process carefully and research why some forums fail. This way, you are more likely to create a sustainable patient forum that can contribute actively to the life of the practice.
- Be open and honest and share as much as possible with the forum, to create a sense of 'all of us' rather than 'them and us'.
- As far as possible, support the forum members and devolve responsibility to them. They are an important part of the practice and can make a significant contribution to improving customer service.

Contact

Amanda Sayer
amanda.sayer@nhs.net

5.1 Achieving patient-friendly services

Case study

The Barton Surgery

The Barton Surgery is the only practice in the seaside town of Dawlish in Devon. It has ten doctors and 13,000 patients. During the holiday season, pressure mounts because the practice has to deal with more patients with fewer clinicians available.

When staff were under pressure, Practice Manager Janine Payne noticed that customer service levels slipped. Using her experience in the private sector, she began to focus on customer care during the practice's quarterly training sessions. These take place when the practice closes on Thursday afternoons to carry out staff training.

In these customer service sessions, staff discuss best practice in private sector customer care and talk about how it can be applied in the scenarios that they encounter every day.

Topics include:

- Don't use the phone when someone is waiting at the front desk.
- Always maintain eye contact.
- Try to make each person feel like they're the only person in the world.
- Don't judge anyone on their appearance.
- Maintain professionalism at all times.

The practice invited an expert to come and talk to staff about neuro-linguistic programming – turning questions around so that an obvious negative answer becomes positive.

This training helped staff to be more helpful for a while, but a lot of reiteration was needed to maintain service quality. For example, when there is high telephone volume first thing on Monday morning, it's harder to remember response approaches that might not come naturally.

So staff are given constant reminders. Staff meetings take place every two to three weeks, and the issue of customer care is raised in every meeting.

'We need to remember that our patients are our customers and they deserve the same good service they would expect in a local supermarket. It's about valuing and respecting each other, and it doesn't hurt to remind ourselves about that often,' says Janine.

Continued overleaf...

5.1 Achieving patient-friendly services

Case study

The Barton Surgery continued

Benefits

- Patients are more satisfied with the service they are getting.
- Receptionists are getting more job satisfaction.
- Teamwork has improved, taking the pressure off receptionists at busy times.

Contact

Janine Payne
Janine.payne@nhs.net

Tips

- Remember that nobody comes to work to do a bad job. If people are not giving good quality care, there's usually a reason for it.
- Analyse what is behind sub-standard care. Have staff taken on too much? Do they need more support? Do they need a break?
- At busy times, it's easy to forget about customer care. Emphasise the importance of quality care positively and regularly.

6.0 Understanding your community



6.1 Five steps to improve access for patients from black and minority ethnic groups

In 2001, the black and minority ethnic (BME) population was 4.6 million and this number is likely to have increased. The 2007 GP Patient Survey showed that some groups reported significantly less satisfaction with access to their local surgery. For example, Bangladeshi patients were 20% less happy with access than white patients.

Professor Mayur Lakhani's review into access to and responsiveness of primary care services for BME patients, *No patient left behind: how can we ensure world class primary care for black and ethnic minority people?*, outlines the need for a culturally sensitive primary care service. It focuses on delivering better health outcomes for all, through managing difference and providing personalised services that suit the needs of BME patients.

Here are five steps to help GP practices better meet the needs of BME communities. These changes reflect existing good practice in the NHS and can apply to all providers of primary care.

Making a difference

This short guide builds on Professor Lakhani's report. It outlines five simple steps to help GP practices better meet the needs of BME communities. They are a lever for improving access, patient experience, value and appropriateness of care. These changes are taken from existing good practice across the NHS and apply across all providers of primary care.

1. Know your patients

Monitoring ethnicity and preferred language, plus all other diversity pointers, is a good start. Data can be analysed to identify which are the main groups in the practice population.

Creating and maintaining a local database of patient ethnicity and preferred languages, and using this information when designing services, is vital if practices are to become responsive and address health inequalities.

Tip

Patient Participation Groups can play an important role in:

- identifying key local support groups;
- doing some of the background research for the practice; and
- supporting implementation of the changes that are necessary.

Helpful resources

1. *DES Guidance* – information from NHS Employers on rewarding practices for recording ethnicity and first language of patients on their practice list.
2. Ethnicity monitoring form, ethnicity and language categories and guidance produced by the Department of Health: *Practical guide to ethnic monitoring in the NHS and social care*.
3. *Ethnic Monitoring in General Practice* (a practical guide), produced by Race for Health.

6.1 Five steps to improve access for patients from black and minority ethnic groups

Case study

Good Hope Medical Practice, Scunthorpe, North Lincolnshire

The practice operates in a multi-ethnic community. But before monitoring of patient ethnicity and preferred language (patient profiling) was introduced, the practice didn't have the exact figures on patient ethnicity or preferred language. The practice was proactive and patient profiling was put in place well before the DES (Direct Enhanced Service) was introduced.

The practice collects data from more than the 50% of patients required, and now holds ethnicity data for more than 95% of all patients. The data is regularly reviewed and updated on a spreadsheet for analysis.

This information is also part of patient records. Patients' notes clearly state the person's preferred language and any associated adjustments required (eg an appointment with a Polish nurse) as well as their preferred communication method.

'It was easy to implement and brings many benefits. It did not cost us anything. On the contrary, we get funding as a part of our DES agreement. Ethnicity can be a key indicator of diabetes risks and of other health problems. If you don't know a patient's faith, that they are fasting during Ramadan, then your advice on medication might be affected. 'Did not attend' patients missing clinics might simply have misunderstood the invitation, because they don't understand English.'

Elaine Southern

Contact

Practice Manager Elaine Southern
elaine.southern@nlpct.nhs.uk

Benefits

Introducing patient profiling helped the practice to:

- identify who is currently using the service and whether those services are accessible for patients from BME groups;
- identify services that patients may require help with during a consultation;
- segment the practice population based on need and design clinics around this;
- check whether any of the groups are over or under represented within any aspect of their work;
- identify any patterns of illness and specific needs within particular groups;
- deliver personalised care through using the information as a part of patient records;
- gain financial benefits in the form of DES payments and reduced DNAs.

6.1 Five steps to improve access for patients from black and minority ethnic groups

continued

2. Improving communication

Good communication between BME patients, healthcare professionals and service providers is vital in improving access to primary care. This does not necessarily mean paying for expensive translation services. Good practice shows that one can use resources that are readily available in the community, such as collaboration and sharing resources with local councils, bilingual staff and telephonic interpreting where appropriate. Improving communication can be as easy as researching where local English for speakers of other languages (ESOL) classes are held and directing patients to these.

Top ten tips to improve communication

1. The **Multikulti** www.multikulti.org.uk website provides accessible, accurately translated advice and information in community languages. It includes information on how to register with a GP, NHS primary care and provisions to complement GP services.
2. A wide range of information on some of the most common diseases is often translated into the main community languages. These resources are easy to download or print, or can be ordered. **Diabetes UK** www.diabetes.org.uk has developed a toolkit to enable community and religious leaders to host diabetes awareness sessions for people from the South Asian communities. It includes a handbook, a presentation on understanding diabetes and food, and speaker notes. **Alzheimer's Society** and **Asthma UK** www.asthma.org.uk also have a range of information translated into various languages.
3. **NHS Direct** www.nhsdirect.nhs.uk provides a confidential interpreter service in various languages. To use the interpreter service, call NHS Direct on 0845 4647.
4. **Language Line** works with organisations to provide a 24-hour telephone interpreting service that connects you to a qualified interpreter in less than a minute. This is cheaper than face-to-face interpreting and is easily accessible. **SignTranslate** www.signtranslate.com is an internet-based translation program that converts English to British Sign Language (BSL) and can also be used for 12 foreign languages.
5. Websites can be translated using translating software. (Please note that the translation service may not provide a perfect representation of the English text.)
6. It's possible to recruit a bilingual worker if there's a 'genuine occupational requirement'. For example, it would be a genuine occupational requirement to employ an individual to provide services to people from a particular racial group, defined by nationality or language, which only a bilingual person could do effectively.
7. Information about local **ESOL** classes can be found at www.direct.gov.uk and researched by your area or postcode.
8. Information on **NHS Choices** is provided in 12 community languages www.nhs.uk.
9. Language cards with the phrase 'I speak ...' contain both the translation and the English text sitting side by side on a poster and are a simple way for patients from non-English-speaking communities to indicate their language.
10. Multi-lingual appointment card – www.communicate-health.org.uk – enables users to type in details of an appointment in English and translate the text accurately into community languages.

6.1 Five steps to improve access for patients from black and minority ethnic groups

continued

3. Involve and engage BME communities

Evidence suggests that strong partnerships and links between healthcare providers and community groups can greatly improve access to primary care for BME groups. An effective local healthcare system should be designed to meet the needs of BME communities. As a part of their legal duty to promote race equality, PCTs need to consider BME issues when commissioning and developing new services. Involvement and engagement in the design of services, as a part of a wider strategy concerning increased patient autonomy and patient-centred decision-making, is needed in order to enable continuous improvement across the whole community.

Helpful resources

- 1. Race for Health**
www.raceequalityfoundation.org.uk is a programme that supports PCTs around the country working in partnership with local BME communities.
- 2. The Improvement Foundation**
www.improvementfoundation.org works with PCTs and practices and runs a health improvement programme. It also offers tailored support on improving access and responsiveness in BME communities.
- 3. Social Action for Health** www.safh.org.uk developed a cutting-edge education and development programme for training health guides across East London.
- 4. The Race for Health guide**
www.raceforhealth.org and good practice resource for commissioning on how to close the health inequalities gap for BME groups provides useful information for anyone involved in commissioning.

- 5. A Dialogue of Equals** www.dh.gov.uk is a guide written to support NHS organisations to better engage with seldom-heard communities and groups.

Tips

- **Black Heath Agency – ‘How the NHS works’ DVD**

This short DVD on how to use the NHS gives simple messages about registering with a GP, making an appointment and asking for an interpreter. It is in English with voice-overs in main community languages. It is a good example of improving both engagement with patients and health literacy. It can be played in waiting rooms as part of an information package.

- **Local BME community groups**

PCTs and practices that have good links with local communities maintain a local database or directory. This includes voluntary organisations and community groups, local media contacts, newspapers and newsletters, other equalities specialists and networks (age, disability and lesbian, gay, bisexual and transgender (LGBT) organisations), as well as members of Local Involvement Networks (LINKs).

- A database can be created simply by searching for the term ‘community groups’ on the internet or by looking them up on www.upmystreet.com.

6.1 Five steps to improve access for patients from black and minority ethnic groups

continued

4. Raise awareness

Training can be effective in improving engagement between patients and GP practices. Front-line staff and receptionists are key to patient access and it helps to have knowledge and awareness of issues that affect BME patients when accessing primary care services. Developing receptionist/navigator skills among staff and training front-line staff in cultural capability are effective ways to better guide patients through primary care and offer culturally sensitive services.

Helpful resources

1. **Transcultural Health Care Practice** www.rcn.org.uk produced by the Royal College of Nursing is an educational resource for nurses and health practitioners.
2. **NHS library resources** www.library.nhs.uk on ethnicity and health aim to select the best available evidence about the management of healthcare services and specific needs for migrant and BME groups.
3. **The Race Equality Foundation** www.raceequalityfoundation.org.uk promotes race equality in health, social care and other services. The foundation has developed a series of briefing papers (*Better Health Briefings*) and training workshops on health issues affecting BME patients.

Tip

Speak to local BME groups, along with BME patients and staff members. Staff awareness needs to be raised and staff must be able to learn from those who they work with day to day.

5. Reflective workforce

Given that all health organisations run people-to-people services, the quality of staff that GP practices employ is of paramount importance. There is no compromise on the overriding objective of employing and developing the best talent available. However, this means using the local talent pool as well. It is important that careers in local health services are accessible and attractive to suitably skilled local people. Any good recruitment strategy must rely on having a reputable presence in the local community. In the internet age, however, this historically important area often remains overlooked.

Helpful resources

1. **NHS Employers** www.nhsemployers.org represents trusts in England on workforce issues and helps employers to ensure that the NHS is a place where people want to work.
2. **The NHS Institute's Breaking Through programme** <http://www.institute.nhs.uk> is aimed at identifying, developing and positioning talented managers from a BME background into director-level opportunities.
3. **Race for Opportunity** www.bitc.org.uk is committed to improving employment opportunities for BME groups across the UK.

