Public views on the themes of the GP Access Guide

Insights and transcript

Tuesday 26th January 10.00-12.00

Healthwatch Croydon, Zoom

Final version

September 2021

Background

On Tuesday 26th January 2021, Healthwatch Croydon organised a focus group to provide feedback on the Healthy London Partnership GP Access Guide draft. Reflecting on the themes of the survey accompanying the discussion paper, Healthwatch Croydon created a focus group to discuss:

- General Practice activity and measuring demand and need.
- Self-care and taking responsibility for your health.
- Inequity and access.
- Improving patient experience.

The following comes from a professional independent transcript that was taken at the event and is included below. The colours reflect areas in the transcript where these issues were raised for further reference:

Insights

Theme 1: Appointments and waiting

- Difficulties for carers in waiting for a callback.
- Long telephone waits to get through.
- Waiting longer for a specific GP.
- Waiting for an interpreter.
- Waiting in the surgery - wait times not suitably communicated to manage expectations.

Theme 2: Trust

- Only trusting specific GPs.
- Building trust in relationships and with the community.
- Reducing language barriers as a key to trust.
- Serving the community with trust and dedication.
- Trust patients to know their bodies and their issues.

Theme 3: Self-care

- Inadequate resources are provided for patients to enable them to self-care.
- Feeling that self-care will leave vulnerable patients adrift.
- Examples of gaps in self-care.

Theme 4: Training

- Patients report areas that health care providers may require training.

Theme 5: Interpreters

- Lack of interpreters is consistently reported.
- Barriers to peer interpreters.
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Theme 6: Registration, access and documents

- At registration, surgeries are asking for identification which contradicts the Primary Care contract.
- Refugees and Asylum seekers have been informed that they do not have correct documents or are being asked wrongly to produce documents.
- Older people report that they are unable to access appointment locations.
- Issues with access to primary care, appointments, and telephone systems.

Theme 7: Patient and appointment types

- Asylum seekers, refugees, carers, homeless, vulnerable, mentally and physically disabled and other marginalised groups such as patients who are autistic may need different appointment types.
- Where patients are not computer literate, they may require extra support.
- Patients may not understand the healthcare system, and report not knowing if they have had an appointment.
- Patients require a variety of media to clarify and support their journey, from registration to post-appointment and follow up.

Theme 8: Communication

- There is a feeling that communication can resolve most problems.
- Patients reported a lack of communication where there will be a long wait.
- GPs communication is not always being understood clearly at appointments.
- There are reported gaps in communication and follow up.
- Friendly and welcoming communication is required at each stage of the process.
- Communication between healthcare providers can be lacking regarding outside agencies and referrals.

Theme 9: Discrimination, Privacy and Dignity

- Receptionists triaging patients.
- Patients are feeling embarrassed by disclosing health information to receptionists.
- Patients report both feeling discriminated against and being discriminated against.
- Reported 'investigating' of asylum seekers, not being trusted regarding their status.

Theme 10: Risk

- Some patients have been left without healthcare, in one case at a risk to their life.
- Patients report not being able to access medication because of barriers of ethnicity and language.
- Insurmountable barriers mean patients are going without the healthcare that they need.

Theme 11: Information and solutions

- Patients offer ideas for solutions around appointments and waiting, communication, inequity, and training.

Suggestions to include in revised guide

Personal approach

- Take a person-centred approach, welcome patients with a variety of accessible information, consider using a glossary for practice produced materials.

- Be prepared to be more flexible, more often, where different patient types have been identified such as carers or those with poor mental health.

- Offer a named contact at the GP for those who need extra support.

Information

- Where patients have little experience of the NHS include key information in a welcome pack when they are booking to inform patients of their rights and to manage expectations.

- Reflect back to patients, particularly around self-care, to ensure they understand the process fully.

Language and support for refugees and asylum seekers

- There should be a commitment to use interpreters, but on some occasions use common sense when serving non-English-speaking patients in an emergency, asking friends or volunteers to interpret is felt as preferable to going without treatment.

- Make it clear that refugees and asylum seekers are welcome at the practice, allow extra time for speakers of other languages, consider holding this information on a list, such as the list of carers that GP's hold.

- Consider printouts of what was discussed at the appointments so speakers of other languages can be helped to understand their health more fully.

Technology

- Utilise technology for booking and cancelling bookings for those who are computer literate to free up staff and phone lines.

- Consider investing in technology for interpreting where other languages are frequently spoken in your borough.

Community

- Get to know your community, understand their culture and health needs. Invite feedback from these groups to improve the service.

Staff and training

- Recruit staff who understand and love the community they are serving, create a culture of friendliness through the workplace.

- Ongoing equality and diversity training is a priority, patients are reporting continued discrimination.

- Communicate a friendly welcome and use open body language and eye contact, treat patients how you would like to be treated.

Impact statement from Siân Howell, GP and Clinical Lead for Access, Transforming Primary Care Team, Healthy London Partnership, NHS England and Improvement

“The contribution of the team at HW Croydon and the wonderful patients you recruited for our focus group has been invaluable.

“The patients were well briefed and gave well informed, thoughtful and constructive feedback on the work we are doing.

“We made lots of changes to the London General Practice Access Guide and Manual guide because of the HW Croydon patient focus group. This included strengthening the role of carers, the importance of working closely with your community, the clear requirements of practices to provide of translating services and why we should all offer prompt care for patients who may only be with registered for a short period.

“We look forward to continuing working with Healthwatch Croydon as we launch and share the guide across London, to ensure the patient voice is at the heart of general practice access improvements across London.”

