Patient Access practices

Research survey

H Longman, July 2011, rev 4 Jan 2012

1. Purpose and background

With over 90% of patient contacts taking place in primary care, access to GPs is of critical importance for patients, doctors and the wider NHS. A small number of practices, about 1 in 200 in England, were found to operate an innovative and promising access method, based on an initial GP callback. The survey, conducted by H Longman while at LCR PCT and analysed subsequently, aimed to record both the operational characteristics of these practices, and the subjective views of staff.

2. Summary findings

The main operational features of these practices are:

- The majority, around 80%, of demand is initially responded to by a telephone call with the doctor. This is within typically 41 minutes.
- Doctors will take a number of clinical actions over the phone, but just over half the calls complete the consultation.
- About one third of the calls result in a face to face appointment with the doctor, and nearly a tenth with a nurse.
- The appts are normally offered on the same day, and while 80% of patients choose to come on the same day, they may come later if they wish.
- The appts are mainly with the same doctor who spoke earlier, depending on timetabling choices.
- DNA rates are about one quarter of those experienced previously.

Questioned on the change to the method and how it is viewed by patients and staff:

- The motivation to change was principally a need to handle patient demand better while managing doctors' workload. The trigger was often a crisis.
- The source of knowledge was in 18 cases a new invention, in the remainder hearing of the method from others locally or in published material. A small number of nuclei have helped several other practices make the change.
- The vast majority of patients like or love the system, and many practices report growing lists. A few don't like it, or didn't at first, and some practices

say they would like to have done more preparation with patients before making the change.

- Staff are overwhelmingly positive, and would not go back. This includes receptionists and managers as well as doctors. A small number of doctors have difficulty with the telephone consultations.
- The practices have diverse populations, covering the full extent of England by geography and deprivation, ranging in size from 2,000 to 20,000 patients.

3. Survey Method

Prior to the survey practices had been asked to describe their method of managing access to GPs. 225 practices were interviewed in earlier research conducted by the author, some others by Dillon Sykes, revealing a variety of systems for managing the response to patient demand. Most of these were in the highest 2% on the question "very easy to speak to doctor" in the GP patient survey. A subset of these practices was identified, previously unknown to each other, later adopting the name "Patient Access" as a community. They described, with variations, a system where all or the majority of demand is handled in this way:

- The patient calls the surgery
- The doctor speaks soon and directly to the patient
- The problem is dealt with today, or later by patient choice

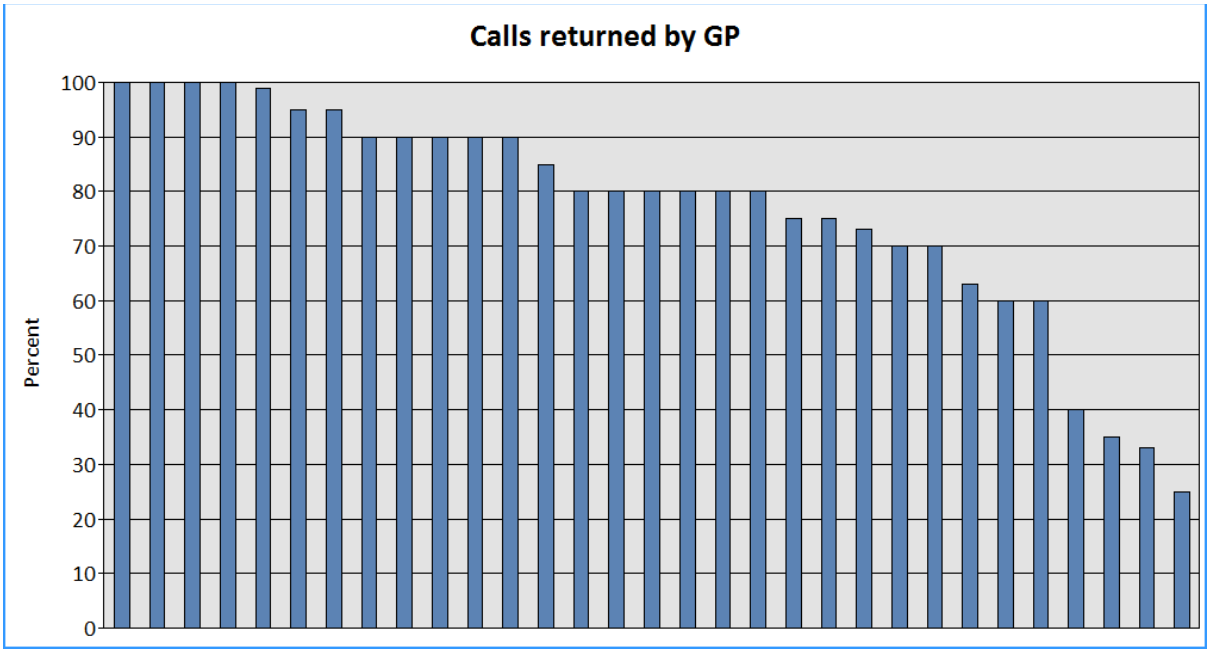
An online questionnaire was created using SurveyMonkey software courtesy of EMQO. 41 practices were invited to take part, and 32 responses were received. One was from a practice which later decided not to be further involved as their method differs too greatly from Patient Access. The survey was completed by a GP or practice manager. Estimates were allowed where numerical data was requested.

Fully detailed responses to the survey are appended.

4. What proportion of patient demand is handled initially:

By telephone response from a GP	76.9%
By appt booked through reception	18.7%
By patient walk ins	1.4%
By telephone from a nurse	2.1%
By patient over phone/internet	1.0%

Chart showing percent of calls responded to by a GP, each bar representing one practice (names are withheld for anonymity).



The dominant route for those surveyed is clearly a telephone call, though there is some variation and four practices say more than half of appointments are booked through reception.