6.2 Improving the experience of people with hearing loss



The experiences of people with hearing loss using primary care services often include frustration, confusion and, critically, some patient safety issues. Practical solutions exist that are simple to implement for little or no cost. The focus of the solutions is on awareness and practice process change. It is supplemented with a simple but powerful IT-based communication tool which is available free to GPs.

The challenge

There are about 9 million people with hearing loss in the UK – this is one in seven of the population. On an average day in the consulting room, a GP will see several of these people as patients.¹ In the same day, the reception team in an average-sized practice will have managed 40 to 50 interactions with people with hearing loss. The experiences of these patients have been captured² and make for challenging reading.

Here are some examples from some recent research undertaken by SignHealth:

- **Of the clinical consultation** – patients leaving the surgery with no idea what is wrong with them and others leaving the surgery with little or no understanding of their medication and then taking the wrong amount.
- **Of the appointment and reception systems** – difficulty or even inability to get an appointment by telephone. Some patients suffering stress, embarrassment and missed appointments, partly due to waiting rooms operating 'listen for your name' systems.

The Disability Discrimination Act requires that practices make reasonable adjustments for patients with hearing loss. The definition of 'reasonable adjustment' involves a consideration of whether it would be impossible or unreasonably difficult for a person with hearing loss to use your practice without the adjustments. These adjustments can include the way in which you provide your service, but they don't have to be expensive. Making reasonable adjustments can help your patients, and save everyone time and money that could be used for patient care.

¹ Royal National Institute for Deaf People (RNID) (2004), *GP guidance for deaf patients*

² SignHealth (February 2009), *Deaf and disabled people's experience of primary care*



6.2 Improving the experience of people with hearing loss continued

Here are five solutions that are simple to implement for little or no cost.

1. Appointment booking

There are three potential ways to improve the appointment booking experience for people with hearing loss: maximising the potential of existing landline telecoms, harnessing mobile telecoms and implementing an online capability.

Maximise the potential of existing landline telecoms

Make sure practice staff are aware of Text Relay. This service allows communication between textphones and telephones. Text Relay is a national telephone relay service, letting deaf and hard of hearing people use a textphone to access any services that are available on standard telephone systems. A practice does not need any new or special equipment to use Text Relay. The link between the patient and the practice is a highly trained Text Relay operator, who provides a discreet and confidential service.

How it works

The patient dials 18001 followed by the full practice telephone number from their textphone.

When the call is answered by the surgery, a Text Relay operator is brought into the call.

The patient types a message from their keyboard and the operator reads it word for word to the practice staff.

The practice staff then verbally respond, and the Text Relay operator types exactly what is said so that the patient can read the conversation on their textphone display panel.

Text Relay is a national service and operates 24/7. Practice staff can also use Text Relay to contact a patient by dialling 18002, followed by the patient's contact number.

What does it cost?

For outgoing calls from the practice to a UK landline or UK mobile number, the call should cost you no more per minute via Text Relay than it would for a voice telephone call – although it may take longer. Because calls from a textphone can take longer, some telecommunications providers offer a refund on textphone calls.

Continued overleaf...

6.2 Improving the experience of people with hearing loss continued

Training

Practice staff need to know how to answer and make calls using Text Relay. Everyone who might answer a telephone in the practice should be able to recognise an incoming call from a patient using Text Relay.

Surveys show that this is not always the case in a busy practice with multitasking staff. A quick solution may be to ensure that every staff member knows that when a call is received from an automated voice, 'Please hold for an operator-assisted call from a textphone user', they should pause to allow the connection to be made and the relaying of the patient's words. Practices will need to think about how any out-of-hours services need to be briefed in order to take Text Relay calls. However, practices should bear in mind that automated telephone systems can be problematic for deaf and hard of hearing people. These systems cannot be accessed easily using Text Relay, particular where the different options are read out quickly.

Surgeries should take into account the fact that it will take longer for a Text Relay call to be connected. For example, many surgeries offer a same-day appointment if you make contact at a particular time in the morning. Phone lines are often very busy at these times and require the patient to redial many times – something that places patients using Text Relay at a disadvantage. Therefore, surgeries might consider offering a bespoke telephone or minicom number offering direct access to deaf patients.

Full instructions for Text Relay are available at: www.textrelay.org/files/Typetalkleafletv7.pdf

Harnessing mobile telecoms

Patients with hearing loss can use text messaging (SMS messaging) to book appointments. It is a relatively inexpensive option to set up, but careful consideration is needed to ensure that processes, roles and responsibilities in the practice are agreed and communicated. The key tasks for a practice are to:

- dedicate a phone number to receive the messages and publicise it to patients;
- secure the equipment or applications to receive the messages and ensure reasonable visibility if the equipment is shared with other tasks. A PC or terminal in the reception area is ideal. Suitable applications are available free from many of the usual mobile contract providers; and
- ensure practice staff know how to receive and send messages, and whose job it is to check for incoming messages on a regular basis.

Implementing an online capability

Providing an online capability need not be as complicated as providing real-time access to the live appointments database, with all the potential issues around security and interfaces to the clinical system. A simple email account, set up to receive emails from patients, may be a good compromise between increasing access for patients and increasing complexity for practice staff. As with SMS, the technology exists and is inexpensive.

However, a practice would need to think carefully about confidentiality and data security issues before setting up an email facility. Just as with SMS messaging, the practice would need to address new processes, roles and responsibilities. (See section 2.2 Internet appointment booking for more details.)

Continued overleaf...

6.2 Improving the experience of people with hearing loss continued

2. Increase staff awareness

All front-line staff members should have basic deaf awareness training, but preferably the whole team should be involved. In order to maximise efficiency, practices can get together locally and arrange a single training session for staff from each surgery. There are a number of charity and third sector organisations that provide this sort of training.

Tips for communicating with deaf or hard of hearing patients

- Eye contact matters. Make sure patients can see your face before you speak.
- Speak clearly but not too slowly.
- Don't shout. It distorts your lip patterns and can look aggressive.
- Check the patient has understood you and take the time to clarify details if necessary.
- Don't keep repeating yourself. If the patient can't follow what you've said, try saying it in a different way.
- Write things down if necessary – use plain English and clear handwriting.
- If you're talking to a deaf person and a hearing person, don't just focus on the hearing person.

3. The waiting area

Practices should consider fitting an induction loop in their reception areas. Ensure that the logo informing patients that the loop is fitted is easily visible and has not been covered with notices and stickers.

The loop should be tested and maintained on a monthly basis. The responsibility for this should be agreed and communicated between staff, and a record should be kept of each time the loop is tested. In addition, a sign should be displayed encouraging patients to report if the loop is not working.

The ambient noise level in a waiting area is often low; by contrast the reception area is often very busy with telephone calls and multiple conversations taking place. The need for the practice team to demonstrate deaf awareness can be appreciated by anyone by standing in the quiet of the waiting area for a few minutes and then walking up to the busy reception desk.

All practice staff should make an arrangement with a deaf or hard of hearing patient, when they first check in, how they will notify them when it is their turn to see a doctor or nurse. The traditional system of calling out patient's names is clearly limited.

Practice staff should be helped to realise that it takes no more than a few seconds to walk out into the waiting area and make direct eye contact with the appropriate patient. Patients with hearing loss worry about missing their turn and can find sitting in the waiting area very stressful. The practice team can really improve the patient experience by demonstrating their deaf awareness through their actions.

Continued overleaf...

6.2 Improving the experience of people with hearing loss continued

Some practices have visual systems to indicate the 'next patient' message. These can range from sophisticated screens linked with the reception system to simple pegboards with numbered and coloured tags. If a practice is considering changing their system, some thought should be given to how it will be used by patients with hearing loss.

Although it might be tempting to believe that a visual system caters completely for the needs of those with hearing loss, feedback suggests that this is not the whole picture. The patient needs a visual signal to tell them to 'go to a consulting room now' and not just 'it's your turn next'. Patients with hearing loss report that they tend to watch these systems intently, determined not to miss their turn or avoid an embarrassing situation. But they often miss the 'your turn now' signal. If the receptionist confirms with the patient when they first check in that 'someone will come and tell you when it's time', then the patient can avoid a stressful wait, staring at the visual system for what might feel like a long time.

Alternatively, deaf patients could be issued with an alerter system on arrival. This would be linked to the visual system and would vibrate each time a name appeared on the system, letting the patient know when it is their turn to go into the consulting room.

4. Communication support

Practices will be used to providing communication support, such as sign language interpreters, under local arrangements. Where possible, practices should use a qualified language service professional. However, these arrangements can be challenged by availability, especially at short notice. An alternative might be to use SignTranslate:

- SignTranslate is an internet-based translation program that converts English to BSL and also can be used for 12 foreign spoken languages.
- The program is free of charge for all GPs in England, currently until the end of July 2009.
- SignTranslate is already used in the NHS by doctors who need to be absolutely sure that their diagnosis and prescriptions are properly understood.
- The program can be accessed through any internet browser.
- It is also accessible directly from internet links within EMIS practice systems.

As long as a patient can see the screen in the consulting room, the clinician can click on context sensitive questions that are provided on screen. They are translated instantly to BSL. It is fast, robust and very cost effective. Clinicians would need to spend only a little time becoming familiar with the on-screen layout before using the system with patients. Practices will need to evaluate if SignTranslate would add to their communication support options. A good place to start is the demonstration area of SignTranslate at: www.signhealth.net/login2.asp

Continued overleaf...

6.2 Improving the experience of people with hearing loss continued

5. Deliver a personalised experience

In order to deliver a personalised experience for patients with hearing loss, a patient's written and electronic notes should clearly record the person's disability. The notes should also record any associated adjustments required and the patient's preferred communication method.

For this information to be of value in improving the patient experience, it should be accessible in such a way that it does not have to be 're-discovered' each time the patient contacts the practice.

Key resources

RNID GP resources:

www.rnid.org.uk/information_resources/information_for_health_professionals/

Text Relay information:

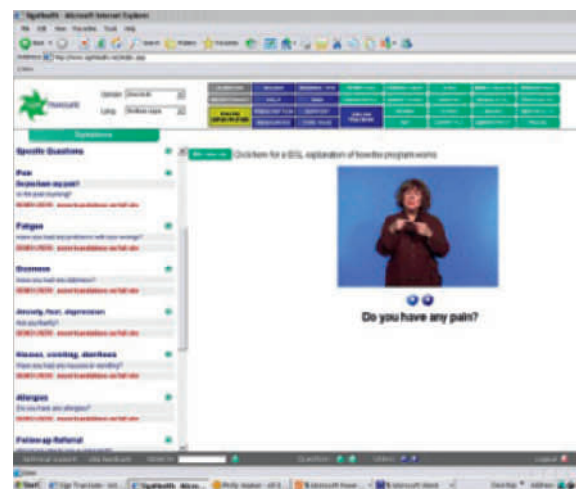
www.textrelay.org

RNID deaf awareness training:

Email: training.services@rnid.org.uk

SignTranslate information:

www.signtranslate.com/freegp.php?page=freegp



6.2 Improving the experience of people with hearing loss Case study

Greystone House Surgery

At the Greystone House Surgery in Surrey, doctors struggled to communicate with deaf patients and with people whose first language wasn't English.

Deaf patients would have to book an interpreter for their appointments, giving three weeks' advance notice. In order to communicate with patients who did not speak or understand English, doctors would have to use an expensive telephone translation service.

So it was no surprise that Dr Joe McGilligan jumped at the chance in 2008 to try SignTranslate, an internet-based translation program that converts English to BSL and 12 foreign spoken languages.

SignTranslate is partnered with EMIS and is provided free by SignHealth, a healthcare charity for deaf people. There is a link to SignTranslate within Emis, and practices with different clinical systems can access it via the internet at: www.signtranslate.com.

To use the service, practices just enter their NHS practice codes.

Once logged in, doctors see a set of pre-defined medical questions. The doctor clicks on a question and a BSL video clip is produced for the deaf patient. The patient can then respond with 'yes' or 'no' answers, or can point to icons on the screen to ask his or her own questions.

For non-English speakers, the question appears on the screen translated into their language, and it can also be spoken out by the computer to help illiterate patients.

SignTranslate was trialled in 2008 at 20 practices in a commissioning group that Joe chairs and was well received by all.

'Everyone thinks it's fantastic,' says Joe. 'Patients don't have to book three weeks in advance. They can ask a question and they don't need an interpreter there, so they don't have to share their personal details with someone other than the doctor, as used to be the case.'