Transcript

Gordon Kay: Facilitator, Healthwatch Croydon Manager (GK)
Sian Howell: Healthy London Partnership (SH)
Atiyah Patel: Healthy London Partnership (A)
Robyn Bone: Host, Healthwatch Croydon (RB)
6 females participated: (F1-6)
2 males participated: (M1-2)
2 others were in attendance.

(Session begins at 10:00)

GK: I'm Gordon Kay, I am the manager of Healthwatch Croydon and the aim of today is to get some feedback over a GP access guide that has been produced by NHS England's Healthy London partnership. This is a guide, as you might have guessed and I know it's been shared, I hope you've had a chance to look at it, isn't for the public, it's for GP surgeries to get to learn about how to deliver better services to their patients, particularly in access because we know there's an issue with GP access. And, Healthwatch have done some work in this area before but-, so, what we want to know is we want your feedback though of whether anything in there-, what you think is useful? What you think could be added? Is there anything missing? Are there any themes that are missed and what could be improved? And, that's generally the idea. There are no wrong answers. This is the most important thing. It's not like a test. I know we gave you some homework, for want of a better word, but it isn't a test. We want your views and we want them the way that you would want to say them. There are no ways to sort of-, you know, we just want your views and your experiences. We have Sian here, who I'm going to introduce her in a moment. Sian Howell, is the lead for this project at NHS England and is a GP herself. She's going to-, we're going to have a series of sections and Sian will introduce a little bit herself about how it has come about and also, each section, she is going to talk about why they have that section there to give an overview. We have taken it as read, that you have at least had a chance to have a look at the guide because we're not going to spend too much time going through details of it. But, it is obviously-, what we want to do is really get your views and your experiences and what you think could be done. We also have Atiyah here who supports Sian in delivering it. I think between them they have written this together. It is-, we accept that it is a complicated document and as we say, it isn't for the patient. But, it's important that the patient insight helps shape the project and we hope that this will be very useful. And, I tell you, you're going to have impact today because, as I say, when this is published, it will go out to all 1,500 GPs across London and I imagine it will be something of-, it will start to have significance nationally, not just regionally. So, what we're going to do, I'm going to introduce Sian who is going to introduce this and then I'll talk a little bit about how we're going to go through each section. So, over to you, Sian.

SH: Thank you and thanks everybody for coming today. We really appreciate this. As, Gordon, said it's a document which is a bit techy in times and it is targeted at practice managers and practice teams and GPs. What we thought we would do today is we're really here to listen and to get some of your information in so that it really does-, although it is targeted at GP practices, it's only going to be helpful if it works for patients because this is about improving access for patients across London. So, I'm a GP in London (audio distortion 03.18-03.22) as the clinical lead around GP access and I've been working really closely with Atiyah on this project and Atiyah can introduce herself and then she's going to talk through a little bit about how we've got to where we've got to with the guide and what the next steps are. And then, as we go forward into each section, as, Gordon, leads us through, I'll talk about each section in turn. So, that's me and I'll hand over to Atiyah.

A: Hi everyone, my name's Atiyah. I'm project officer in the transforming primary care team which is part of HLP. So, I'm just going to give a brief overview of the guide. So, we've produced the London General Practice Access Guide and Manual to bring together all the many components that London practices need to deliver good access to their patients. And, both documents, the guide and manual, are aimed at practice managers and practice teams and it's been produced by a group of GPs, managers, and data specialists with experience in general practice access. So, the guide is for the whole team to bring people on board and the manual basically has more detail and resources for those working on projects to make improvements in their practices. We appreciate that the language and detail may not always be obvious to a patient audience and we're here today to explain anything that may not be clear. We really, really value this opportunity to check in with you all that there's nothing from a patient perspective that we've missed and we're planning to do a similar workshop with a group of practice managers later this week, so the guide will then be updated with everyone's comments and then later be shared with a design and editing team who will hopefully make it look a lot better and put together. We're hoping it will be finished by the end of April if all goes to plan. So, I can hand it back over to, Sian, now because I think she's going to be introducing the first chapter that we're going through.

GK: **Just before, Sian, begins, so just to give you an idea of how the structure will work. So, we're going to have approximately fifteen minutes on each section with the exception of the section that says, 'Working with patients,' because, of course, that's a section which will probably be most relevant and which I expect we're going to have the richest discussion. We've allowed half an hour for that, broadly. That will allow for time at the end for us. If we overrun, because the point of this is that firstly everyone gets a view and I will try-, I'm monitoring to make sure that everyone gets a chance to speak. Obviously, if you don't feel you have something to say, that's fine as well, but the nature of this as a focus group is to try to get**

everyone in the room to have something to say. And, it may be that you're supporting something else that you've heard but you may have something new yourself. Do not hold back. We really want to hear your views, that's what is going to help. Each part of this, we'll start with Sian giving an introduction, and then I'm going to work it around two or three questions to get your insight on that and I'll be monitoring to make sure I cover everyone and that everyone gets a chance to speak. So, okay. Again, if you're having a challenge with being able to speak, maybe turn off the video. It would be great to have the video on but if it's difficult-, and, of course, if you fall out, try and come back in. Robyn is on the waiting room making sure that everyone comes in there and they're keeping an eye on things. So, we'll start with-, go on, Robyn, do you have any other questions?

RB: I have to ask that everything be left in the room today so that if people see each other out in the community that this wouldn't be discussed. Let's just leave it here, what we talk about today, just to reassure everyone that any information they give will be anonymised. Even though we're recording this session, nothing you say will be traced back to you. So, feel free to speak. That's what I wanted to say, thank you.