5. What do receptionists ask patients when they call?

Out of 31 respondents

What is the nature of the problem?	18,	58%
Is it routine or urgent?	21,	68%
Is it for advice or appointment?	9,	27%
Can anyone else help?	14,	45%

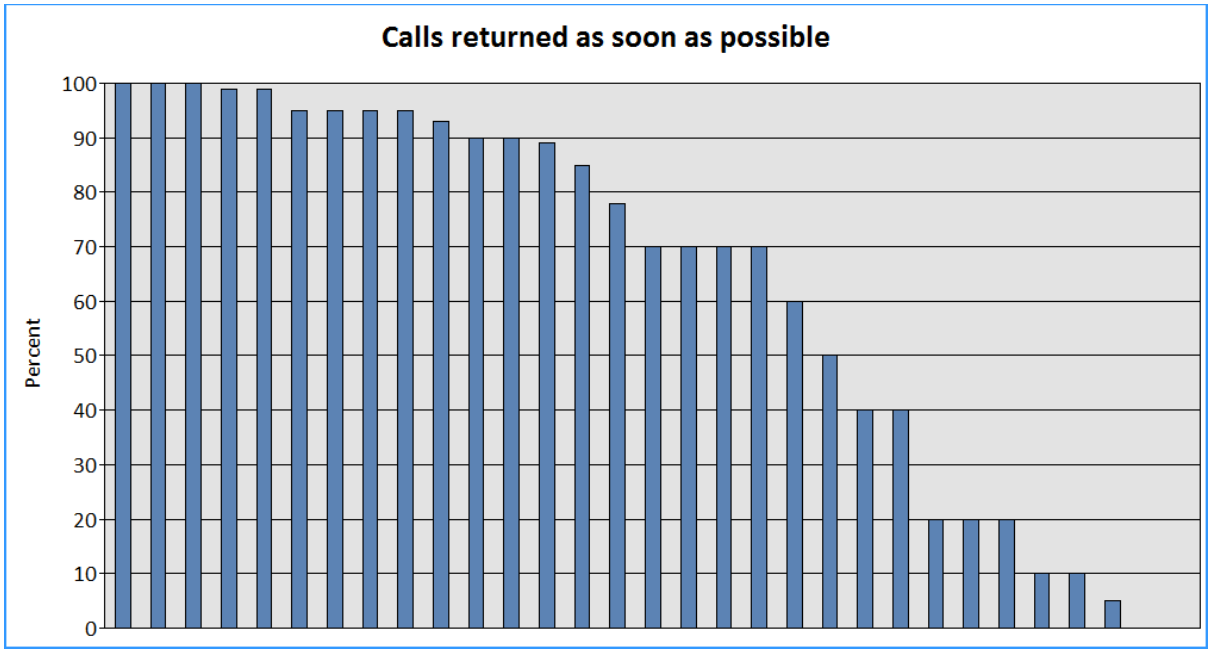
Among other responses, receptionists ask to confirm the number to call back, including mobiles. They may ask about a convenient time to call. Flexibility is reported in some cases, depending on what the patient says. One urges patients to try to see the same GP for continuity.

6. What happens to effect the telephone conversation?

An approximate % of each was requested. Overall:

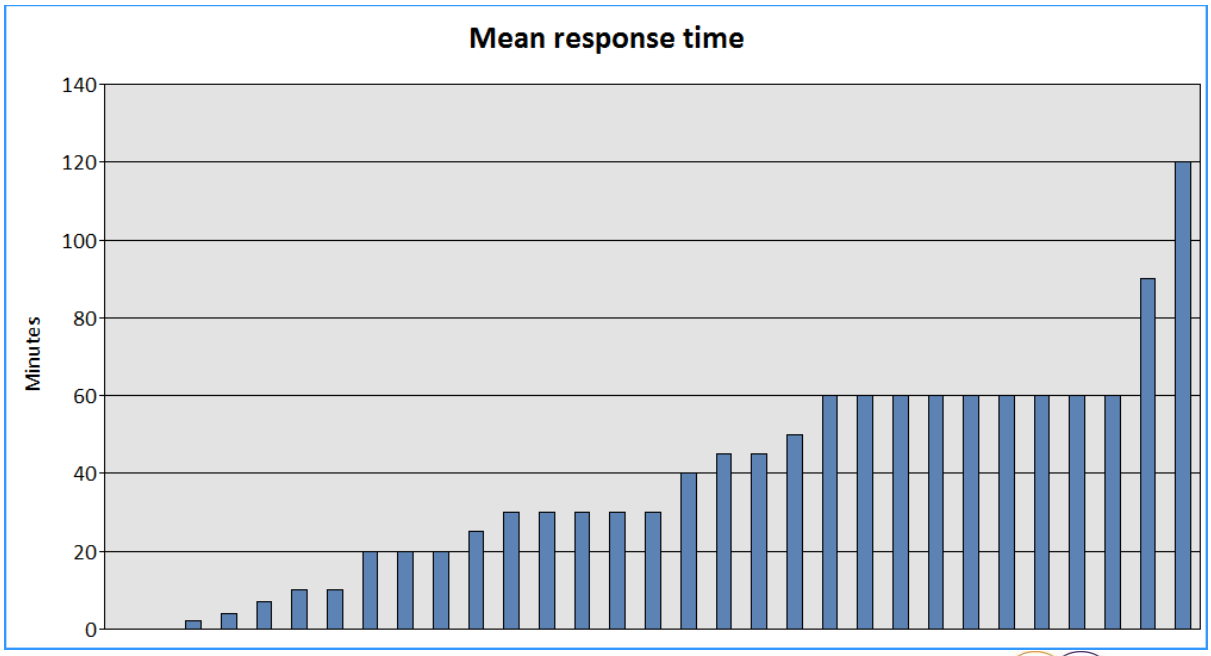
Doctor calls back as soon as possible	63.2%
Doctor calls back at surgery specified time	14.2%
Doctor calls back at patient specified time	11.4%
Patient stays on phone and doctor picks up	11.3%

Percent where doctor calls back as soon as possible – most calls in most practices.