SignHealth also offers a live webcam link to a sign language interpreter, for a charge of £2.50 per minute for a minimum of ten minutes. This requires a software download from the internet.

Continued overleaf...

6.2 Improving the experience of people with hearing loss Case study

Greystone House Surgery continued

Benefits

- Deaf patients and patients who don't speak English don't have to book appointments weeks in advance.
- SignTranslate spares patients the embarrassment of having to share their personal details with a third person.
- Using the free service saves on interpreters and telephone interpretation.
- Patients can understand the diagnosis better than they would without any kind of interpretation, reducing the need for repeat appointments and thus saving time and money.
- The system improves communication between doctors and patients.
- SignTranslate reduces health inequalities.

Tips

- It initially takes time to get used to the system and to master the various icons and questions.
- SignTranslate is not a substitute for an interpreter. There may be times when the presence of an interpreter is essential, and deaf patients or patients who do not speak English should always have the option of booking a live interpreter.

Contact

Joe McGilligan

joe.mcgilligan@gp-h81030.nhs.uk

6.3 Improving the experience of people with sight loss



An average practice will have around 150–200 patients with significant sight loss. Service improvement needs for patients with sight loss have been consistently identified in the UK. There are simple practical approaches to improving the experience of these patients, many focused on staff awareness and the patient journey. This section should be read together with section 6.2 ‘Improving the experience of people with hearing loss’ since many of the issues, tips and suggested improvements apply across both groups.

The challenge

GP practices are providing primary care services for 309,300 blind and partially sighted patients.³ If we include patients with significant sight loss, this number increases towards 2 million.⁴

The needs of patients with sight loss have been identified through several surveys and studies conducted in a range of general practices across the UK.^{5,6} The two surveys referenced in this guide were made in 2005 and 2009, four years apart – and with exactly the same issues identified in each. Clearly, there is still scope for improvement. There are some simple and very low-cost approaches that a practice can consider in order to deliver worthwhile improvement in patient experience.

Making a difference

There is a great consistency in the messages and conclusions of patient surveys. In the context of this guide, they indicate three areas of opportunity to improve the patient experience:

- improving the experience of attending the practice
- improving the experience of the consultation
- needs of the patient with sight loss outside the consulting room.

These improvement needs are from the perspective of the patient with sight loss. Practices will want to re-frame these improvement needs in order to plan and take practical steps towards addressing them. This re-framing process translates these three areas for improvement into four areas of potential activity through which practices may deliver the improvement:

- staff awareness
- information and communication
- physical environment
- using information to deliver a personalised experience.

³ NHS Information Centre, *People Registered as Blind and Partially Sighted 2008 England*

⁴ R. Tate et al *The prevalence of visual impairment in the UK* (2005), London School of Hygiene and Tropical Medicine

⁵ GP Access and Responsiveness Project for Severely Sight Impaired and Sight Impaired People (2009), Action for Blind People

⁶ *Enhancing Care Provision for Blind and Partially Sighted people in GP surgeries* (2005), The Guide Dogs for the Blind Association

6.3 Improving the experience of people with sight loss continued

The Disability Discrimination Act requires that practices make reasonable adjustments for patients with sight loss. The definition of 'reasonable adjustment' is arrived through a consideration of whether it would be impossible or unreasonably difficult for a person with sight loss to use your practice without the adjustments. These adjustments can include the way you provide your service but they don't have to be expensive. Making reasonable adjustments can help your patients, and save everyone time and money that could be used for patient care.

How to make it happen

In this section are practical suggestions in the four activity areas through which practices may deliver improvement:

- staff awareness
- information and communication
- physical environment
- using information to deliver a personalised experience.

1. Staff awareness

Patients with sight pick up information as soon as they walk into a practice by reading signs and name badges. They observe the behaviour and context of staff and other patients.

Practice staff may become accustomed to this situation being 'normal' and may benefit from sight loss awareness training. This will enable them to work out how their practice needs to operate, and what their own behaviours need to be, in order to improve the experience of patients with sight loss.

Receptionists, healthcare professionals and other staff should introduce themselves by name and the position they hold in the practice. They should also talk through the procedure that they are conducting or about to conduct, even if they are just looking for notes or telephoning through to a consulting room. A 'commentary' on what is happening really helps a patient with sight loss.

An added benefit of awareness training is the potential for practice staff to understand how simple changes to the operational environment and process may greatly improve the patient experience. For example, if a sight loss patient needs to fill out paperwork it is usual for reception staff to help them. They should be given privacy and not be asked to verbally provide personal or medically confidential information at the reception desk.

The reception staff might feel that the reception area is appropriate if they can see that it is separate from the waiting area and there are no more patients waiting. However, the sight loss patient may lack the comfort that this visual information provides. A move to a more private area tells the patient that the receptionist understands the patient's needs and is acting accordingly.

Practice staff should be trained in sighted guide techniques, such as offering their arm to safely guide the patient to a seat or other destination. When guiding a patient to a waiting area, staff should never back a patient into a seat, but always guide them to it and describe it to them. This means telling them if it is a dining chair, low sofa or an office chair for example. Staff should understand how to seek verbal permission before touching a blind person, to avoid alarming them by touching them unexpectedly.

6.3 Improving the experience of people with sight loss continued

Awareness training is available from a number of national and local organisations. Several of the national organisations are listed at the end of this section. Practices should consider combining awareness training for patients with sight loss with that for hearing loss patients. Many of the issues are similar, and combining the approaches offers improvement to an even wider patient group as well as making better use of staff training time.

2. Information and communication

For a sighted person, a general practice may appear to be overloaded with information: notices and posters, leaflets and booklets; sometimes even touch screens and video information screens in waiting areas. Very little of this material is of use to a patient with sight loss. Practices should consider conducting a simple audit of their material to see what they have available for patients with sight loss. Many of the organisations currently providing practices with information will have suitable formats for sight loss patients available. Practices need to take time to identify what is needed and request it.

A sight loss patient may have little access to information about a prescription they have received in a practice. When they take the prescription to a pharmacy, the standard patient information leaflet in the pack may be of little use. Practice staff should be aware that the Royal National Institute of Blind People (RNIB) operates a freephone Medicines Information Line. By calling the Medicines Information Line, the practice can request patient information leaflets in large/clear print, in Braille or on audio CD. Any member of the practice can make this call for the patient – the number is 0800 198 5000.

3. Physical environment

Patients with sight loss are continually faced with issues relating to access to the physical and social environment. Some practices are located in purpose-built buildings but many are located in older or converted buildings.

Such settings can be made more accessible by means of better lighting, appropriate signage, and the use of tactile and auditory cues, especially hazard markers and way-finding devices. Signage should be at eye level, well lit, in large font, and in contrasting colours.

The layout and contents of many busy practices often 'evolve' as time goes on. It may be worth looking at the physical environment of the practice again after awareness training. Look out for obstacles in the waiting room, such as children's toy boxes, pamphlet stands or furniture. Practices might consider involving some of their own sight loss patients and patient organisations in this review exercise.

The NHS Institute of Innovation and Improvement has produced a simple process and set of resources to help this sort of review, called experience based design. This helps capture patients' experiences of a service as the foundation for making improvements. The experience based design resources are available on the NHS Institute's website; a link is provided at the end of this section.

6.3 Improving the experience of people with sight loss continued

4. Using information to deliver a personalised experience

In order to deliver a personalised experience for patients with sight loss, a patient's written and electronic notes should clearly record their sight loss. The notes should also record any associated adjustments required and the patient's preferred communication method.

For this information to be of value in improving the patient experience, it should be accessible in such a way that it does not have to be 're-discovered' each time the patient interacts with the practice.



Key resources

Visual awareness training from Action for Blind People:

www.actionforblindpeople.org.uk/help-advice/employment/what-is-visual-awareness-training,121,SA.html

Visual awareness training from the RNIB:

www.rnib.org.uk/xpedio/groups/public/documents/publicwebsite/public_visualawareness.hcsp

Experience based design resources are available from the NHS Institute at:

www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=index&cPath=84&Joomcartid=ovvqfv05f9td7oo5l2i6r6pob4

RNIB Web Access Centre:

www.rnib.org.uk/xpedio/groups/public/documents/PublicWebsite/public_resources.hcsp

Speech enable your website using Browsealoud or other speech-enabling software.

Browsealoud: 0800 328 7910 or email:

info@browsealoud.com

6.4 Five top tips to support a person with learning disabilities

1. See the person not the disability

At the practice, find the best way to communicate, picking up on non-verbal communication. For example, look at facial expressions, gestures and body language. Keep information simple and brief.

Avoid using jargon. Consider working with national or local groups to establish a procedure that establishes the best way to work with people with a learning disability. Ask if a health action plan exists.

Check how many people with learning disabilities are registered with the practice. If your practice has a high number of people with learning disabilities, then you may want to join a scheme to work with a primary care learning disabilities facilitator. Listen to family carers and support workers to highlight particular access needs.

2. Manage appointments correctly

Train staff to offer the maximum, appropriate help. A person with a learning disability may have difficulty with crowds, lack of space and long waiting times. Not understanding the social conventions of reception and waiting rooms may cause distress.

Consider offering them one of the first appointments of the day or one at a quieter time. Think about offering double consultation times or booking an appointment on the hour (which might be easier for the patient to remember). Some patients may need encouragement to speak up and explain why they need a consultation.

This will help the GP or other clinical professional ensure that they have a full picture. If there is a requirement for more than one type of consultation (eg with a doctor and a nurse), you should co-ordinate the appointments so that the patient only needs to make one visit.

3. Effective communication

Speak to the person first and only then check with the carer if something is unclear. Be sensitive to the person's feelings and be encouraging. Ask open questions or change the question round to check if you get the same response.

Don't assume that the person has understood a particular fact or piece of information. Check whether someone needs help to find their way around the surgery. Ask what help is required and try to provide it. If necessary, guide the patient from the waiting area to the consultation room.

Don't just leave them at the door, but introduce them to the doctor so that they feel secure and welcomed. If a consultation is delayed, offer an explanation; otherwise the patient may get anxious and agitated.

Continued overleaf...

6.4 Five top tips to support a person with learning disabilities continued

4. Use appropriate information

Provide information in an appropriate, agreed format. Consider the patient's needs first. Check how they wish to receive information. Should it be sent to them or to a carer or family member?

Be aware of any additional medical conditions, such as poor sight, when providing or sending out information. Consider working with the local Community Learning Disability team or Patient Participation Group to develop formats for standard letters. Do not assume that a patient can or cannot use a particular format such as the phone. Check with the patient first.

5. Training and development

Staff may not always know the best way to communicate with and support people with learning disabilities.

Link with local groups and societies to work out a plan for training and keeping staff knowledge up to date. Seek a champion from your team to lead on this aspect of the work.

Consider compiling a folder or checklist for staff, including pictures for patients to point to if they cannot explain in words. The website www.easyhealth.org.uk has a vast number of accessible leaflets for people with learning disabilities and healthcare staff. Stay calm and don't rush the patient; they may get flustered or upset.

Link to other awareness training such as hearing or sight loss awareness training. Consider providing a general awareness training exercise for all your patient-facing staff. Explore opportunities for rewarding and publicising extended training through national vocational qualifications, certificates, local newspaper features and photographs in the surgery, etc. Remind patients to help staff by being clear about how they wish to receive information. Ask them to communicate what help and assistance they require.

6.5 Auto alerts on GP systems

Example of an auto alert

Patient has a visual impairment. May need assistance when attending the practice. May need longer to get to the practice.

Good communication is a major part of the patient experience and practices will wish to treat all patients equally and respectfully. An auto alert system can be used to make receptionists and other members of the practice team aware of a patient's particular needs and respond accordingly. For example, if someone with hearing loss is attending the practice, then the receptionist can make sure that he or she looks at the patient when they talk. This helps lip reading.

Benefits for practices

- You have prior warning that a patient has a particular need and can plan ahead, avoiding communication embarrassments when the patient arrives.
- Your practice can offer the right kind of assistance, which will be well received by the patient.
- Staff members can be trained in awareness and guidance, which will contribute to their personal development.
- Clinicians can plan the consultation appropriately and in advance, eg by having a SignTranslate ready to use.

Benefits for patients

- A personal service, responsive to their needs.
- Reassurance that assistance can be requested or provided as a matter of course and they don't have to ask for it.

Collecting patient information

Agree a process to collect the information, for example:

- At initial registration, or during visits, ask the patient if they have any condition or requirement that needs particular help or assistance.
- If a patient asks for your help, make sure you note it.