GK: Yes, that's a very important point, Robyn, thank you for remembering that. Yes, we are recording this. We will produce a transcript which will be published, but as you might have noticed, anyone who has been to some of our other public events, we take out all names and all references to places. Obviously, part of our role as Healthwatch is that we always publish what we collect. But, the transcript in whole will be analysed, but yes, any names will be taken out so you can be absolutely assured that what you say today stays in the room. Okay, so I'm going to start the first section which is about general practice activity and measuring activity. Sian, to introduce.

SH: Okay, so I'll just run very quickly through why we've done the guide and you'll see at the beginning of the guide, we've got this idea of a whole system approach. And, one of the things which is really difficult from a practice perspective is getting all of the different bits of the jigsaw in place. So, what we've tried to do is say to practices, 'You can't just do one bit, you've got to, kind of, start thinking about all the bits and how one bit impacts on another bit.' So, that's how we've divided up the guide. So, the first section talks about why we're doing a guide and I don't think we really need to go into that too much because I think we all recognise that access to general practice is really important for people and I think knowing that when you're (audio distorts 08.44) able to get to see the right person in the right place at the right time is crucial for all of us. And, I think that we're feeling that particularly at the moment in this Coronavirus pandemic. So, that's that, kind of, whole picture at the front which tries to have these little icons to show all the different parts of the jigsaw that practices need in place. Now, the first area is general practice activity, and it's probably going to be the most techy area for all of you guys on the guide, and it might not be the one that you feel best able to contribute to. But, actually, I think it's really important that you understand how important it is for us in general practice and that we haven't been very good up until now in measuring what we do and we've all (audio distorts 09.28) all on the system, but actually we all call them different things and some people measure them and some people don't. And, what this chapter is saying is that it's really important that we start to measure our appointments in the same way between practices and once we start to understand what we do and who we've got working and where they're

working and it's going to be much (audio distorts 09.47) to make the changes that we need to make. (Audio distorts 09.51) see whether it's helping or not. So, this first chapter is all about you measure what you do (TC 00:10:00) and what tools are available to help you. How you look at things like patients who do not attend, so if you've got a higher rate of do not attend, why that might be and what are some of the things that you could do to improve it. So, that's what this section is all about.

GK:
Okay. So, parts around this that are considered, I expect, such as measuring activity and what tools you use. How they measure demand, access points, and different types of appointments and then, there's this issue of those who do not attend, who book but do not turn up. So, looking over this or what you've heard or what you've seen, and you can bring in your own experience as well as a patient, what do you think has been useful about what you've seen in this guide or what you've heard about? You need-, M1, I think you might need to unmute. Yes. By the way, feel free to unmute when we have the open sessions then we don't have to keep saying, 'Mute,' and, 'Unmute.'

M1: Can I start then?

GK: **You can.**

M1: Righto then. I've just got a couple of housekeeping things first. Acronyms, they're the bane of my life when reading NHS documents and this was no exception. Acronyms again and not even spelt out on first usage. There were grammatical errors but they're just a housekeeping thing that can be done later. Diagram X, I take it that the Diagram X was the contents but it was referred to a couple of times, so I wondered if I was missing something there but I think Diagram X is actually the contents.

GK: **Yes, there were a few things in there-, it wasn't-, I think as Sian was saying earlier, it wasn't the final document and there were some bits that were going to be added in.**

M1: Yes, you're right Gordon and I'm sure of that but I just have to have a bash at acronyms again.

GK: **But, the acronyms is, of course, a point-, a very important point.**

M1: And, I'm sure they got lost as to what you're actually referring to. So, outside of the NHS, it's common practice, newspapers, books, and everything first use of the acronym, put what it means and it does speed life along a bit. I've got about eight other points which I wrote down because I read through the document and perhaps you'd like me to cover them now?

GK: **Yes.**

M1: Righto then. Here we go. They're in no particular order. PPGs were mentioned and I found just recently that using videos in the PPG will enhance the use of PPG. My local PPG has started using this and done lectures and it's been most useful.

GK: Sorry, I do have to say, M1-, sorry, I'm just going to hold you a second here, sorry, because we're trying to go through each part of the guide, if you can give us the points that relate to the general practice activity, we will cover-, I think PPGs come up later in working relations. It's just to manage the structure. So, concerning measuring activity, demand, and need, and how the GP manages their demand and their need and appointment types and those who might not attend, have you got any points on that one?

M1: Right, receptionists. You know the problem we've had with receptionists in Croydon and apart from actually doing the booking, using receptionists to give health information is not well received by our clients at all and I thought that that was a point on demand and quality there. Proof of address. We've covered that one before and I'm glad to see in here that proof of address, it was said that it was not required, as we know, and I'm glad to see that that was actually mentioned in there. I did think it was a thorough piece of good analysis and when I was thinking that, I saw a word there called 'Pareto principle' and I thought, 'Where have I heard that?' That was 32 years ago when I did a total quality management course in Eastbourne and suddenly, all fell into place. This was whatever latest consultancy is leading this, this is total quality management and it really is-, and, as you said, Gordon, this is mainly for the central management to examine all of these places and managing, as you can see in the contents box there, all of these desperate-, disparate number of things that have got to be done and you've got to use what resources you can to actually fit them on. And, actually, funnily enough, although they did the course on it, I never actually ever used it. But, one of the things that really did remind me was the 20/80 principle which, in personal life, I have used often to sort my life out.