7. How soon does the doctor call?
   In two practices most of the telephone demand is directly routed to doctors, for specified times of the day. In others, all or most of the demand is noted by receptionists, with a number to call back. How quickly does the doctor call back? This is shown as 0 for direct calls (although it is not recorded how long patients have been on hold). For the others, a range is estimated, all except two stating one hour or less and with a mean of 41 minutes.

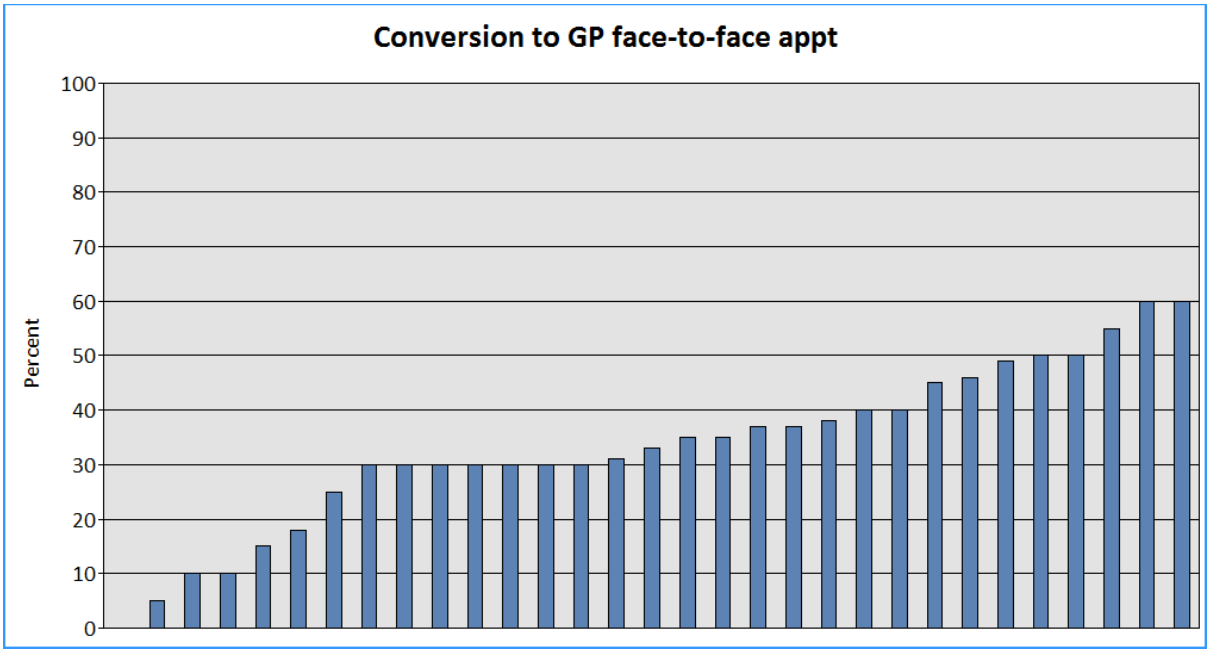
   Chart of stated mean response times, minutes. Each bar represents one practice



8. What is the flow from the initial call?

Completed by the phone call	51.5%
Face to face appointment with GP	34.5%
Face to face appt with nurse	9.6%
Home visit	2.3%

The chart below shows by practice the reported % converting from the call to a face to face appointment. The vast majority lie in the range 30-50%. Note that in most cases these values are estimated by GPs and managers, not directly measured.



9. What clinical actions may be done in the phone call?

Prescribing	31,	100%
Initiate blood tests	29,	94%
Initiate diagnostics eg ultrasound	23,	74%
Refer to secondary care	22,	71%

10. Where a GP appt is made, who sees the patient?

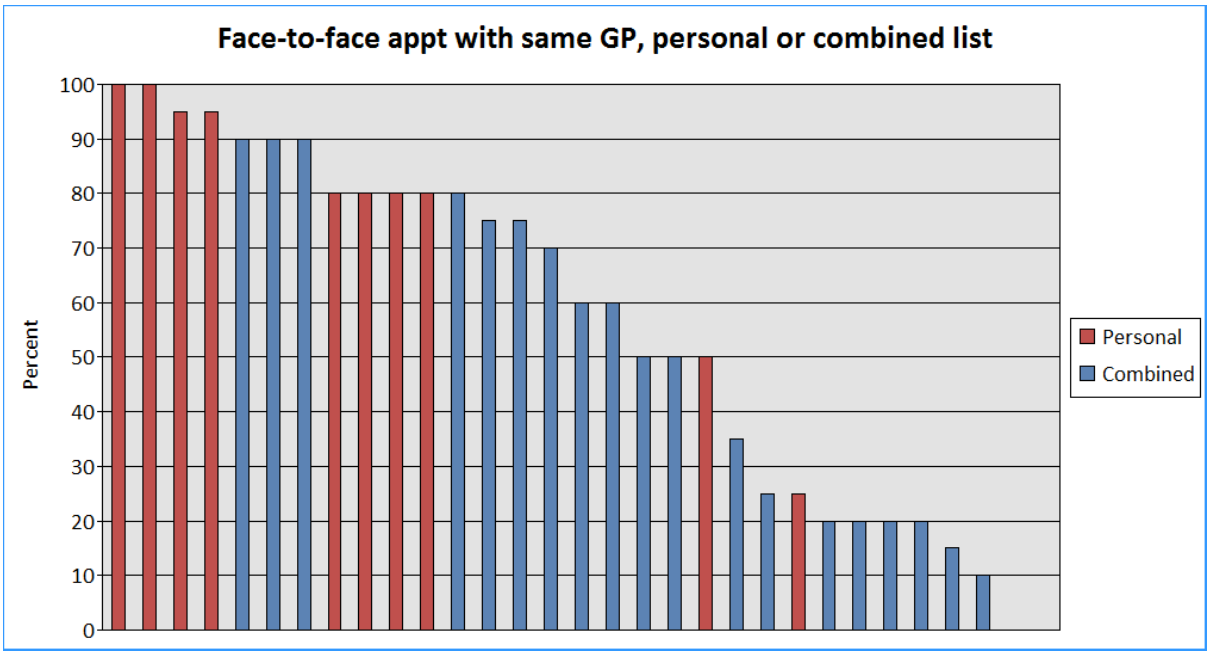
The same GP	60%
Another GP	40%

The reasons for seeing a different GP are several, principally

- One duty/triage doctor takes all the calls, and sends patients to see other GPs who are timetabled to take these patients

- A GP with a special interest may be suggested by the first GP as most likely to be able to help the patient
- Some GPs work part time and the patient or GP may suggest seeing the preferred GP, even if that person did not make the initial call.