How does it work?

Most GP systems provide auto alerts or flags that 'pop up' on the computer screen when a patient's details are accessed. Some preparation may be required to ensure that your supplier has activated the auto alert function. If in doubt, contact your system supplier.

6.5 Auto alerts on GP systems continued

Groups of patients that could be considered for auto alerts

Sight loss

Everyone with a sight loss is not totally blind. Some people have residual sight, which means that they may be able to see light or dark, make out shapes or read material that is printed in a large font size. They may have problems getting around the practice or seeing traditional signs and room numbers. It's important to stress that they may also not be able to see a visual alert system that tells them when it's their turn to see the clinician.

Hearing loss

Some patients may have a small amount of residual hearing. Therefore, people with hearing loss communicate in different ways: hearing aids, BSL, lip reading, etc. Make sure you use the right method for each patient, otherwise everyone will get frustrated.

Learning disability

As with hearing loss, patients with learning disabilities have a vast range of requirements. Good communication is vital. Recognise that people may get easily distressed in a surgery and will need to be kept informed of any unexpected changes. Partnership working is crucial with families, carers and advocates, and patient-centred planning.

Tip

- Offer to book longer appointments for some patients as they may take longer to communicate to the clinician. Offer to co-ordinate any doctor and nurse appointments in one session, so that the patient doesn't have to attend twice in a short space of time.

Tip

Patients may not know what assistance is available from you, but they will know the best way for them to receive assistance. So they need to be prompted to ask. If you agree to a method with them then you should use it every time.

Examples

- When booking an appointment, the system prompts the receptionist to say, 'I see that you have a visual impairment. Will you need an appointment at a particular time or need any help when attending the practice?'
- Prompt the team to know what help to offer at check-in. For example, if the patients have hearing loss do they use BSL or do they lip read? If the latter, remember to look at the patient when speaking! If they have sight loss, use their name so they know it is them you are speaking to.
- Prompt the need for a member of staff to guide the patient from the waiting room to the consulting room and collect them afterwards. They may not be able to see or hear the visual or audio alerts or navigate the route to a consulting room.
- Prompts for information, particularly about prescriptions and medicines, to be given in an appropriate format, eg large print, symbol /picture format for the visually impaired.
- The system should prompt the receptionist to double check that a person has understood the date and time of an appointment offered either over the phone or in person (eg 'could you just confirm the date and time back to me?').

7.0 Communications



7.1 Top tips for marketing your practice

It's not necessary to spend big to be effective in marketing. Here are some tips to help you make good use of social marketing with websites, leaflets, posters, display systems and brochures. Effective marketing will help you support patients in making their own decisions about care and understanding what to expect from the service and what is expected from them in return.

Consider three key factors:

1. What are the features of your service that you want to communicate and promote? Do you want to reduce your did not attends (DNAs)? Can patients book appointments in new ways?
2. Who are you targeting? Will different groups of patients be interested in different services or features?
3. What marketing method will you choose? Is this the best method for the group of patients you have chosen?

Things to consider

What's unique about your service that patients should be told about?

- Are you running new clinics such as weight management or smoking cessation?
- Are you offering appointments in the evenings or at weekends?
- Do you offer telephone consultations?
- Can patients book appointments over the internet?

Who wants to know?

- Is it everyone? Or selected groups?
- Do you want to target the younger working population who are time-poor and would like to see their GP in the evening?
- Do you want to target older people for flu jab clinics?
- Would patients with diabetes like to know that they can email their blood pressure reading to the practice or take it themselves in the waiting room?

How are you going to market your message?

- Is it a poster in the waiting room or a message on your LCD display?
- A banner on your website?
- If you have email addresses, can you send a mailshot to patients or include something in your newsletter?
- A notice in the local newsagent?
- Use the local paper?
- Leaflets in nearby services such as pharmacies or libraries?

7.1 Top tips for marketing your practice

continued

Practical advice on producing a good leaflet

For simple and practical information about practice leaflets and general communications advice, go to pages 59–102 of the brand guidelines for GP services:

www.nhsidentity.nhs.uk/all-guidelines/guidelines/general-practitioner/practice-leaflets

Advice includes:

- information about Core Information Requirements;
- suggested additional information to be included;
- writing your leaflet – advice on the writing of practice leaflets;
- important advice on how to communicate with hard-to-reach groups;
- how to make your leaflets readily available;
- how to evaluate your leaflet;
- practical advice on technical design issues; and
- design templates.

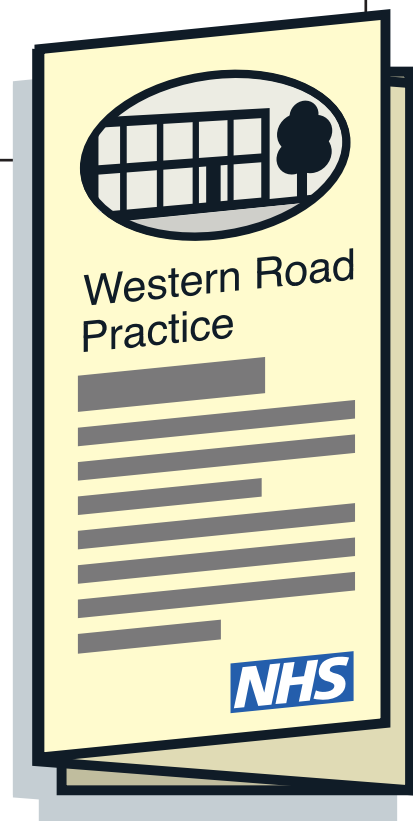
Examples of good practice leaflets

Bromley by Bow Health Centre:

www.eastendgp.co.uk/docs/practice%20leaflet%20BBB.pdf

Perth and Scone Medical Group:

www.perthandscone.co.uk/leaflets/practiceleaflet.pdf



7.2 Why and how to create a website

Patients have an increasing appetite for information about GP services. A website can be a cost-effective way to communicate and engage with your patients 24/7. Setting up a website is not too difficult, can cost very little and generally pays for itself through efficiency savings such as fewer calls to reception.

Benefits

- Usually quick and easy to set up and edit the content.
- Can be used to promote the practice.
- Can host a range of innovative features such as online booking, ordering of repeat prescriptions and pre-registration – freeing up telephone lines and reducing the pressure on reception and administrative staff.
- Can provide patients with live, up-to-date information about services.
- Use it to interact with patients through newsletters, videos, pod-casts and pictures.

Drawbacks

- A member of the practice team will need to take responsibility for keeping the site up to date.
- Not all patients have access to a computer or the internet.
- Technological problems can irritate patients and be time-consuming to fix.

Costs

Costs can vary significantly. If you want to design a site yourself it can be done very cheaply but might be very time-consuming. There are lots of companies that will do it for you but look around for a good deal.



7.2 Why and how to create a website

continued

Features to consider

You can make a website do a few simple things or go for a fully interactive and comprehensive site that offers many convenient features for patients. Use the functionality of your website to its full potential as this will increase how much it is used.

Common features include:

- core information and advice taken from your practice leaflet, and a version that can be downloaded by patients and printed;
- online appointment booking and cancelling (linking to your GP system);
- repeat prescription forms and systems;
- a registration page with a downloadable GMS1 form (or interactive form) with instructions on how to register and a map of the boundary;
- newsletters and bulletin boards;
- pictures of staff and of the practice – which patients like;
- patient survey zones and feedback forms;
- links to other helpful sites;
- a secure summary of patient records; and
- useful phone numbers and email addresses.

Tip

- You can make text available in different sizes and languages to make the website as accessible as possible. Have a look at BrowseAloud (www.browsealoud.com).

Tip

- Don't make the site too lengthy or text heavy as it will become harder to update and may appeal less to patients.

7.2 Why and how to create a website

continued

Step-by-step guide

1. Who is responsible?

Is there an IT-literate member of the team who can research, set up and manage the project? If not, is there a member of staff willing to train and take responsibility for updating the site? What do patients think? Could the Patient Participation Group take responsibility or would they like to manage their own section of the site? Can your PCT help? Some have their own web teams. Are there any local practices that have developed a website? Could they give you some ideas?

2. What is the purpose of the site?

Is it simply to promote the practice leaflet/brochure or do you want something more innovative that patients can interact with?

3. Specification

Before you start, develop a specification of what's required and the budget you have in mind.

4. Supplier

Many independent web designers and organisations specialise in setting up GP practice websites. Look them up on the internet and compare your specification to the various packages on offer. Consider the ease with which you can update the website – some use Microsoft Word templates. Also take into account the fees for web hosting and maintenance.

5. Communicate

Once the site is up and running, make sure patients know about it. Put the address on posters and letterheads, in your newsletter and in your leaflet.

7.2 Why and how to create a website

Case study

College Surgery Partnership

The College Surgery Partnership in Devon serves around 14,000 patients. Many live in rural communities over an area of 100 square miles, and its ten doctors operate over four sites.

On the lookout for ways to

- communicate better with its patients
- offer more choice
- and highlight its broad range of services

the partnership set up its own website in 2004.

The website (www.collegesurgery.org.uk) displays basic information, from surgery hours to site locations. It also updates patients on health campaigns and upcoming talks held at the practices. It's enhanced by photographs of the doctors and of the practice premises.

In addition, the website serves as the gateway to the partnership's online facilities, including appointment booking and repeat prescription services. The practice's Patient Support Group can also upload information to the site.

The website is well used and well liked by patients, who often point out when something is out of date. Statistics show that the website got 1,542 hits on one day in May 2009, and the practice gets hundreds of repeat prescription requests through the site every week.

The website was built by the partnership's IT Manager, Nick Bunn, with the help of an external supplier, and it took about a month to get off the ground.

The external supplier was initially paid £1,000. The website costs another couple of thousand pounds a year to maintain, split between the external supplier and the time Nick spends on maintenance. (He says he works on the site monthly.)

'Some of our patients can't always come to the practice, so it's great to be able to communicate with them electronically. The website makes it easy for them to access information about us,' says Wendy Evans, the partnership's Strategic Manager.

Andy Barrett, chair of the Patient Support Group, says the website is clear and simple to use, although he notes that many of the practice's patients – mostly the older generation – do not use it.

'It provides useful content on who is who at the surgery, opening hours, and the various ways that you can get treatment. The repeat prescription service is very useful, as well as easy to use – I'm a regular!' Andy says.

Continued on the next page

Contact

Wendy Evans, 01884 831301

[wevans@nhs.net](mailto:w.evans@nhs.net)

7.2 Why and how to create a website

Case study

College Surgery Partnership continued

Benefits

- The practice can communicate effectively with patients across a wide geographical area.
- Patients can access a whole range of information and services at the touch of a button, including booking appointments and requesting repeat prescriptions.
- It reduces telephone queries about simple information.
- It gives the practice a human face, with photographs of the various surgeries and doctors.
- Patients know they have arrived at the right place if they have seen photographs of the surgery on the website.

Tips

- A website requires an investment of time and money.
- Provide information posted on the website in paper form, for patients lacking access to computers.
- Keep the website up to date and assign one or more staff members to refresh it regularly. An out-of-date website may be worse than none at all.
- Make sure you maintain strict controls over what is posted on the site.
- Note that some doctors may be reluctant to have their photographs on display.

Contact

Wendy Evans, 01884 831301

wevans@nhs.net

7.2 Why and how to create a website

Case study

Marple Cottage Surgery

Marple Cottage Surgery, on the outskirts of Stockport, near Manchester, has around 6,000 registered patients. Some were not visiting the practice regularly and were unaware of the range of services on offer.

The practice was also finding that some patients were telephoning or dropping in to the practice with simple queries that could be answered online.

After developing its own website (www.marplecottage.co.uk), Marple Cottage:

- keeps its patients better informed of the services it offers;
- can educate them about health issues; and
- can enable them to perform a number of tasks online that would otherwise require a phone call or an appointment (these include emailing doctors, ordering repeat prescriptions and booking appointments online).

Patients access the online facilities through a security portal, which requires a log-on password and identification number. These are easily obtained from the practice.

Marple Cottage outsources the technical maintenance of the site, but all staff members are responsible for updating the information on it. Websites cost anything from several hundred pounds to thousands of pounds to build, depending on the structure and provider.

'We're a business, and a business needs to inform its customers about what it's offering,' says Practice Manager Johan Taylor.

'It's a two-way thing. We ask patients to communicate with us, and we put things up there to communicate with them, like patient or screening questionnaires. We're currently updating the website to make it more interactive, to get more involvement from the patients,' adds Johan.