GK: So, this is the suggestion that 80% of something can be as a result of 20%. So, I don't know if it's true, Sian, that 80% of your appointments are from 20% of your list or something like that.

M1: Yes, that's right, yes.

SH: It's also that we spend a lot of time on things-, you (audio distorts 15.58) time to spend (audio distorts 15.59) because otherwise what's easy to do is to, kind of, go off and do a small project and spend hours getting absolutely perfect on how you manage a small disease rather than going, 'Actually, what we really need to sort out is how our receptionists talk to patients,' for example, which really matters because that's done all the time. So, concentrate on the things that really matter and that are used a lot and matter to patients. And so, that's part of what we're hoping to hear about a bit today so that that 20% that really matters comes through from you guys a little bit.

GK: So, it's an interesting point that M1 raised around receptionists because you think, 'Oh, the receptionist is at the patient end,' but actually, it's quite an important end in how appointments might be booked and managing demand because they're suddenly being gatekeepers to that demand. Does anyone else have a view? I mean, I'll go round. Looking at the screen-, F1, do you have a view on how GPs should be managing activity and the different types of appointments? You need to put it off mute. I think-, can we take her off mute?

F1: Okay, can you hear me now?

GK: **Yes. By the way, if I do this by the way, that means you're on mute. There we are-, if you see me doing that, it's not because I've got an itchy mouth, it'll be because you were on mute.**

F1: Yes. I think the GPs should try and, you know, make their appointments more flexible. For example, sometimes when you book certain days of the week, like my GPs, they will tell you, 'Oh, you have to go to the hospital because they are not available.' And secondly, because of the pandemic, they have, you know, like Zoom appointments or sometimes you can call and the GP will call you back. The worst thing about it is when you do not know the time when the GP is going to call you. So, you'll be waiting for the call, they don't give you a time frame. For instance, for us, like me, who has a child with needs, I would like a time possibility (ph 18.32) that the GP will call because I have to look after my son. It will be very hectic, especially with children who have autism. So, it's so difficult to be on the phone waiting for the call and the call sometimes will come late and sometimes I even miss the call because there is no time frame. They will not give you a time frame. So, it's difficult especially for us who have children with needs, trying to manage your child and trying to book appointments and manage the GP time without having no time frame that they are going to call you in. They just said, 'The GP will call you.' That's it. So, they have to be specific.

GK: **Yes. And again, that's another issue of managing capacity, isn't it? And, understanding that actually some people could wait but for some people, it's more difficult for them to wait and trying to, sort of, code that. So, it's almost an aspect of coding the patients. And, we talk about appointment types, but maybe there's an aspect to talk about patient types as well because clearly when you've got a special need, and it could be any kind, a physical or mental health need or a learning disability need, there might be a need to prioritise. That might well exist, but it's something that perhaps isn't-, you know, the panning is around appointment types (TC 00:20:00) rather than people types. F2. Thank you, F1.**

F1: You're welcome.

F2: Thank you, Gordon. Yes, I echo what F1 says. I mean, my surgery in particular, you've got two appointment slots to either ring up at 8:00 in the morning for an appointment and then you've got 3:00pm for emergency appointments only. So, I mean that's not really a lot of options to get through to the doctors and, like F1 was saying, I'm a mum, I've got a small child, so that might not-, you know, it's not really accessible for me and I was just reflecting, thinking, 'Perhaps GPs could have an answer phone maybe where patients can leave messages. I know, my daughter actually doesn't have the same doctor as me and you can actually send messages to like a hub where receptionists can actually pick up messages at a quicker pace instead of, sort of, having to, you know, make the time to ring back the GP. It's a little bit difficult. I've had all sorts of different experiences with GPs. I've never just had one GP. I've, sort of, moved around so I've got a lot of patient experience. But, I think that booking appointments is not always easy from my experience.

GK: **What are the biggest challenges in booking appointments that you have, F2?**

F2: I would probably say, you know, ringing up at eight o'clock and then you're in a queue of like maybe twenty-odd people so that's bringing you to, like, nine o'clock. So, you're left on the phone for-, sometimes, I've been left on the phone for a good 40 minutes so it's just, sort of, like impossible and it's like, 'How am I going to get an appointment?' you know. Sometimes I've been left on the phone for 40 minutes.

GK: Yes. And, what do you think could be improved in that area, do you think? What would you like to see?

F2: Well, I think that they should be a little bit more flexible, like F1 said, in terms of times that you can access to speak to a receptionist, book an appointment, perhaps. Perhaps, you know, there could be some sort of answer phone so that they can access more patients at a time. Perhaps, they could set up some sort of hub where people could message in for people who can use the Internet. You know, just looking at-,

GK: So, like a text message? Almost like a social media-, obviously, that kind of platform?

F2: Yes, yes.

GK: Almost like a Facebook? A private Facebook, kind of thing, where no one else can see you or obviously your details? Okay. So, effectively text. Okay, that's fine. Yes. Okay. Well, thank you-, sorry, F2, do you have anything else to add?

F2: No, I think that's it for me. Thank you, Gordon. Thank you.

GK: Thank you. F3. By the way, I'm just going through the line of how I see everyone. So, no one's getting picked-, I'm also ticking it off on a list so everyone gets covered. So, F3, next. F3, your experiences of what was useful, what could be added, what could be improved?