The following chart shows the distribution of the % where the patient sees the same GP, coded red for practices using a personal list system.



Most practices operate a system where over 70% of patients see the same GP, while a minority operate the other way round, with most seeing another GP. This suggests that the principal reason for the difference is the timetabling choice. Both list types operate both systems, but those with personal lists are more likely to ensure that the same GP sees the patient as makes the initial call.

Clearly there are implications for continuity of care both on the day and in the long term, a matter on which both doctors and patients often have strong views.

11. Where a face to face appointment is needed, when is it offered and when chosen?

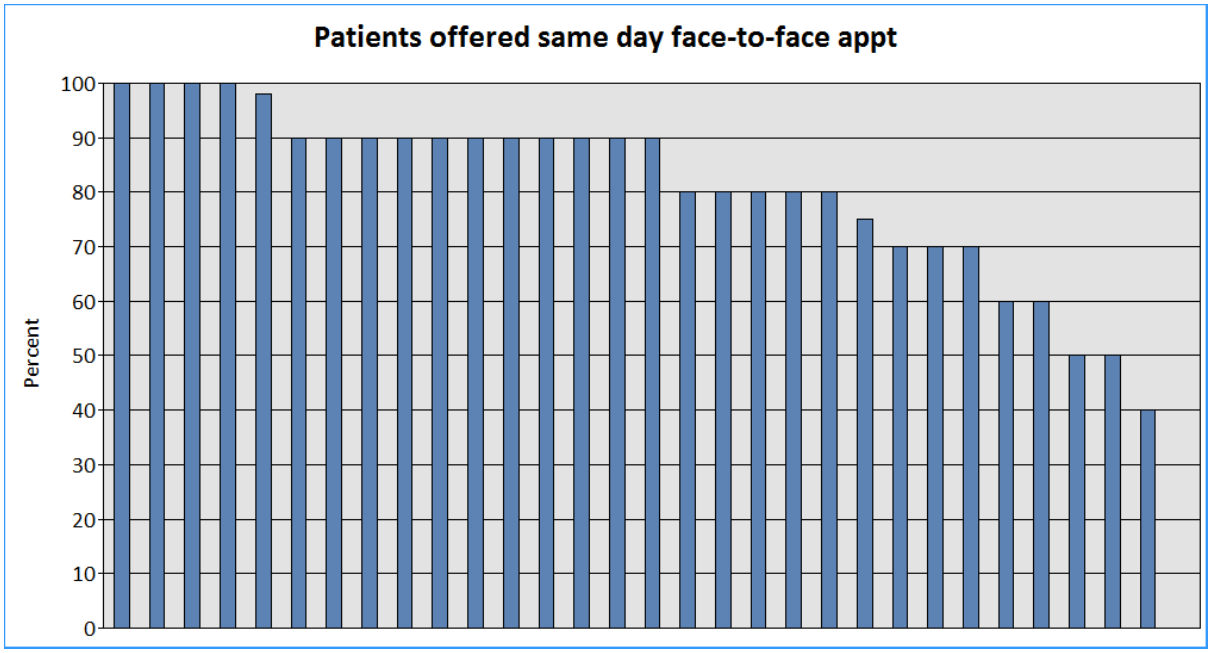
Offered same day	81.1%
Offered next day	11.0%
Offered later	7.9%

Chosen same day	79.3%
Chosen next day	11.2%
Chosen later	9.5%

The first remarkable statistic is that over 80% of appointments to see a GP are made on the same day. Secondly, almost exactly the same proportion of patients choose the appointment to be on the same day.

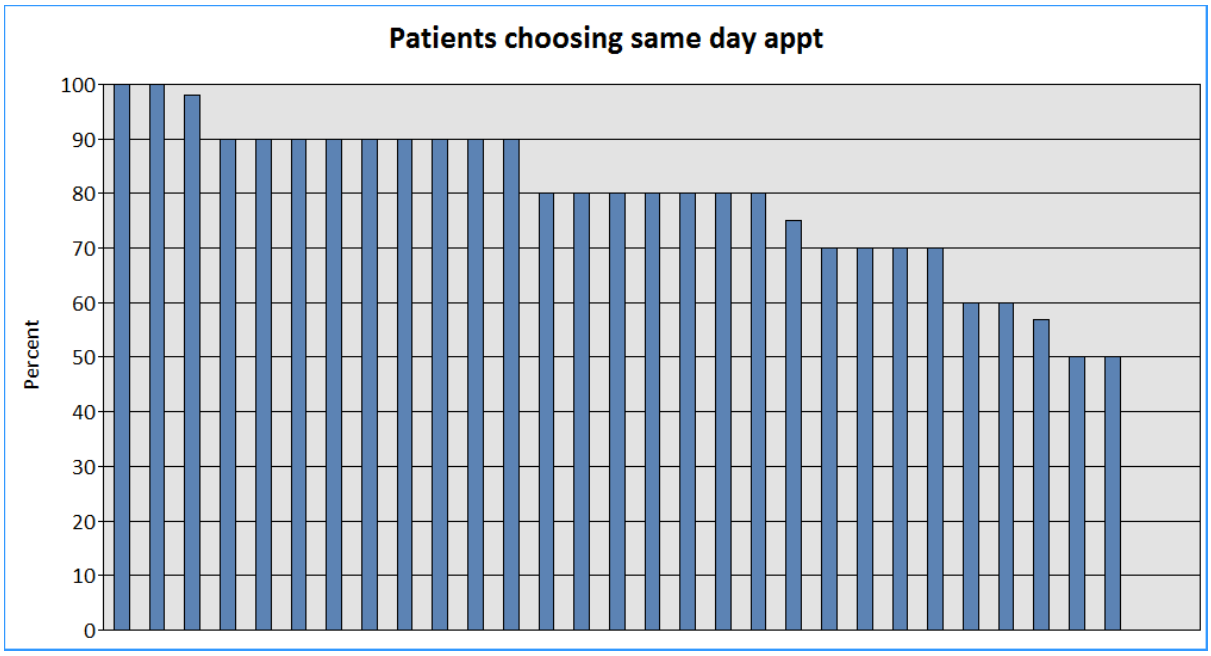
These findings directly contradict current orthodoxy on what is possible for GPs to offer and what most patients want most of the time. It highlights the success these practices have had in creating sufficient capacity to offer this service, and their ability broadly to match capacity to demand every day.