He says the website is well used and well liked by patients, a view supported by Sandy, a 62-year-old patient and regular website user, who is disabled.

'The online system is a lifesaver. I use it to book appointments and get repeat prescriptions and I can also email my doctor – which if you're housebound is marvellous. I can also access my medical records,' she says.

Continued on the next page

Contact

Johan Taylor

johan.taylor@gp-p88006.nhs.uk

7.2 Why and how to create a website

Case study

Marple Cottage Surgery continued

Benefits

- The website informs patients who don't visit regularly about available services.
- It provides a central database for practice information, such as opening hours and address.
- It can save time on telephone calls and appointments, as patients can order repeat prescriptions, book appointments and email doctors through the website.
- It enables patients to be better informed about health issues before they see their GP.
- It encourages patient–practice interaction and feedback, which can help improve services.

Tips

- Before setting up a website, think about what you want to achieve with it, in terms of benefits it can offer the practice and patients.
- Keep the website updated.
- Start with a simple site and develop it slowly. Ignore the fancy add-ons until you have mastered the basics.
- Ensure that your technology is sound, so the website doesn't crash.

Contact

Johan Taylor

johan.taylor@gp-p88006.nhs.uk

7.3 Taking control of your information on NHS Choices

NHS Choices (www.nhs.uk) is an online health information service, designed to meet the huge public demand for reliable and authoritative health information. It's important that the information on your GP practice is up to date. This explains how to do it.

Over 7 million people visit NHS Choices every month. It is quickly being recognised as the primary online source of health information for the public.

People are looking for:

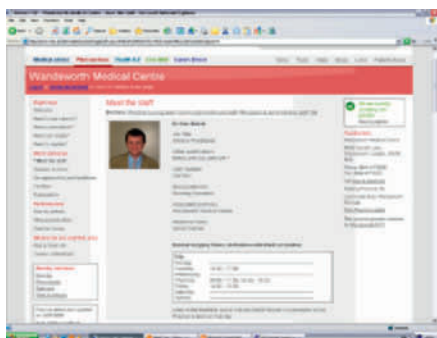
- details of local health services (GP surgeries, pharmacies, dentists);
- information on different medical conditions; and
- information about changes of lifestyle to help them make decisions.

Making the most of your information

One of the most visited parts of the site is the service directory. This includes a detailed profile of every GP practice in England, with information on opening hours, clinics, staff, how to register or make an appointment, and contact details.

You need to keep your details as up to date and accurate as possible. GP Practice Profiles are designed to complement a practice's own website (if you have one) and include a link so users can go straight to your site.

Your profile gives you an opportunity to engage with your patients. You can include videos, newsletters and pictures of staff and premises.



Is your GP practice registered?

To get the most out of this resource you need to register for a username and password. To register, call the NHS Choices service desk on 0845 4023089 or email thechoicesteam@nhschoices.nhs.uk

If you have an NHS email address, NHS Choices will email you the practice's username and password. If you don't have an NHS email account, you will receive a new username and password by post. This is necessary for security.

To help you to start changing your profile information, NHS Choices (www.nhs.uk) has created a Practice Based Editing (PBE) Guide. This includes examples of good profiles and offers some ideas of how you can make the best of the space. This is available to download from www.nhs.uk/pbe

7.3 Taking control of your information on NHS Choices continued

GP patient feedback

Soon the public will have the opportunity to give feedback on their experience of their GP and put this on NHS Choices (this starts in autumn 2009).

This will not be a mechanism to 'rate your GP'. Comments will be restricted to a patient's experience of their practice (opening times, out-of-hours service, ease of making an appointment, disabled access and so on). Comments on individual GPs will not be published.

A careful pre-moderation policy will be in place to prevent offensive or potentially defamatory comments going on the site. Practices will have the right to reply online to all comments and this is highly recommended.

Further details of the patient feedback mechanism will be made available to GPs shortly.

Frequently asked questions

Where does the information already on my profile come from?

NHS Choices automatically transferred existing information on your practice from the Primary Care Information System and from PCTs to avoid patients being presented with a blank page.

What can I do to correct a mistake when editing?

Just go back into your profile and re-publish it. It shouldn't take more than a few minutes.

Once I start editing, will anyone else be able to change my information?

No. But this also means that you are responsible for accuracy. If NHS Choices gets a complaint from the public it will be referred to your practice, not the PCT.

Do I have to check everything with my PCT?

No, but nothing should be published on your profile which does not accurately reflect your contract.

If I don't fill in a box, what will appear?

Nothing. The system is designed to show only what you complete.

Can I promote a particular clinic or service on the front page?

Yes. If for instance you are giving out flu jabs, put the announcement in the news box on the 'news and documents' page. This will then appear across the top of the front page.

Do we have to add details of every member of staff?

No, but there is clear evidence that suggests that patients really value this information – to see if there is a female GP at a particular practice, for example.

8.0 Patient engagement



8.1 Techniques for engaging with patients

Closer engagement with patients has developed rapidly and is now seen as a vital activity. It helps patients understand their rights and what they should expect. For the practice, it means invaluable direct feedback that can be used to improve services.

We address three key questions for practices:

- Why do this?: **Benefits**
- What do we need to think about?: **Key considerations for practices**
- How do we make it happen?: **Resources available to practices**

Benefits

Benefits for the patient	Benefits for the practice
Helps to improve communication between patients and staff.	Builds trust and communication between patients and staff.
Helps patients to shape the practice services that they use.	Provides information about patient experience to help improve planning and services.
Patients gain a better understanding of the services at the practice and how to use the NHS as a whole.	Practice identifies people's needs and wants and this can be used to develop accessible and responsive services.
	Helps to grow patient confidence in the practice and the NHS.

Key considerations for practices^{1,2}

This field is developing rapidly and considerable experience is being gathered by NHS organisations. This section brings together some of the available literature and resources. Use the seven key considerations below as a starting point.

1. Be clear about what patient involvement means.

- The whole practice should share the same understanding of what is meant by involvement and its purpose.
- Be clear about the difference between working for and working with patients and the public.
- Be clear about the purpose and objectives, for example, is it to raise awareness or gain feedback on a new system?

8.1 Techniques for engaging with patients

continued

2. Be clear about why you are involving patients and the public.

- Involvement is a means of improving services, not a problem to be solved.
- It's not enough to be more engaged. Practices need to demonstrate change as a result of patient engagement.
- Be clear about the objectives of the work. What is the rationale, relevance and connection to other practice priorities?
- Be honest about what can change and the reasons why. Also do this for what you are not prepared to change.
- Find out and use what is already known about people's views and experiences.
- Be clear about what is being measured and why. How it will be measured?
- Make sure you measure what matters to patients, not what you think matters to patients – involving them in the design phase is a good idea.

3. Identify your 'patients and public'.

Define who needs to be involved, who needs to be informed and who is likely to be affected by the issue under consideration. You may need to think outside the practice as well as within the practice.

Patient and public engagement should always seek to be as inclusive as possible.

Practices can include:

- individual patients;
- patient groups based around a particular service or therapy area, eg asthma;
- people who care for someone who uses the practice services;
- local people, individuals or groups who do not necessarily attend the practice regularly; or
- local voluntary and community sector organisations.

Particular consideration will need to be given to seeking feedback from:

- people who do not speak English as a first language;
- people with hearing, speech or visual impairments;
- people with learning, communication or cognitive difficulties;
- people with physical disabilities;
- mental health service users;
- older people;
- young people – ie teenagers and children; and
- people who are housebound.

Continued overleaf...

8.1 Techniques for engaging with patients

continued

4. Design your approach

Consider the benefits and practical constraints of qualitative versus quantitative methods.

Quantitative methods	Qualitative methods
Postal surveys	In-depth interviews
Face-to-face surveys	Discovery interviews
Telephone surveys (interviewer administered)	Cognitive interviews
Automated telephone surveys	Focus groups
Online surveys using web-based or email questionnaires	Web-based feedback
Surveys using touch-screen kiosks	Comments cards and suggestion boxes
Surveys using bedside terminals	Complaints and compliments
Staff surveys	Patient diaries
Administrative data	Mystery shopping
	Customer journey mapping

Key considerations before you start

- Build in your sampling and data collection strategies.
- Make sure the sampling will realistically give you the response rate you want to achieve.
- Have all data protection aspects been considered?
- Before you collect any data, set some aims or benchmarks. What constitutes a good score now and in the future? Good quality improvement schemes are based on achieving step-by-step changes.
- Survey questions are best developed with patients and staff.
- Always test and carefully pilot the questions before launch. What seems like a sensible question to one person can be interpreted in a very different way by someone else.
- Cognitive testing helps you to understand the range and diversity of ways in which people answer survey questions. It will help you know if questions are working as intended and whether the wording and layout of questionnaires is clear and unambiguous.

5. Getting the most from feedback^{3,4}

- Use feedback as a tool to help identify priorities for the practice.
- Avoid trying to focus on everything at once – pick one or two areas to begin with.
- Focus on the issues where patients give you *least* praise.
- It is better to make a small difference for many people, than a large difference for just a few.
- Use feedback as a way of evaluating the success of improvement work.
- Avoid measuring progress too narrowly.
- Avoid 'paralysis by analysis' – resist the temptation to gather ever more data before taking action.

Continued overleaf...

8.1 Techniques for engaging with patients

continued

6. Measure improvements

A good idea is to re-run elements of your engagement approach to measure how much the patient experience has improved. Use positive data to communicate with patients as this is invaluable in demonstrating the value of the process. It also boosts practice staff as they find it rewarding and motivating to be moving in the right direction.

7. Keep people involved

Promote opportunities for people to be involved. Find out how people prefer to do this. Make sure your methods suit the purpose of the involvement exercise. Make special efforts to involve people whose voices are seldom heard. Provide feedback to people about what you have learned from them and what action you intend to take and have taken in response.

Resources available to practices

NHS Institute for Innovation and Improvement *Patient and Public Engagement Toolkit for World Class Commissioning*

www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&products_id=439

NHS Centre for Involvement *Key Principles of Effective Patient and Public Involvement*

www.nhscentreforinvolvement.nhs.uk/docs/P0006%20-%20Principles%20of%20Patient%20and%20Public%20Involvement%20-nci.pdf

NHS Institute for Innovation and Improvement Experience based design approach guide and toolkit

www.institute.nhs.uk/quality_and_value/introduction/experience_based_design.html

Department of Health – Local Involvement Networks (LINKs)

www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/DH_076366

References

1. **NHS Centre for Involvement** *Key Principles of Effective Patient and Public Involvement*
2. **NHS Institute for Innovation and Improvement** *Patient and Public Engagement Toolkit for World Class Commissioning*
3. **Frampton, S. et al** (2008) *Patient-Centered Care Improvement Guide*. Planetree Inc: Derby, USA
4. **Picker Institute Europe**, Patients Accelerating Change Programme

8.2 Setting up a Patient Participation Group (PPG)

The number of PPGs in England is increasing – 40% of practices now have one. Each PPG will be different, evolving to meet local needs, but they often work to give practices a patient perspective on services. PPGs are supported nationally by NAPP (National Association for Patient Participation).

Patient participation is:

- patients working with a practice to improve services;
- varied to suit local needs; and
- based on cooperation.

Patient participation is not:

- a forum for complaints;
- a doctors' fan club; or
- a time-consuming activity for practice staff.

Benefits

Good for patients

- Patients will take more responsibility for their own health.
- Patients will have a clearer understanding and knowledge of the practice and staff.
- Patients will be consulted about their primary healthcare before decisions are made.
- Patients will benefit from improved communications with staff.
- Patients will have a forum to suggest positive ideas and voice their concerns.

Good for practice staff

- Staff will be able to plan services jointly with patients and this should make services more effective.
- Staff will be able to help patients with non-medical and social care issues.
- Staff will be able to get help from patients in meeting targets and objectives.
- Staff will have a forum to voice concerns, ideas and suggestions to patients.
- Staff will build stronger links with their community.

Costs

It is inevitable that the group will incur costs. These may be running costs for administration etc that are minimal and that the practice is willing to absorb. There may be higher occasional costs for some of the more ambitious objectives (such as a wheelchair for the practice). Most PPGs run on less than £500 per year.¹

¹ Based on *Growing patient participation – Getting started* (NAPP 2009, and NHS Norfolk, NHS Milton Keynes and Liverpool PCT).