F3: Well, following on from what F2 just said, I will echo on that one is the timing on the phone. But also, you just mentioned about something set up online and I feel that for older people, not all of them have got a phone or any contact like that. And, you're waiting and waiting for an appointment. And, another thing is to do with the ethics. When you call a GP surgery and you have the receptionist booking your appointment, you've got to explain why you're calling, why you want to see the GP. And, sometimes it's very embarrassing because you just want to see the GP to talk to the GP about whatever happened. So, you've got to disclose for them to put you, I suppose, in the priority line, I don't know. But, most of the time, the appointment things are gone. I looked at the timescales already because it talks about your symptoms, what I have just said, and the ethics. And, I talked about for older people and the access going there. And, when they go to the GP surgery as an older person, you have eight minutes. This is the time that they've given you. And so, therefore I understood that you have to have two bookings before you-, with the GP, make two bookings. I haven't done that as of yet because the GP that I have will let you know that at the same time they're talking to you, they are typing. So, excuse that. I feel what can improve with them is the

telephone calls and appointments. I mean, when I'm booking an appointment-, example, I've got to look at the time and it's eight o'clock and you'll be on the phone and when you go, all the appointments are gone. I don't know how they go in that time I got on, but all appointments are gone.

GK: And, what time is that? What time are the appointments gone by? What time do you get through?

F3: Well, when I get through, it's really because they said, 'All the appointments are gone.' So, they said to me-, example, if I call on Monday, I can have an appointment on the Thursday. And then, what I found is and the lockdown time now, I rang my GP, they talk about-, you know, they've got to go through your assessments. Have you got a cold? Do you think it's-, you're going to need to call 111. They did all the procedures and things like that. They look at those things and then you explain what you really, really want. And then, you have a GP. I don't know if it's because they're locum, because when you go to your GP, you trust in some GP, you ask for a GP, and then you have to wait longer. Then, the locum-, no, I can't believe at one stage when I was suffering this dizzy spell I could say that to you because that's not so personal, and, I got something for different calls. Then, I've got to call back again and the chemist said to me-, and I said, 'What's this for?' I rang the chemist, thinking it was the chemist who gave me the wrong prescription. And, it wasn't. It was the locum. And also, they have this booking system that you can do straight to your pharmacist for your medication when you order, they go directly, then you collect or they deliver. So really, I was very disappointed in that. Then, I had to call back again with the same symptoms and then the GP who was on, who I knew, I was sorted out.

GK: So, there's that relationship between the GP you know and the locum. But, from your point-, and obviously, that's always going to be something, especially if it's a local surgery where you've gone for a number of years, but what you are looking for is a consistency in service. And, we will pick that up a bit later, okay? Thank you, F3, I just want to move on because we've got a few areas to cover and none of these areas are exclusive. So, there will be plenty of opportunity to pick up on this area afterwards, but it's interesting to hear the challenges on time-, on the time you can book an appointment, and the fact that you've got to give details away. And, sometimes you might be sitting there and not get an appointment. This is starting to come out. But, we might hear different things. F4, what do you think has been useful about what has been suggested, because there are a lot of tools in there. Or, what you think could be added or improved?

F4: Yes. First, thank you for this opportunity and sorry my English is not very good. Yes, I work for asylum about maybe five or six years, supported them, and as refugees as well. Yes, I have seen four problems again and again and again. The first one is interpreters. Lots of GPs across London don't use interpreters and sometimes say they don't have interpreters available and I have examples for big problems for a family. (TC 00:30:00) And, the second one is-, sorry, I have to write, is about investigation and testing asylum seekers. It's really, really important. Especially, when they are in initial accommodation rather than this dispersal accommodation. Or, sometimes not believe and not referred for testing or investigation. I don't know maybe because the GP thinks that it's better to leave it until they have moved and I have the example about cancer, lady cancer. They believed her and now this cancer has spread. And, the refugee's GPs

often refused to register asylum seekers at all. Asylum seekers don't always know their rights or who to ask for for help when this happens to them. And, they sometimes go without medical care that they need. And, I have examples if I have time. And, very, very often, dentists, many people have needed dentists for a long time. Four problems. If you need them, I can give you the example.

GK: I have to say, F4, that it would be great to hear your examples. I mean, the object of today is to hear a wide range of views, but if you wish to share those with us after that, I think this is really important stuff that we rarely hear and I think it would be good for us to know. And, I think there are also complications as well. For instance, dentistry, I know in other countries of the world, dentistry might be dealt with by a doctor or referred to by a doctor. Here, very rarely does it go through a-, a GP will refer you to a dentist but we have a separate NHS service that delivers dentistry. But, it's more complicated in the way that they do things, it's not like GPs. But, yes, I would love to hear-, and in fact, we should probably work for you to share, if you can share your stories and indeed, there may be something we can do beyond this particular event. But, this is a really useful insight, thank you, F4, and obviously we'd like to hear your views as we move on through it. M2. Hello, M2? Do you have any views on what you think is useful, concerning, measuring activity and demand and capacity and what you think could be added or improved?

M1: Right, text messaging.

GK: Sorry, it's a different, M. Yes so, there's two Ms. So, I'll say, 'M1,' and, 'M2.' Sorry about that, M1. M2.

M2: To me, I think I'm just going to pick up on F4-, I'm sorry if I've pronounced your name wrong, she's just mentioned that is basically something that is very common that I have even faced myself when going to the GP. Number one is you're already profiled when you get there because I think society is beginning to have these hard conversations and for us to move forward in terms of best practices, there's conversation around race and how people have been perceived in existing perceptions and stereotypical conversations need to be had. Sometimes, it makes us feel a little bit uncomfortable but it's the only way to move us forward.