The distribution below shows that most practices are able to **offer** a same day appointment to at least 90% of patients.



Patient Access
Simply transformed

The chart below shows the **choices that patients make**, when given a free choice, as estimated by respondents. Again, an average of 80% choose the same day.



While these measures are estimates by the practices, and not necessarily backed up transaction data, they match very closely measures produced from original data in two practices operating the method, over a nine month period.

12. What are your DNA rates?

Before introducing the method	10.0%
Currently, with the method	2.8%

The figures both before and after are estimates in most cases, but the change is clear. The reduction of 72% is likely to be because patients are seen when they want to be seen, which is, 80% of the time, the same day.

13. Concerning the change to the current system, how many days were there between the decision and making the change effective?
The answers ranged from overnight up to two years, with a median of 30 days and many others around 60 days

14. **Free text questions**
Responses are shown below the question, each sorted in alphabetical order.

Was there a specific event or situation which triggered a change?

Trigger for change
A fire at the surgery
Appropriate appointments for patients, GP can make on the spot decision regarding when, where and by whom a patient is best seen
Change in partnership - two GPs retired.
Continual lack of appointments / Dr stress
demand & changes to doctor access
demand exceeded supply
Failing on Access
General abuse of same day appointments by patients with trivial issues whilst genuine urgent cases not seen early enough.
I had difficulty fitting in patients requesting same day appts so I started to phone these patients back rather than see them and in 2000 started to do this with all patient requests for appointments. However a patient is never refused a face to face apt
I had to change something to reduce the stress created by patient demand. Managing demand rather than increasing capacity seemed a logical way forward. I started to enjoy general Practice again soon after..
Initially implemented "total triage" but patient feedback was so poor we changed it to offering telephone appts as well as face-to-face appts.
Introduction of walk in center - pts expectations and on the day demand high and increasing daily workload.
Just wanted to look at a different way of working
Managing demand many instances when patients coul dnot book
misuse of appts causing lack
New manager, 6 months in post, creaking, unsatisfactory system in place, then attended conference
No
No
No - general build up of workload and lack of control
On going issues around access
One bloody awful day when we triaged successfully and realised how well it could work
part of advanced access
Partners always booked too far ahead
Re-assessment of capacity management after a busy period and concerns about safety
Recognition that demand at certain times of the week exceeded capacity and that this represented an option for meeting that demand without using all the appointments for the week ahead, which often having been made were not fulfilled, as self limiting ill
Swine flu
the lack of appointments available for patients to book, and the doctors feeling that certain types of issues could be dealt with over the telephone.
The realisation that we were not adequately meeting increased demand
Untenable demand and a conference event presenting alternative access ideas
We are a new APMS practice. We decided to offer a different service

Please name any other person, practice or published material which was important in your decision to adopt a new method

Source of knowledge
Blackbrook Surgery, Taunton
Blackbrook Surgery, Taunton Dr Lisa ??
Cornwall GP conference. A Newquay (I think) practice was doing it and I liked the idea
Dillon Sykes and Steve Clay from Productive Primary Care
Discussion with one other practice in Bristol (sorry, not sure of the name)
Dr Graham Archard, GP in Dorset talking at NHS Alliance conference in Dublin
Dr Steve Clay
Dr Zia Noor (Partner at Cofton)
Dr. stephen Clay
Essentially we did it off our own bat, although I can remember speding a day at an NHS London hosted conference where outside speakers talekd about 'doing today's business today'
Flyer came round about a practice in Dorset/Pool who had trialled it which prompted practice to find out more
I ahd worked at a previous practice who used this method and presented to prcatice as an option
I felt the concept of Advanced Access was flawed and decided to "do my own thing". I liked the idea of "doing todays work today" had some merit but modified it and decided to run with the telephone system. We have not looked back.
Local practice in Preston we met at the
n/a
NHS Stour booklet
No
None
None
None that I recall
Personal experience from a gp friend
Really just one arrived at by the partners
SL
Stour surgery
Talk by Blackbrook Surgery in Taunton on "total triage"
we met with Quorn Medical Centre as they were already using the triage system
We spoke to a local practice, and discussed how they worked their triage system.
We were not aware of any material at that time

How do your patients view your access method?