8.2 Setting up a Patient Participation Group (PPG) continued

Step-by-step guide

1. Getting started

Practice staff or local patients can get the ball rolling. Practices can start by:

- talking to their PCT;
- canvassing interest from local people;
- approaching an existing user group; and
- contacting NAPP or talking to another PPG.

2. Recruiting your group

Hold an open meeting inviting patients to attend or contact individuals who you know may be interested. For an open meeting, remember to publicise well in advance, pick a topic of general interest and offer refreshments.

Be representative

A common criticism of PPGs is that they are not representative. Make sure that you try to contact a diverse range of people. It takes time to develop this wider outreach and PPGs will naturally grow and become better known over time.

3. The first meeting

Make the first meeting short (one hour), positive and productive as people will decide here whether they wish to continue. Use the meeting to identify skills within the group, agree the aims and role of the PPG (and be clear about what it is not going to do), then decide on next steps.

Continued overleaf...

8.2 Setting up a Patient Participation Group (PPG)

Step-by-step guide continued

4. The second meeting and ongoing issues

Use the second meeting to address administrative and organisational issues, including:

- appointment of a chairperson, secretary and treasurer (if fund raising);
- terms of reference for your group;
- prioritising what you want to achieve in the short, medium and longer term;
- agreeing some 'quick wins' to boost confidence early on;
- deciding frequency, timing and venue for future meetings;
- deciding on the quorum – the minimum number of members who must be present for the PPG to conduct business; and
- making plans to review these arrangements annually.

Ideas for further support

- Find a local 'buddy' group
- PCT communications and engagement manager
- Local Council for Voluntary Service (CVS)
- NAPP (www.napp.org.uk)
- Your local LINK.

5. Communication and reporting back

PPGs tend to work best if representatives from the practice, as well as patients, are present on a regular basis. Between PPG meetings, it can be useful for the PPG chair to have one-to-one updates with the practice manager. Regularly feed back PPG activities to patients and practice staff via practice and community email, websites, newsletters and notice boards.

Why some PPGs fail

- Lack of focus and commitment
- Poor planning
- Poor communication to group from the practice and vice versa
- Hostility between group and practice or vice versa
- Relying too heavily on one or two people
- Unclear ground rules.

8.2 Setting up a Patient Participation Group (PPG) continued

One example of a PPG

Although relatively new, the PPG at Whaddon House Surgery in Bletchley was one of the first to be established in Milton Keynes. Some really positive changes have been put in place as a result of its regular meetings, including:

- introduction of a new appointments system and a considerable improvement on the old system, with fewer patients failing to attend their appointments;
- an easy-to-operate self-check-in system;
- a website that allows patients to instantly order repeat prescriptions (www.whaddonhousesurgery.co.uk);
- a quarterly newsletter with profiles of GPs and staff and seasonal suggestions on how to keep healthy; and
- 'early bird' appointment times to help people see a GP at a time that is convenient to them. The practice was one of the first to offer extended hours appointments.



8.3 Real-time patient feedback

With a good feedback system, you can increase your understanding of what patients think about your practice, understand areas of concern and take action to transform the experience for patients. You can make changes and use the system to monitor patient reaction, gradually improving the practice based on accurate feedback, not guesswork.

Step-by-step guide

1 Planning

Before you start, you need to form a clear view of what you are aiming for – a high quality, accessible and responsive service. The purpose of obtaining patient feedback is to test how you live up to this. The feedback system needs to work so that it helps you accurately identify aspects of the service that need to be improved. To help you focus on aspects of the service that need changing, consider the results of previously run local surveys or the national GP Patient Survey.

2 Method

Measure what matters to patients rather than what you think matters to them. The most effective way to do this is to involve them when designing the survey, for example, through your PPG. Also look at comments and suggestions sent to the practice.

3 Collection

How will you collect the data from patients? There are many data collection techniques. Here are some strengths and weaknesses of the most common methods:



Continued on page 141

8.3 Real-time patient feedback continued

Feedback method	For	Against
Survey using handheld portable devices	<ul style="list-style-type: none"> • For data collection at the practice • Questionnaires easily tailored to local setting • Automatic data entry • Rapid turnaround of results possible • Can be self-administered by patients/users 	<ul style="list-style-type: none"> • Questionnaires must be brief • Consider infection control if patients handle devices • Needs member of staff to manage devices and monitor use • May be difficult to track response rates • Sample will be unrepresentative if staff avoid potential negative respondents or 'difficult' volunteers because of language barriers or disabilities
Touch-screen kiosks	<ul style="list-style-type: none"> • For data collection at the practice • Can be sited in waiting rooms • Automatic data entry • Rapid turnaround of results • Anonymous 	<ul style="list-style-type: none"> • Questionnaires must be brief • Consider infection control if patients handle devices • Impossible to calculate response rates • Patients may submit answers more than once • Time pressures may put people off taking part • Vulnerable to misuse
Online survey	<ul style="list-style-type: none"> • User-friendly design – questions can be tailored to respondent • Reminders easy to send to patients • Data entry is automatic • Rapid turnaround of results possible • Can be self-administered by patients/users 	<ul style="list-style-type: none"> • Requires email addresses • Requires access to internet so representative sample not possible • Questionnaire needs to be brief • IT issues because users have different operating systems and browsers • Poorer quality responses – fatigue in answering questions may be more evident in online surveys • May not generate high response where trust and understanding of technology is low

8.3 Real-time patient feedback continued

Feedback method	For	Against
Postal survey (self-completion)	<ul style="list-style-type: none"> • Can reach large numbers • Less intrusive than other methods • No influence from interviewer so chance of bias is removed • Questionnaires can be fairly long and detailed • Can collect demographic data • Possible to achieve high response rates if reminders are sent • Relatively cheap 	<ul style="list-style-type: none"> • Not suitable for patients with low literacy • Not suitable for non-English speakers unless language known in advance or translation service available • Requires careful administration • Data entry (manual or scanned) takes time • Requires expertise in use of statistical package to analyse results
Interviewer-administered survey (eg someone in the waiting room)	<ul style="list-style-type: none"> • Suitable for low literacy groups • Can include more detailed/complex questions • Can collect demographic data • Can enter data during interview (CAPI) 	<ul style="list-style-type: none"> • Training required for interviewers • Similar problems as for postal surveys – language barriers, data entry (without CAPI) and analysis • Time-consuming and expensive
Telephone survey	<ul style="list-style-type: none"> • Suitable for low literacy groups • Can enter data while conducting interview (CATI) • Results can be available quickly 	<ul style="list-style-type: none"> • Requires phone numbers • Response rates often low • Requires frequent call backs at different times of day to obtain representative sample • Questionnaire needs to be brief • Interviewers must be trained
Automated telephone survey (Interactive Voice Response (IVR) or key press)	<ul style="list-style-type: none"> • Suitable for low literacy groups • Data entered automatically • Can be produced in multiple languages 	<ul style="list-style-type: none"> • Requires phone numbers • Response rates often low • Questionnaire needs to be very brief
In-depth interviews	<ul style="list-style-type: none"> • Can produce richer, more detailed data • Allows respondents to express themselves in their own words 	<ul style="list-style-type: none"> • Expensive • Interviewers must be trained • Problem of interviewer bias • Transcribing and data analysis is time-consuming

8.3 Real-time patient feedback continued

Feedback method	For	Against
Web-based feedback (free text)	<ul style="list-style-type: none"> • Allows people to make any comments they want to about the care they've received • Respondents can be asked to give their views on specific topics • Responses are available for others to read 	<ul style="list-style-type: none"> • It is not suitable for people who do not have internet access, so representative coverage not possible • Sites must be moderated to avoid malicious comments • It may not represent majority view – likely to attract those wanting to give very favourable or very critical comments
Comment cards, exit surveys, suggestion boxes, video boxes	<ul style="list-style-type: none"> • Can be used to collect on-site feedback, usually unstructured • Feedback can be analysed quickly 	<ul style="list-style-type: none"> • Likely to be completed by a small minority unless patients are specifically invited to respond

Table adapted from *Measuring patients' experience of care*, part of the King's Fund's Point of Care Programme.

8.3 Real-time patient feedback

Step-by-step guide continued

4 Triangulation

None of these methods will give you all the information you need to make informed decisions. You will need a combination of methods – quantitative (eg questionnaires) and qualitative (eg forums).

Involve your PPG. They offer a valuable testing ground and can act as a ‘critical friend’, helping you to understand what patients think of the issues and how you can take action. For more information on PPGs go to section 8.2.



5 Action

Once you know the areas for improvement, target one or two priorities rather than change everything at once. This makes it easier to measure the impact of the change.



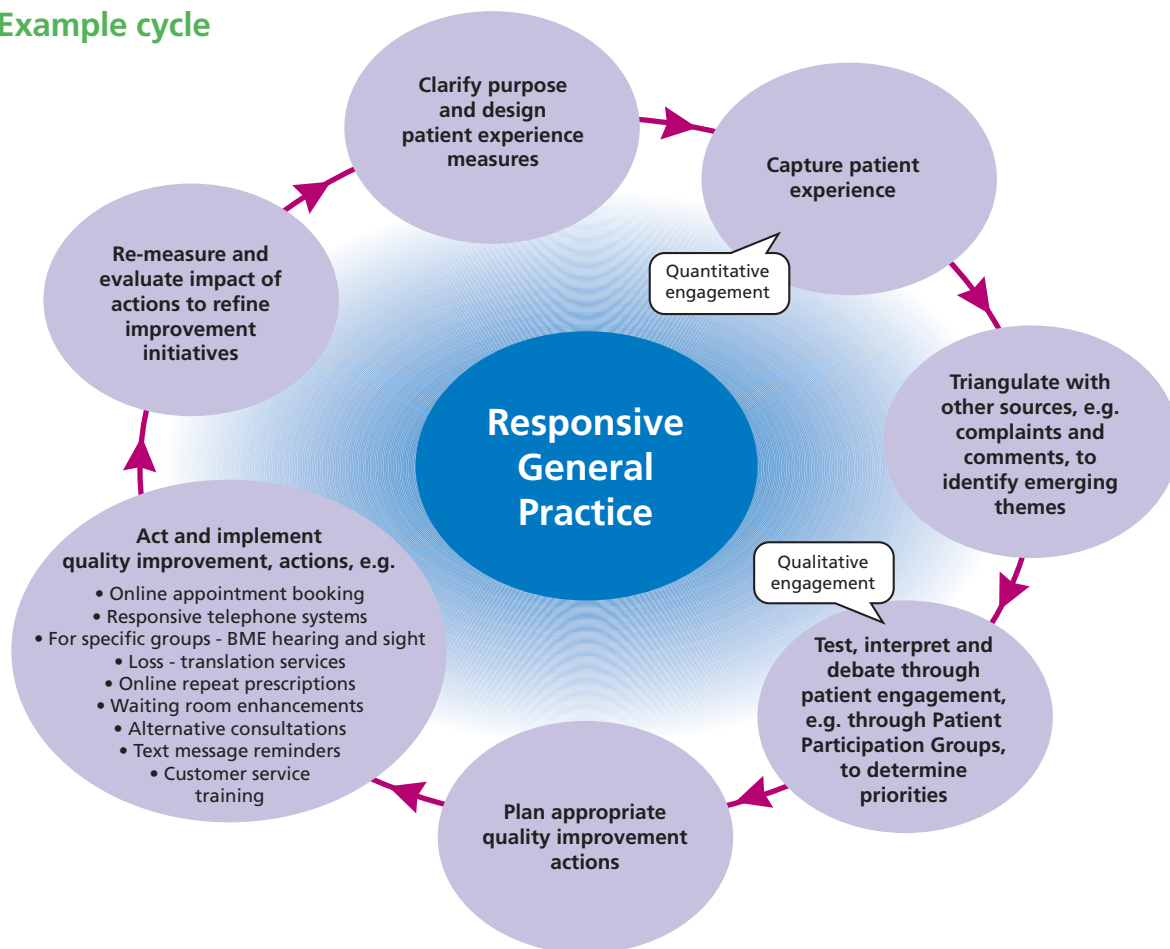
6 Evaluation

It is important to demonstrate to patients how feedback has been used to improve service delivery and how they have contributed.

These three steps can form part of an ongoing cycle to improve the ‘responsiveness’ of the practice as shown in the diagram on the next page.