Lack of interpreters. This is a multicultural Britain and there has been a lot of things that I've read in the media in terms of people coming in and stealing jobs and things from Brexit, we still need to heal as a country. But, we have to move forward as one nation and there are people from diverse backgrounds and countries who have now made Britain their home. And, we will expect GPs to represent the communities that they serve. So, I live in Sutton for example where there is a high population of African American and British Africans and Romanians who live in this local neighbourhood. I am always surprised when we go to local GPs and people have to wait for three hours because there is no one who can interpret or communicate in a language they understand and comprehend. And, I've seen that people being profiled. This happens. It's not only just with the police, this happens in most public institutions, including the GPs.

GK: How does this express itself, M2? I'd be interested. Just give me an example of how you feel that's being-, yes.

M2: Absolutely. Again, one is getting to the counter and saying, 'Hi, I'm here for this,' and they're like, 'What are you talking about? Huh? Huh?' And, I'm like, 'I am speaking English. You can hear me.' That is a typical one. A second one is literally looking down like they're busy, typing on the keyboard while you're right in front of them. Not recognising that it's a human being that's right in front of them so that does happen. So, you have all of this kind of body language that communicates that you're not wanted, or I don't want to serve you, or, you're not part of this community. They don't physically or verbally say these things but their body language makes you feel unwelcome. That's a very typical example that even I, myself, have-,

GK: And, you noticed that as different-, I mean, if you're sitting in the surgery and someone has come in who is of a different ethnicity, you've noticed that they get treated differently when they get to the counter?

M2: I've experienced that and I'm very surely walking into-,

GK: That's very interesting. Okay, I just wanted to clarify that point. So, it's not that you're just perceiving this, but you are observing it when you are sitting in the waiting room?

M2: Absolutely. As someone who has talked to a lot of people within the corporate level on diversity and inclusion. I see these things, I understand those perceptions, and when those things do happen, we do acknowledge them and if possible, try-, because it's ignorance, really, and it's education that can kill that ignorance. So, when there's an opportunity to educate them, we do so in a very subtle way like when I did at a counter, I told the ladies that, 'I totally understand that you don't want to serve me, but what you need to realise is that if I walked out this GP today and I did die, my life is on you. How would you feel about that?' And then, she was like, 'Oh. I didn't mean it that way.' And, yes, I did finally get the medication I needed but for this to still exist and it's really hard for people who look like me or people from other parts of the community, to talk about these things because people don't believe them anymore. People will use the word, 'Oh, it's another race card.' It's not a race card, these things are actually there. They happen every day.

GK: It occurred to me also, there's another point you raised where you were talking about that there were in some areas large concentrations of particular communities, but you didn't feel that maybe that GP was reflecting that community very well. Do you think there may be a role for GPs to actively be involved in their communities and build relationships? You know, if there's a large Romanian or Black African community on their doorstep, it isn't just that they expect them to turn up for appointments, but actually, there might be a little bit of communication that could be done between them outside, you know, community engagement and relationship building.

M2: Absolutely. To me, everything is about trust and relationships and GPs are very vital to our community. They're not just a stand-alone service provider and, to me, more engagement in terms of involvement in community activities will probably help

them to learn more about the community they serve and will probably help them to self-educate some of those presumptions they have about these communities. So, direct engagement with the community they serve, that will help them as well. It will also forge the trust between the community they serve and the GP themselves because clearly with most of this (TC 00:40:00) community, there is a lack of trust as we speak today and by actually creating (mw 40.04)-, because communication can solve 90% of existing problems. So, if you look at creating an opportunity to engage and have dialogue, and GPs are not just looking at when they're sick enough to come to me, but actually involving, immersing themselves in those community activities, that would build trust, that would build a good community spirit and that would probably have a positive impact in the overall service delivery of this GP.

GK: Okay. So, looking beyond merely the service they provide and actively being a wider contributor to their community. And, there's a lot of that going on at the moment if you think about the way that social prescribing models of ways of GPs being more than just a place you go when you're ill, but actually a way that can support better health, before you get ill and prevent you from getting ill. Maybe that community engagement aspect could be wrapped around that in some ways and indeed, I know in some places it is happening. Thank you, M2. Now, I've got Lenovo Tab M7 which says is connecting to audio. Can you hear us? Can you speak? If not, it might be worth going off and coming on again. Can you hear us? I think I'm going to say that's a no at the moment. Hopefully, they might be able to come onboard. Robyn, if you can-, I don't know if you know who that is or maybe you could just send them-, you might all get an email saying, 'Are you Lenovo Tab 7? Logout, login again.' But maybe, Robyn, you could just send an email out because we-, the challenge is we don't know who-, we can make a deduction because we know who said they were going to come, but without knowing the name, we don't know who is who. I hope we can come back to Lenovo Tab M7 and who they are soon, but I'm going to move on to, F5. F5, from what you've heard about measuring activity and demand and capacity and appointment types, what do you think could be useful, what could be added and improved?

F5: First of all, can I say, my contribution is that I'm just welcoming being here. Everyone who has presented thus far has echoed extremely positive suggestions that could all be imported into the system. I almost feel that I am the last in the queue and haven't anything that can be added because I identify with all that has been said. F3, picking up on what she has said, I almost feel I need to take a drug before I go to the GP service because the receptionist will ask me, 'Well, what do you want to speak-,' 'Well, why do I have to tell you? It's personal between me and the doctor. I don't need to tell you.' So, that's one of the things that I have. The other thing again is that I tend to call from my house phone and my mobile as well so that I don't miss the queue because very often, I'm told, 'You're number seventeen in the queue,' and I'm waiting and waiting and then sometimes the phone just cuts dead and I have to start all over again. So, now that I understand what's going on, I dial on my house phone and I dial on my mobile.