Patient view
>90 % positively
Almost all view it as highly effective and efficient
Anecdotally they find it easy. Many comments are positive
Can be mixed, but on the whole thay can be seen the day they call
Clearly, the ones who used to abuse the old system don't much like the triage system but on the whole the approach is popular with patients. They often get the reassurance they need without being seen.
Generally like it
Initially some doubts. Now generally accepted and liked by many.
It is now universally accepted
majority think its great - occasionally one odesn't like the method but most are now used to it
Majority value being able to speak to a doctor on the phone. When the system was first introduced it was unpopular, but as it progressed patients came to understand how to use the system and see the positive aspects of it. We've had to 'tweak' the system over the years to make sure that it is accessible for all patient groups i.e. those who work, or those who rely on others for transport. The key to any appointment system has to be flexibility. Volume of calls and resources in answering are the biggest limiting factor.
mixed feedback, some feel its a barrier to getting an appointment, others like the fact they can speak to a gp and not have to come to the practice to get problem resolved.
Mixed, more in favour than not
most are happy/accept it
Most like the system although there are people who would rather book an appointment than speak to a GP on the phone
Mostly positive. A small minority don't like the call back, mostly teachers and others who find it hard to talk at work. Some older people don't like it and some feel "fobbed off".
Number of respondents Percentage respondents I got to speak to a clinician I liked 73 97% Telephone triage is a good way of getting the advice you need 66 88% The person I spoke to / saw dealt the problem in a safe and satisfactory way 75 100% Overall I prefer the telephone triage booking system to the old system 57 76%
Patients wishing for a nurse apt speak to reception, those wishing to speak to a GP are automatically put in line to speak to them directly. There is a call back system for patients who needed to speak to a GP but are unable to call in the am when the GPs are answering calls. This system is often very different from a previous GP experience, but once patients get used to the system we find that they are mostly happy with with the ease of access it provides. We also believe that patients are more happy to disclose medical information to a GP than they would a receptionist and as such the GP is able to triage appropriately to the need of the patient in a way that reception never could.
Still some doubts, but patients seem to be getting used to the system and those that work and can take calls like it. Positive feedback is growing.
The love it
The majority of our patients are happy with our call back system as it allows them to see the doctor at a time and date convenient to them. There are a few who see it is a barrier to accessing the doctor.
The majority of patients enjoy the improved access. There were issues initially with patients who

Patient view
couldn't take a call back or worked in an open plan office. If this is the case we now put them in a pre-bookable slot.
There were negative concerns when we first moved to the telephone triage system, especially amongst the elderly population as they did find it intrusive when asked questions by reception, we do stress however that they do not need to give an explanation but it can help reception staff offer the best service by offering a GP tel call, nurse practitioner appt or nurse appt. Now patients realise that if they speak to a GP first they can either deal with a query over the phone or get an appt time that is convenient to them, they are extremely satisfied. Reception can book an allocated number of GP appts each day to allow for those pts who do not have telephone access. Our appt system is always explained in detail to new pts who register.
They like it. Satisfaction rates are in the 90+%
They love it
They love it
Those that understand it love it!! Unsoliticited feedback has been extremely positive. Especially from patients that historically complained about the old system
Usually more positive than negative feedback
Very favourably (once new patients have had the method explained) - it is widely accepted by all patients that the telephone is first call and they appreciate the prompt service
Very popular
very satisfied - consistently score well above national average for satisfaction in GPAQ survey
Well received, although we're always slightly concerned that this represents a barrier. this hasnt been born out in surveys

How do your doctors and other staff view your access method?

Staff view
again feel its great, wish their doctors used it
All the staff feel that we are providing a good service for our patients.
Better than standard appt system
Bottom line is that they would not go back to the old system.
doctors would not return to previous methods and staff almost all feel it works extremely well
Doctors: all feel that we are very available to patients, that we save on a lot of unnecessary face to face appointments and we feel that out patients are more than satisfied with the service we offer. Staff: 100% positive. Doctors make more of the de
Fab
generally happy - all staff who worked under the previous method prefer the present way. Some salaried doctors find triage hard (but like it when they go home with no extras on "normal" days!)
Happy with it in the main
Our staff and Doctors love it, but the local GPs in other practices do not want to change their method of working
Reception staff like it. Doctors like the control, but don't like the open-ended workload.
Receptionists are pleased with the system now they and the patients have got used to it and

Staff view
understand how it works.
Receptionists wish their own GPs ran this system Less stressful for reception in terms of booking appointments Partners would never go back to old system Associate Doctors more mixed opinions depending on familiarity and confidence with system. Views o
Recpetion like it; Its hard work for doctors, especially for those not accustomed to this way of practicing
See it as a prefered method to manage demand
sometimes difficult, flexible, needs consistency
Staff like it so long as there are enough appointments in general. Most of the doctors love it, albeit the odd one sometimes feel they are doing the work a receptionist!
System is constantly being tweaked to ensure the best is gained from introduction of Tel Triage
The doctors prefer this appointment system and would be very reluctant to revert to the old style appointment system.
The GPs like the control this gives them and are sure that every patient in the list is appropriately assigned. Reception staff are free to deal with ongoing nurse, phlebotomy and other primary care appointments such as physio, podiatry and are able to f
The main doctors would not go back. We are constrained by the fact that one of the is on maternity leave, so locus are used. This has had am impact of delaying access as they are uncomfortable using Patient Access approach.
The majority of the staff feel it is a great step forward, however two of the Doctor's are not comfortable with the triage system.
They all like it and recognise that it reduces stress, improves patient satisfaction and happiness, is simple and efficient
They love it
They much prefer it, across the board.
They would not go back to the old system. We could not manage the patient list size in any other way. Telephonists / Receptionists do not want to triage patients or ask what the problem is.
Very popular with some doctors - others dislike consulting over the telephone
Very positively
Very well, we have done this for so many years that it is just "how we do it"
We like this as it helps us manage our time
We would not change it

Would you do anything differently in making the change?