8.3 Real-time patient feedback continued

Example cycle



Supporting resources

Final report from the University of Birmingham on behalf of NHS West Midlands
Investing for Health: Real-time Patient Feedback Project

www.hsmc.bham.ac.uk/news/news/2009/3/sha-real-time-report.shtml

King's Fund Point of Care Programme

www.kingsfund.org.uk/research/projects/the_point_of_care_improving_patients_experience/index.html

8.3 Real-time patient feedback

Case study

Worthing Medical Group

The Worthing Medical Group was keen to increase patient engagement. Staff realised that in today's more competitive environment, they needed to know what people liked and didn't like about their services and adapt accordingly.

Dr Bruce Allan knew that customer feedback screens were being used for various PCT provider services and wondered if there was a place for them in general practice. He piloted it in his own practice, Shelley Surgery, for three months from January 2009.

During that time, 400 responses were registered on the machine, providing valuable feedback about the practice's telephone and appointment systems. The practice has decided to continue using the screen, and the system may be rolled out to all 13 practices in Worthing.

In Dr Allan's surgery, the touch screen unit is fixed to the wall of the waiting room and is used by patients voluntarily and without prompting. The machine's set-up is quick and simple, taking just an hour or two of the practice manager's time. In addition, it's significantly cheaper than a paper-based system.

The machine, made by NETBuilder (www.netbuilderhealth.com), can be completely customised, with practice staff choosing how many questions to include and what they should be. The results are registered in real time, via 3G technology, and can be viewed on a web-based interface. The questions can be changed at any time, via the same interface.

'We deliberately decided not to ask patients to use the feedback screen, because we wanted to see how many would find it and use it by themselves. We were amazed to get 400 responses in three months – which proves that patients are comfortable using touch screens. If receptionists actually asked patients to use it, I think we could double or triple that response rate,' Dr Allan says.

Continued overleaf...

8.3 Real-time patient feedback

Case study

Worthing Medical Group continued

Benefits

- Receiving real-time feedback in this way enables the practice to adapt its services to meet patients' needs.
- The touch screen interface is familiar to patients, who are used to using a similar screen to check in for their appointments.
- The machine requires very little maintenance. Apart from setting the questions and reading the reports, the practice doesn't have to do anything.
- This system can be used to collect other data, in addition to patient feedback.
- Introducing the feedback touch screen reinforces the idea that services should be patient-focused, helping to change entrenched practice attitudes.

Top Tips

- Put the touch screen somewhere where patients will see it and want to use it.
- Changing the questions every three months keeps patients interested, while allowing for a useful number of responses to be gathered.
- Ten questions on one topic is sufficient. It's a good idea to include a mixture of response options, including scaled opinions and yes/no answers.

Contact

Dr Bruce Allan
bruceallan@nhs.net

9.0 Change



9.1 Redesigning the process

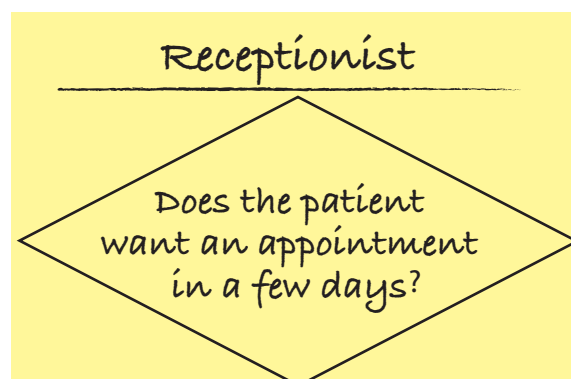
Here we describe two complementary ways in which any process within your practice (or between the practice and another organisation) can be analysed and visualised. By doing this, it is much easier to identify the strengths and weaknesses of the process and use the information to successfully redesign it.

The two approaches are:

1. **Map the process.**
2. **Map the patient experience.**

Following and capturing the process

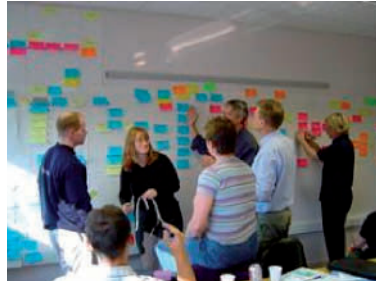
It is usually easiest to follow the process starting at the beginning – but you may sometimes want to work backwards and start from the end. At each stage write down the key points on a Post-it note as suggested below. You may also want to collect example screen shots and write down any points that need discussion and agreement, again noted on Post-it notes.



9.1 Redesigning the process continued

Building the process map

Building up a map provides a valuable and comprehensive flow of a process. Mapping allows the team to build deep knowledge about the process and the problems. You can use the map used to educate staff, and as a basis for accurate analysis.



Expect to have to rearrange the diagram several times as you find out more about the process. The map should expose the complexity of the 'paper-chase' and make bureaucratic waste highly visible.

- Try to arrange the main flow across the top from left to right.
- Identify where the decision points are.
- Show where there are variations to the main process.
- Show different versions, rework or repeated steps.
- Identify queues or time delays.
- Be specific about quantities. For instance, to map the process of people calling for an appointment, quantify how many users ring per day for this service, how long they have to wait and the percentage of calls compared with other reasons for calls.
- The map needs to represent what really happens, so it will not necessarily follow written procedures.
- Add documents and screen prints to the map – include photos and copies of performance reports if available and relevant.
- Print off examples of all documents/screens/spreadsheets that are used during the process.
- Show all duplicates/triplicates.

If the documentation, screens or spreadsheets are poorly designed:

- Highlight parts of the document or screen that are not relevant.
- Highlight double entries.
- Highlight areas where frequent errors occur.
- Identify waste.
- Highlight good points about the process.
- Identify issues that need to be addressed and use colour to distinguish the two (see example below).

Staffing levels and rotas are matched to demand. We respond to call in 30 seconds

Protocols for identifying potentially life-threatening conditions not well understood by reception staff

9.1 Redesigning the process continued

What can you learn about the process?

Form a group of those involved in drawing up the process map and people who are familiar with it. Then work together and use the map to identify:

- what works well – parts of the process that you must maintain;
- what needs fixing – and how might this be done;
- where delays occur – and why; and
- what goes wrong – and why.

Agree some design principles for the new process. The lists below suggest a number of topic areas and possible principles that may trigger more specific points relevant to your process:

Process

- Standard procedure
- Responsive, minimal delay
- Predictable and reliable
- Performance measured
- Right first time
- Minimal paperwork
- Few hand-offs
- Visibility.

Patient

- Supportive and welcoming
- Inspiring confidence and trust
- Quick, easy service
- Appropriate security
- Give information once only
- Minimal delays for patient
- Clarity on what next/follow-up.

Staff and organisation

- Satisfying work environment
- One process owner
- Individuals responsible for doing it right
- Improve personal and professional development
- Improve flexibility to cope with peaks in workload
- Co-location of team.

Technology

- Minimal IT investment
- Data entered once only
- System ensures right first time through validation
- Integration of systems
- Standard packages only
- No spreadsheets
- System must free up people time
- Strong support and help available
- Easy to use.

9.1 Redesigning the process continued

How to view the process from the patient perspective

You can capture structured conversations with a number of patients and map them out to see the issues at each stage of the process.

Four or five key aspects identified with a prompt for the interviewer

Verbatim quotes from the patient interview captured

Patient experience feedback form

Contact point/ stage	Reliability <i>'Did we do what we said we would do?'</i>	Responsiveness <i>'Did we respond promptly to what you told us?'</i>	Assurance <i>'Did we reassure you and explain things?'</i>	Empathy <i>'Did we show sympathy and understanding?'</i>	Tangibles <i>'Did we make it easy for you? Did you have any difficulties?'</i>
Initial telephone contact	The call was answered promptly		I wasn't sure what was going to happen next	The new receptionist sounded friendly	
Ring back for telephone assessment		I was rung back very quickly		The doctor understood all about my condition	
On arrival in reception		Jane knows me and helped me with my frame			It was difficult for my daughter to park near enough - and my legs aren't good now
During the face to face consultation			I was pleased to hear that it was nothing to worry about	She's a lovely doctor	

Key process stages identified

Use colour to distinguish praise from possible improvements

9.1 Redesigning the process continued

How do you turn the analysis into a new process?

Redesigning a process is a creative process. The analysis will have identified the strengths of the existing process and areas that could be improved. The points below provide some suggestions that teams have found useful, but you will add many more by looking at your own process and considering the design principles that should apply. Examine the design principles and consider which of them are relevant to your process. Translate them into specific recommendations that begin to capture the key points about the new process such as:

'The duty doctor will take responsibility for the overall process and re-allocating resource if necessary.'

'We will use the capability of the EMIS system to capture information throughout the process.'

'We will minimise ring-backs to patients by identifying potentially life-threatening cases and those that are likely to be completed by the clinician by phone and only pass these on for telephone triage/consultation.'

Look at where work builds up in batches in the process, causing delay. Where a number of people are involved in a process, consider locating them in one place or allocating routine times every day to deal with issues to 'stay on top' and stop the delays happening. Can some steps be eliminated or combined? Sometimes it's essential to check processes (and give them adequate time and focus) but often responsibility for getting it right can be left with the person who does the work. Look at which stages really 'add value' to the process and which do not. Can you omit stages that do not add value?

Look at points where errors occur and any 'side loops' for specific cases and consider how these might be merged with the main process. Map out the timeline and assess where the long delays are and what can be done about them. Imagine a perfect process for the patient or transaction involved. What would be different? How near could you get to that process?

Draw a new process map

You have now developed an expertise in process mapping. Map the new process, following the same conventions as you used in mapping out the existing process.

Focus particularly on highlighting what is different and explain the rationale for each change. The task now is to convince clinicians and staff that they should adopt the new process. Think particularly about:

Costs. Identify the costs associated with the change. System changes? Training? Relocation costs? Management and governance cost?

Clinical risk. Address any clinical risk. How is the new process safer than the existing one?

Risks of inertia. Set out the advantages of the change and the cost or risks of not changing.

Patient benefits. Clarify the benefits to patients and highlight the criticisms that you will address.

Explain the process. Set up a session to explain the process more widely.

Gain support. Identify those with a particular interest, include their suggestions and gain their support.

9.2 Planning tips for successful change

You might come up with a great solution to improve access or responsiveness – but not everyone seems to agree that it's such a great idea. How can you plan for a successful change? What do you need to think about, do and say to make it more likely to achieve (and sustain) the change?

Major considerations

- What is the reason for the change?
- Draw out a map to show how you are going to achieve change, step by step.
- What is the incentive that will motivate people to get behind the change? Will additional incentives be needed?
- Is there a proven methodology that can be used to help make the change?
- How will you know that change has taken place? How will you measure it?
- How will you enrol the support of stakeholders?
- What training or education will people need to help make the change?
- What information are you going to use to support the change and sustain it?
- What feedback mechanism will there be to review the changes made?
- What personal support will people receive who are involved in the change?

Who will be affected?

Consider people involved indirectly as well as those involved in the task or activity and key decision-makers.

- It is often people who are not directly involved who can scupper progress – not because they are being uncooperative but because there are practical considerations that you haven't considered.
- For instance, if surgery hours are extending, you will have thought about the staff who need to be on duty, but have you remembered the cleaners who might now have to work later? Are they able to do this?

Tip

Write down a list of all the people or roles you think you might need to consider. Ask other people to check if you have missed anyone off the list.

9.2 Planning tips for successful change continued

How might people affected respond to the change?

'It's just change for the sake of change.'

'Yet another government-imposed change.'

'How are we supposed to cope with yet more change?'

'It's going to be a real benefit for our patients.'

'It feels really positive that we're shifting our focus to support our patients to care for themselves.'

How can you change negative perceptions? Perceptions are not right or wrong – they are just how people see things. For change to be successful, people need to see the future, after the change, in a more positive light. They also need to agree with you that the practice cannot stay as it is. If the change is being imposed externally, you still need to identify meaningful reasons for change and potential positive outcomes for all those involved.

Tip

Preparation is everything. Step into the shoes of everyone you have identified as affected by change. What might they see as the main drawbacks? Start to identify meaningful reasons from their perspective as to why you need to change from how things are now, and the potential future benefits.

When should you communicate with those involved?

- Early and often!
- Don't wait until you have got answers to all the difficult questions and sorted out exactly how things will work in the new way – the risk is that the team involved in change will be disappointed and demoralised when others find fault with the thinking.
- Once you have considered how people *might* view the change, you need to have early discussions with them to establish their real perspectives.
- Encourage each person to explore how they feel and their worries – capture this in writing as you go along, so you can summarise back and check that you have understood their points correctly. This will increase their trust in the process and strengthen their belief that their input does count.