GK: Double your chances.

F5: Yes, I double my chances. What, M2, has said, being a black person, that is something that we live with everyday. And, you know, you see, you can bring into play lots of changes but if you do not get into the mind of the white person sitting behind the desk that you have black skin, but you also have blood, you have veins etc., and that you need to be treated with respect. If you do not, if you cannot cut out that cancer of racism from people's minds, no amount of training that you give them is going to help 100%, but, yes, you do need some training in there. Yes.

GK: What do you feel, F5, on that particular issue? What would you like to see or what do you think can be improved to sort of-, you say, training can only go so far, but what else do you think the GP could do?

F5: Training, at the end of the day, I think GPs' attitudes-, GPs, surely, some of them will be aware of what's going on and they're the ones who have the power. So, yes, all we've got left is training. Although-, but, I think the training doesn't necessarily have to be done by professionals, but it needs to be done with people who are actually using the service who could then transport back their feelings of situations that they've evidenced, yes? Then, it becomes real life.

GK: Yes and there was this assumption and I don't know if it's changed but the idea that you somehow could only have an appointment for one thing, and some people do actually have multiple things and, you know, I mean, I remember experiencing that many years ago about being told, 'You should have had a double appointment,' but they were two very minor things. I don't know if that's changed but the exception is that no two people are the same.

F5: Exactly. Exactly, Gordon, and if you're like me who has a thyroid problem and I'm told I'm type two diabetes and now I'm waiting for a hip replacement. I mean, where do I begin?

GK: Yes and that's the challenge. Okay, thank you.

F5: Before I go, this is absolutely marvellous. You know, I am thoroughly learning a lot and I welcome the opportunity of being here.

GK: It's great to have you here, F5, and there's going to be many other aspects that we're going to cover over this time, so you'll get a chance to talk later and you raised a point about being one of the later ones. So, next time I'm going to start at the end of the queue and work back, so sorry M1 you'll probably be the last to speak on the next subject area in the interests of fairness. So, I'm going to move on. I think we've got a couple of other people who haven't had the chance to speak yet. F6, do you have any points about how GPs could manage demand and different types of appointments?

F6: I'll speak as quickly as I can. I mean, one of the main things that I've noticed through working with asylum seekers and people who have just recently moved to this country is a lot of people even have a problem registering with a GP. A lot of people

are told that they don't have the correct documents or photo ID and they can't register and that's completely not true. A lot of people are then having to get support and assistance to do, like, the basic need to register with a GP. The other thing that I've noticed that's quite prevalent during COVID is a lot of people if you're not used to having a telephone appointment rather than a face-to-face appointment you don't really understand what's happened. So, you might have called your GP and you don't understand that you've actually registered and that you've maybe even had an appointment because you haven't had a face-to-face appointment with the GP and you haven't understood who you've spoken to and what's happened, and it's not been clearly explained to you. You might not have, like, a paper document or something to confirm that you're registered and what's happened, what to do next, how to follow-up. It's just that understanding that people coming from different backgrounds have maybe accessed health and GPs differently before and they don't really have that clear understanding of what's happened to them where they're registered in the UK and what will happen next and how to make appointments and follow-up on anything, and to feel able to follow-up on things.

GK: Yes, I think that's a very interesting point there, particularly with a different kind of culture. The GP system is a very, sort of, British way of delivering health services. I know that other parts of the world you go to the hospital for anything and that means that the idea of registering with a GP is not something that they're used to, or you go privately to the doctor but to the hospital for something else. That's a good point. V6, is there anything you would like to add in terms of what you think could be (TC 00:50:00) improved in this area of access? Particularly this bit around registering.

F6: I think it's about clarity that you can register without photo ID. It is very common that lots of GP practices just if someone's an asylum seeker they're asking for documents that they shouldn't be asking for because those people are still able to access and register with a GP regardless. Also just about how to make appointments, the kind of appointments, how to follow-up and that sort of information being clearly provided in different languages to people or different ways, different formats so people know how to follow-up.

GK: Thank you. We also have a Zoom user who I don't know, it would be good if you can say what your name is and to give your views. Hello Zoom user. Okay, I don't know. Maybe they can't hear us. I'll give you a chance again. You're registered as 'Zoom user', so it will be on the bottom of your screen. You're certainly logged in but I don't know who you are.

F5: Can I just say that that person may be X?

GK: X, okay.

F5: Yes, it may be X because I know she was trying to get through. I've sent her a message.

GK: Okay, if they can come off mute and say hello, or come off the screen so we can see you so at least we might be able to recognise you or hear you.

F5: I'll send her another message.

GK: Okay. Obviously, I want everyone to have their chance to speak but we have amazingly on the first subject area covered this and it's taken about 40 minutes, which is fine because we've covered a lot of areas that go beyond measuring activity but I do feel we need to move on. I hope that Zoom user will get-, and Lenovo Tab M7 will have a chance to speak later on when we can connect through. As I say, you know, it's great. What we've heard so far is very interesting and overlap, and as we're saying, you know, the nature of this guide it's got to be done in sections but these things overlap. It may be that we'll reflect some of these issues again but we'll move onto another section now which is actually all about working with the patient and I'm going to ask Sian to give a little introduction about this section and what they're hoping to get out of this section.