Do different?
Advertise it more. It was done bit by bit and only really worked when it was implemented fully about 9 months ago driven by a new practice manager.
At first, we allowed some same day appointments to be bookable without triage. After a few months, we abandoned this and therefore duty doctor gained more support from other doctors.
Demand is ever changing - would book in under1's without call back
I would engage with Patients more and ensure they understood the system before introducing it. The Doctor's need to be signed up for it and although not all of them need to do the triage, they all need to understand what it involves and play to each others strengths. This needs to be understood and agreed beforehand!
Ideally we would prefer a local calling number than an 0844 number however at the time this was the only type of system that provided the solution we needed to deliver our vision. In the future if there are alternative options that provide the same service we would be prepaired to review. We are also interested in looking at new technologies to deliver this vision as well.
Keep all partners workload equal from the start
Make sure that staff are fully briefed and accepting of the new system - stress the benefits of the change and if the staff are happy and accept it the patients will too!
Maybe give more information to the patients about the changes
More communication with patients.
More staff training and more information for patients. More positive spin on it - we didn't know how successful it would be!
n/k as I wasn't involved in the change- before my time
No
No
No
No
No
No
No
No
No I feel our preparation was good and overall the method exceeded all expectation
No, we have evolved and are broadly happy
No.
not at all - we continually modifty the system to suit our needs or capacity i.e during holidays etc
Publicise to patients much earlier and more widely More training to new GPs coming into the system More information to new patients coming to the surgery - dedicated information leaflet Sceptical GPs moved to the method on seeing it work for other partners. Patient group meetings to explain the method - We have done this successfully subsequently
Reception might screen a little more. ie ask if this purely an admin enquiry
The system has evolved and works well as it is . We tweak things but basically we like the system as it is.
We are always tinkering with the timings of surgeries
we are continually making changes to improve the system

Do different?
We would not have changed our telephone system at the same time.
We'd run several 'pilot' days prior to making the change and were therefore able to iron out any teething problems. On the whole the change went very smoothly. There was always an intention to keep auditing the system and responding to patient concerns.
We've revisited our system with aptients, admin and clinical staff and think we've got a fair balance.

Do you use any measures to understand your performance in practice, and how do you use these for improvement?

Meaures used
complaints - massively reduced in number with regard to access Incoming call stats on the phone to predict need for phone appointments Staggered start times to reflect phone peaks Triage rates periodically fed back to consulters Looking at continuity currently, 3 site practice 10 consulters potential for loss of continuity. Significant events - or lack of them - related to triage.
Data audits for telephones v face to face
Feedback from patients to patient group, patient surveys and informal feedback in writing, face-to-face or via website.
GPAQ mainly but will be using a patient paryticipation group in future for feedback We did some early analysis of what was happening with each call - but the overall improvement was so positive we felt confident of the effects on patient care
I have an access database which allows me to analyse the utilisation of appointments in any which way. For example, we reduced waste in clinic appointments by reducing "sent for" appointments.
If we get any complaints - these are rare
It's a dark art honed over years but always subject to review
measure response times, volumes, analyse trends/patterns on days, sessions etc, doctor popular trends. All used to best match capacity to demand
monitor against Patient Surveys
Monitor demand management
Monitored number of calls, some data regarding appointments given and resolved over the phone was collated in the early days to monitor whether it was worth continuing with the trial
No formal measures - it is clear when system is/is not working. We may audit triage calls per doctor to maintain equal workload
No, other than soundings.
No. We keep an eye on our level of patient satisfaction in the surveys, and we do periodically look at our A+E and OOH figures.
Number of requests per day, number of extras, patient satisfaction, outcome of appointment. Used to ensure adequate capacity and identify areas for further study or improvement.
Patient survey
Practice initiated patient survey Patient forum
regular audits of rates of consultation, speed of access etc. outcome data for referrals admissions adverse events, Access Survey DES in past, CFEP patient survey
Survey

Meaures used
The practice is growing quickly at the moment and we are now starting to look at how many GPs are picking up the phone at peak times to reduce overall waiting times for the patient. This is now ongoing and we don't yet have the results of this, if such an audit show clearly new ways to build and improve on our model we will make changes and review the improvements. We are looking to build in more of a PDSA approach for continious improvement into the model.
Triage system is audited regularly and changes made when needed. Regular meetings with partners and staff provide a forum for discussion about how the system is working for the practice staff.
We collect data and take the results of the MORI survey
We have a KPI access report made quarterly.
We have comment cards in the waiting room for patients and we also involve our PPG. We also take note of comments on the national and in-house surveys. Discussions are held at team meetings which held at regular intervals throughout the month and amendments/adjustments are made to the system.
We look at patient feedback surveys eg MORI polls and from our own patient group as wel as feedback from NHS choices. We also look a A&E and unscheduled care attendence and write to patietns to explain the option avialable at the surgery.
We measure call rates, conversion rates and compare rates between Doctors. We monitor work load and keep an eye on pinch points. e.g. returning from holiday and after Bank Holidays.
We monitor complaints, record the stats of patients contacts etc and are going to look at our hospital emergency admissions. We also monitor our new patients and deductions to see if there has been an impact there.
We take all patient feedback very seriously.
We used to, but its running so smoothly we don't monitor it that much. Practice manager no longer gets complaints about access! Repeated surveys showed 95% or more of patients happy with the appointment time they got. We monitor number of calls and consultations monthly, and if calls are going up and level of trivia increasing, try and look at signposting to self-care or admin staff or other services.

Have you noted any other effects of your access method, positive or negative?