Tip

Expect early reactions to include concerns and discomfort – encourage people to be as specific as possible about what worries them.

9.2 Planning tips for successful change

continued

Do people recognise the need for change?

- If not, what else can you do to help them see this for themselves?
- Have there been issues or grumbles in the past about the existing approach that you can use to campaign for change?
- Can you get those who oppose change to conduct some interviews with patients so they can hear about how individual needs are not being met?
- Have you identified positive benefits of the future you want for the practice that are meaningful for all involved? The closer these benefits can tie in with people's concerns and the reasons for change, the more motivated everyone will be to achieve it.
- Without a perceived need for the change, it will be very difficult to achieve it and make it last.

Welcome feedback

Welcome the feedback you are given. When people express their thoughts and feelings about change, this is valuable. If you label disagreement, concerns or reluctance as 'resistance', you might not utilise the full value of the feedback you are being offered.

Feedback shows that people care and view the change as important – but make sure it is specific and not just discomfort with any kind of change. Probe people to help them pin down what's driving their anxiety or the cause of their disagreement.

Be warned. Apathy or passive agreement may disguise a lurking problem, which can sabotage the change at a later time. It's better to have all the concerns out in the open as early as possible.

Next steps

Work with everyone including your critics to develop what you would like to change and how – involving them helps develop a sense of ownership. If there are too many people to work with simultaneously, ask individuals to be your 'sounding board' or 'critical friend', to spot flaws in your proposals and help develop better solutions. This is more effective than presenting the idea or solution without consultation and hoping people will agree with it.

Tip

In all your communications encourage people to spot flaws and flag up specific concerns. It helps you identify things you may have missed and shows that you value individual contributions. This input gives you a chance to develop a more workable design or solution – and reduces the power of potential saboteurs.

9.2 Planning tips for successful change continued

Tailoring your message to different types of people

<p>Analytical</p> <ul style="list-style-type: none"> • Formal • Measured • Seek accuracy and precision • Dislike unpredictability and surprises. 	<p>How to communicate</p> <ul style="list-style-type: none"> • Provide facts and figures in an orderly fashion, with supporting documentation. • Define the change clearly and their role in it. • Give them a chance to examine it all carefully and think about it – actively listen to their concerns and encourage them to think through solutions.
<p>Driver</p> <ul style="list-style-type: none"> • Business-like • Fast and decisive • Seek control • Dislike inefficiency and indecision. 	<p>How to communicate</p> <ul style="list-style-type: none"> • Want to know what we are going to do, and how soon we can do it? • Talk results, don't waste time, find short cuts. • Involve them in the pilot/prototype so they see a real model of change.
<p>Amiable</p> <ul style="list-style-type: none"> • Conforming • Easy going; less rushed • Seek appreciation between others • Dislike insensitivity and impatience. 	<p>How to communicate</p> <ul style="list-style-type: none"> • Make sure you include the human dimensions of the situation. • Want to know how others feel, who else will be involved – take time to talk. • Encourage them to chat through with colleagues throughout the change – value and use the feedback they provide.
<p>Expressive</p> <ul style="list-style-type: none"> • Fast and spontaneous • Seek recognition • Dislike routine and get easily bored • Like brainstorming ideas. 	<p>How to communicate</p> <ul style="list-style-type: none"> • Will be looking for what's new, exciting and innovative. • Don't want the detail. • Keep it fast-paced and fun. • Let them try out the change and then motivate others through their enthusiasm.

Adapted from source reference: Merrill and Reid 1999 as in *Improvement Leaders' Guide – Managing the human dimensions of change* (from the NHS Institute for Innovation and Improvement)

9.2 Planning tips for successful change continued

How will you plan for a successful transition?

There are two key aspects in planning the transition:

1. Make sure the steps involved are feasible and practical.
2. Make sure you have the capacity to make the required changes.

Learn from others. Find another practice that has already implemented the change you want to introduce. Pay careful attention to what they found to be the essential first steps.

Research. Could a member of staff go and see how the solution works elsewhere (shadowing)?

Set up a pilot. Could you pilot the approach in a small way to assess what's involved, spot teething problems and calculate what's required to make it work in your practice? Do you need to run two systems in parallel for a defined period?

Do you have capacity? Do you have the necessary resources, skills, training, equipment, infrastructure, time and energy to make change happen? What do you need to do to make sure these are in place? Can you cope right now with yet more change or should you prioritise and reconsider the timing of certain changes?

Are you ready? Do you have the confidence and belief that you can take the actions required to get the change going and make it work? If not, what else do you need to think about or do?

Tip

Expect the unexpected – like most things in life, change will rarely go exactly according to plan. But the more you consider the feasibility and capacity issues in advance, the greater the chances of success.

9.2 Planning tips for successful change continued

And finally

There will be a risk, once you have introduced the change, that things slip back to old habits (think about the parallels of sticking to a diet or giving up smoking).

So you need to think in advance about what might slip back to the old way and why and how you can reinforce and support the new way. If it's an option, can you remove the old way completely?

Can you make it easier to do things the new way? At the very least, you should build in review points so that any complaints or difficulties can be channelled and addressed.

Additional resources

Improvement Leaders Guides – order or download at

www.institute.nhs.uk/improvementleadersguides

Managing Change in the NHS and related publications – order or download at

www.sdo.nihr.ac.uk/managingchange.html

Author: Jo Hollands of Navigator Research & Consultancy Ltd has extensive experience of facilitating NHS groups developing ideas and plans for service improvements, and the associated changes.

Tip

Celebrate the achievement of small steps along the way and keep up a positive momentum.

Glossary



Telephony terminology

ACD – Automated Call Distribution

This system includes a range of sophisticated call management solutions employed in call centres.

ADSL – Asymmetric Digital Subscriber Line

A broadband technology that delivers very high data transfer speeds over existing telephone lines. More bandwidth is delivered downstream than upstream; ie you can download items faster than you can upload them. This is ideal for residential connections or businesses not running a server.

Alternative carriers (also known as CPS)

This feature allows the telephone system to be programmed to select more than one carrier (telephone line provider) for your calls. You program the system to recognise which type of call is to be carried over which network at which time of day. This enables you to always get the lowest available call rates.

Analogue lines

The original telephone lines. They are still the common choice in smaller telephone systems; however, current technology has resulted in a shift towards more cost-effective options such as ISDN and SIP trunking.

Auto attendant (see IVR)

An automated answering system that uses prompts to guide the caller to the correct department or extension by pressing keys on the telephone handset, eg 'For appointments, press 1'.

Bandwidth

A measurement that gives an indication of the amount of data that can be sent through a connection.

BlackBerry

A handheld device that gives you mobile phone, email and other useful functionality away from the office.

Call forwarding

This feature enables incoming calls to be forwarded automatically to a different number, eg a mobile or home number.

Carrier

The telephone company or the provider of telephone lines into your facility.

Glossary continued

Centrex

Centrex is a PBX-like service providing call handling at the main telephone exchange of the telephone company, such as BT, instead of at the customer's premises. Typically, the telephone company owns and manages all the communications equipment and software that is necessary to implement the Centrex service and then sells various services to the customer.

Channel

This is another word for telephone line, usually in the context of digital lines.

CPS – Carrier Pre-Selection

This feature allows the telephone system to be programmed to select more than one carrier (telephone line provider) for your calls. You program the system to recognise which type of call is to be carried over which network at which time of day. This enables you to always get the lowest available call rates.

CTI – Computer Telephone Integration

Also known as unified messaging, this system provides one centralised mailbox for all email, voice and fax messages, and all messages can be received, replied to, saved or deleted in this one inbox.

CLI (Calling Line Identification) Presentation

Clever technology that displays the telephone number of the caller on the receiver's telephone display.

DDI – Direct Dial-In

This is the ability to assign individual telephone numbers (DDI numbers) to extensions, faxes, computers and departments, enabling callers to dial them directly and automatically through the switchboard without having to go via a receptionist.

DECT – Digital Enhanced Cordless Telephony

DECT handsets provide wireless communications within an office, building or site, and they can be fully integrated into the company telephone system.

DSL – Digital Subscriber Line

This technology brings high-bandwidth information to homes and small businesses over telephone lines. It can carry both data and voice signals (see ADSL).

Hosted

This phrase is used to describe a service that is provided to the customer using equipment that is located remotely from their facility.

IP – Internet Protocol

This is the generic term to describe the way that voice and data signals can be sent between devices connected to a network, including across the internet and LANs.

Glossary continued

IP Centrex

IP Centrex provides similar functionality to Centrex but calls are handled via a broadband connection.

IP PBX

An IP telephone system.

IP telephony

IP telephony is the use of IP signalling methods to send voice traffic across a data network. It can eliminate the need for separate voice and data networks by converging all traffic on one network, and it provides a wide range of other benefits for business telephone users.

IP/VoIP gateway

A gateway for existing telephone systems, converting traditional telephony traffic into IP for transmission over a data network. Using an IP gateway can be considered as a 'migration path' towards IP telephony, as you can gradually transfer to IP telephony while adding longevity to your existing telephone system.

ISDN – Integrated Services Digital Network

ISDN is a digital public network for voice and data communications with charges for line rental and calls. ISDN is available as 'ISDN2e', where the lines come in pairs, or as 'ISDN30e', which comes in groups of up to 30 lines, the minimum order being eight.

IVR – Interactive Voice Recognition (also known as auto attendant)

An automated answering system that uses prompts to guide the caller to the correct department or extension by talking instead of by using telephone keys, eg 'What do you want to do? Book appointments? Order a repeat prescription?' The caller then tells the system what they want to do based on the suggested options.

LAN – Local Area Network

A computer network within a limited area, eg within a building or a specific floor of a building.

MAC or Moves/Adds/Changes

These are the processes of moving staff to a different desk location, adding an extension or changing an extension number at a certain location.

Network

A computer network consists of two or more computers that are connected to each other so that they can share and exchange resources.

PBX (or PABX) – Private Branch Exchange

A private business telephone system.

Glossary continued

Pots vs. Pans

One of our favourite acronyms: Plain Old Telephone Systems versus Pretty Amazing New Systems!

PSTN – Public Switched Telephone Network

This network was traditionally analogue but now includes digital (ISDN).

QoS – Quality of Service

This is used to provide acceptable voice quality across IP networks.

SIP trunking (Session Initiation Protocol)

In order for your telephone system to be fully IP enabled, you will need a SIP trunk. A SIP trunk is a pure IP connection between your premises and the national telephone network. SIP trunks can work on broadband and other types of data connectivity such as leased lines.

Smartphone

A mobile phone that is like a mini-computer and can browse the internet, receive email and let you work on documents and spreadsheets while on the move.

Softswitch – Softphone

A software application providing server-based telephony, eg a softphone on your laptop allows you to make calls from it.

Telephone extensions

The number of extensions that you will require depends on how many staff you have needing desktop phones.

Telemedicine

The prefix 'tele' originated from the Greek meaning 'far off' or 'at a distance'; medicine being defined as 'the science and art concerned with the treatment, alleviation and prevention of disease and the preservation of health'. Telemedicine is a telecommunications and computer technology that allows medical care to be delivered for remote patient care, continuing education and research using electronic signals to transfer information from one site to another, irrespective of location.

Telecare

The term 'telecare' is used to refer to care for the chronically sick, who are usually being managed at home from a health centre or hospital. It is seen to be part of telemedicine as a whole.

Trunk

Not to be confused with the front end of an elephant, in telephony a trunk is another way of saying a 'line' or 'channel' that you need for making a call.

Glossary continued

Unified messaging

Also known as CTI, this system provides one centralised mailbox for all email, voice and fax messages, and all messages can be received, replied to, saved or deleted in this one inbox. When used in conjunction with CLI (Caller Line Identification), information is selected automatically that relates specifically to the incoming caller's ID and can 'pop up' on receptionists' PCs.

Virtual

This phrase is used to describe a service that is provided to the customer using equipment that is located remotely from their facility.

Voicemail

Allows callers to leave messages in individual mailboxes. These messages can often be retrieved remotely.

VoIP – Voice over Internet Protocol

VoIP = IP telephony. VoIP is the transmission of voice traffic over a WAN, VPN or the internet.

VPN – Virtual Private Network

Linking telephone systems and/or data networks together across the internet. A VPN is a fast and secure way to transfer data between remote sites.

WAN – Wide Area Network

A computer network that covers a large area rather than being limited to one building or site.

WCA – Web Content Accessibility

Web content is accessible when it may be used by someone with a disability.