Effects seen
Continuity of care is an issue
Expanding list size
Flexibility when under pressure, avoid running late as all pre-planned, appropriate use of attached staff, need fewer locums and even partners! doctors survive better.
good patient feedback results and positive comments individually from patients
high demand, as patients know they can speak to a doctor easily DNA rate is 0.006% approx, it wouldn't let me input this figure in the previous set of questions
High levels of patient satisfaction - especially from patients who join from practices where appointments were a major headache. The only downside has been reduction in being able to see the Dr of choice for long term conditions
If a doctor is sudenly absent it does mean that the others can give cover because the patient is initially only expecting a telephone call and in nthose circumstances the doctors will work hard to deal with as many problems as possible during the intial call. We believe that the triage should be done by a doctor so that the patient does not feel that they "only" talked to a nurse.
Increasing use for minor issues as telephone access to GP is easy.
less DNAs, easier to cancel surgeries (in times of sickness), bank hols more manageable without a knock on effect on the rest of the week.
Morale is much improved with less stress and flexibility is easy. By being in control of our timetable we have improved our working conditions. We are less grumpy and patient satisfaction has improved as a result.
More time to take on additional patients as the process of telephone consultation is quicker
Much better and more appropriate use of nurse practitioner appointments. Very rare that there is an "endless" session with people still waiting to be seen at 6.30pm. Reduces the number of appointments wasted for simple prescription requests or fit notes.
No real demand for extended hours
Now that the system has been in place for a number of years patients do find it more beneficial to be able to speak to a GP before making an appt. Our workload has generally shifted to 'todays work today' and not much is now prebooked very far in advance so it is easier to cancel/change clinics during the working week should sickness or meetings crop up.
Our list size increases steadily, which signifies that we have a good reputation locally. Telephone access is a constant concern as although we have 6 incoming lines, because the patient speaks to the doctor immediately the phones are constantly engaged at peak time. We have introduced email and text messaging in an attempt to alleviate the phone access problem. A & E attendance and emergency admission rates are significantly lower for our practice compared to other local practices. Whilst we have no concrete evidence to support this, we can't think of any other reason than the accessibility of doctors.
Patient are use to speaking to a gp now so at times we are over easily accessible. Often they will tag on admin/ repeat script requests, knowing there are procedures in place. We are growing at a rate of 100 patients per month.
Reduced OOH use (initially, not looked at it again recently), reduced visits (ditto), reduced A&E use (ditto).
Reduction in A&E attendance.
Sometimes patient really wanted to speak to a particular doctor and this can mean another phone

Effects seen
call on another day
Staff less pressured as can usually offer appt when patient wants it.
The day to day non traige surgeries become mmore complex and demanding as 'routine' or more mundane issues eg BP checks, minor queries etc are dealt with on the phone whihc means more 'meaty' consultations predominate face to face surgeries. People increasingly want to know what we do and how we do it.
The duty doctor can be stressed by the workload at times but we now have adapted so each of the other drs have a small triage slot to help. Positive - patients are dealt with in an efficient way,calls returned to a time specified if so, work is dealt with mostly same day, patients know that they will speak to a dr at least and if need to be seen will be
The receptionists are busier, we do not have as many complaints about appointments. The Doctors are busier throughout the day. Telephone calls are spread throughout the day rather than all being at 8am in a morning.
This system has proven itself to be very effective, however as our patient population grows we just need to ensure that where we expect peak times to be are in fact still appropriate to the need of the changing patient group and that we take the right steps to match this need.
Too accessible, patients now calling for most minor reasons, call slots getting full quickly again - need to find ways of teasing out which calls can be dealt with by other staff, eg pharmacist, nurse, receptionist. continuity focus now means we are looking at other areas such as path link reports Much more focused on patient experience now, used to be firefighting permanently. Flexibility of whole system a bonus to cope with unexpected absence of staff members Each time we liberate the system it brings benefits - to a point now reached in first point above. Morale greatly improved.
We tell all new patients at the point of registration of the system we operate, some a a little hesitant however we find once they have tried it they really like it.
We've always worked this way, so I can't say
We've had an ebb and flow of patients as a direct result of this. Also have far higher incidence of appropriate treatment. Worried a bit about reduction in visits but have under review.

What are the main characteristics of your practice population?

Population notes
0-65yrs 5604 66-75yrs 398 76+yrs 491 High asian and polish population
8 400 patients mainly middle to upper class. majority white british
high elderly, urban. 9300 patients
High proportion of British Bangladeshi/Bangladeshi population many of whose first language is not English. Inner city. High deprivation index. Skewed population towards the young. High birth rate. High annual list turnover (35%)
inner city
inner city, very deprived, high use of language line, reasonably transient, low employment, higher emphasis on children and younger people that the elderly
Largest practice in Cambridgeshire, mixed demographics, high patient demand
Last analysis march 2011. Age 0-29 54%. 30-49 30%. 50-64 12%. 65-79 5.3%. >80 1.5%. causation

Population notes
and afro Afro-carribean. English speaking. < 10 families requiring interpreter services.
List size of 11,300. Predominantly white with above average over 65,s, fairly affluent area, little depravation. 2 sites
mixed age range, very transient population with being a seasonal holiday resort.
Mixed rural/urban, preponderance of elderly but also young and students; deprivation high in some areas
mixed socioeconomic - deprived urban to rural. low numbers of ethnic minority, but increasing.
Mixed socio-economic and rural/urban
Mixeed demographics
most aged between 24 -55 - much lower than the national average on the elderly
Pretty average 8,100 patient pop
Prosperous area with low prevalence of chronic disease and a significant group of patients who either work in London or outside the immediate area. Also significant group of patients with Asian origin and 20% with poor English.
Rural 4500 Affluent Cotswold town
Rural village - mostly local people, many long-standing and many elderly
Rural, deprived, aged. High unemployment, high obesity, high drug and alcohol abuse, poor housing.
Rural, stable, low turnover
Semi rural with a high number of ex miners
social class 1 & 2, proportionately more elderly
Suburban practice, predominently white working class, average spread of elderly and under 5s. In terms of chronic disease, substance misuse, mental health and obesity the practice is fairly typical of a suburban practice on the outskirts of Birmingham.
Two sites - one with a large aged population, chronic disease and one with a mobile changing population, with large percentage of different ethnicities
Urban, young and deprived.
Urban/suburbia mixed social class
Very average, demographically. Some deprivation
Very diverse. A lot of students. Inner city. Deprived. High turnover. Language issues.
We are a seaside holiday town. We have a large holiday camp in the town for which we cater for staff (mainly young, single people) and also temporary residents on holiday. We also have a high elderly population.