SH: Okay, thank you. Thank you for all of those comments. Really, really helpful. Can you hear my voice alright? Will you give me a wave if my voice is breaking up and I'll turn the video off? I just quite like to have the video on to show I am actually here and listening. I'm just going to respond to some of that stuff, which I thought was all really useful and really valuable. I'm a patient too and I've had difficulty getting through to my GP and it's exasperating. I look at some of the things that my practice does or other practices do and I'm kind of like, 'Why do we do that? Why aren't we better?' I just think we will capture as much of this as we can in the guide and I think M2's point particularly, you know, if we do nothing more than say, 'Look, train your staff in diversity training and cultural training, connect with your local communities because if you understand them better you will serve them better.' All of this stuff I'm taking on some of it will go into the guide and we will try and put in what we can. I'm not pretending this guide is going to solve all the problems of general practice across London because it's more complicated than that but I absolutely hear what you're saying and it's really helpful. As we move onto the patient section, the patient section and, again, it's all kind of chunked down which makes it feel a little bit artificial sometimes. What we've talked about is really thinking about patient experience and patient expectations. One of the things we suggested in the guide, and I'd be really appreciative of people's thoughts, is almost like the idea of having a welcome pack for new patients to explain, 'Look, this is what we're going to give you and this is what we expect from you.' So, this is around, kind of, courtesy and actually all patients should expect courtesy and you should absolutely expect a reasonable level of care and not in anyway think that who you are or your background, or your language or your colour impacts on that and if patients are feeling that then practices are getting something really wrong, and I'm not saying that that's not happening because I know it is.

Perhaps thinking about this new welcome pack for patients saying, 'This is how to make appointments, this is how we work, this is how to feedback if things aren't happening.' We've got some ideas in here about patient experiences and some resources to signpost

patients to. We've then got a whole section on self-care, so how can you support patients to look after themselves, how can they use pharmacists, self-management, self-care, self-service, how can they access their own notes? That type of thing to really support practices in empowering patients to look after themselves and this is where we get into the very tricky front desk relationship with patients that's come up several times in that last conversation of how can you actually get your front desk team to work with patients in a way that they feel trusted and supported. When they say, 'It would be really helpful to know why you're contacting the GP today so I can prioritise your care.' That's very different than saying, 'What's wrong with you?' I think that does come down to training and trust and I think we haven't got that right in all our practices. So, something about how do we work with the front desk team and then we've got a whole section on equity and practice and how we can reach out to our patients. This is around need and not demand, so demand is the patient who comes in and says, 'I want this.' Need maybe somebody who's not even coming into the practice or if they come to the practice we're not responding to them because we don't have a translator, for example. So, this section really starts to say to practices, 'You need to think about equity, you need to think about your patients who may have difficulty accessing your services.' We put into the list some of the groups of people who may have trouble with digital access, protected characteristics which includes race and disability, homelessness, insecure housing. Practices really need to think, 'How do we offer a really good service to everybody that's equitable but how do we know our local community? What are the particular groups we need to reach out to?' For example, do we have sex workers on the patch? Do we have a homeless population that we need to design particular services around? Then there's a little section on patients that we've described need additional tailored support.

These are the patients who consult over and over again, sometimes in excess of over 100 times a year and we're clearly not getting it right for these patients or they wouldn't need to be coming back so much but they use a huge resource of general practice time and we're probably not looking after them as well as we could do and we need to think about things differently. So, this is a big and complicated section picking up on lots of the themes that you've brought up, so I'd be really grateful for your thoughts. Thank you.

GK: So, as we say, this is the big section. This is probably the one that's most important. We will have a half an hour for this section. If we cover this section, I think Sian will agree if we cover this section with detail we've probably covered off a lot because the other sections, although we still want your insight on are more around about how the team is recruited and how they connect across other providers, which we want to hear your views on. But this is the big one.

SH: Gordon, to just say, a lot of the stuff that people are saying fits into this as well, so some of the stuff I've made notes. Yes, we'll take the comments and then make sure we put them into the right section.

GK: Yes. I also have been making a few notes and obviously we've got the whole thing recorded but, yes, all this stuff will slot into that. You don't need to worry of

whether you're talking in the right section. We just want to hear your views. So, you know, the big aspect I think is around patient experience and then there's another bit about expectations and you've talked about that, of what you feel you need. I don't think you've made particular significant demands but there are issues around expectations and then, as we say, this big area of self-care how much responsibility do you think you have for your own health care and what could be done there and how could the GP help you to take more control? We've done a little bit of research in this area before and found out, we did some stuff around respiratory services, that actually people wanted to have more control over their health. They wanted support in doing that and that was actually more engaging than just turning up at the surgery and being given medication or their exercises. When they took control of their condition in some way, and it can't work for everyone of course, they felt that they were much more-, they had a little bit more of engagement and they felt more involved and they felt better, and indeed their health improved as a result. So, that's an area I'd like us to cover and also this issue to do with equity, everyone being treated according to need and that again is about access and patients who need support. This time in terms of being equity and even I'm going to go the other way, so I'm going to start with Zoom user first. I don't know if you've been able to get through. I realise that we can unmute as well just in case you can't hear us, so I don't know if you can unmute.

F5: Robyn-, sorry, she said that-, what did she say? She said that she's trying and she's still waiting to be let in.

GK: Let me just have a quick look a second. Robyn, are you just-,

RB: Yes, I understand (TC 01:00:00) what's going on but X wasn't invited to the group.

GK: Right, okay. Okay. So, what are we going to do, Robyn?

RB: We'll just stay with the session, just move on.

GK: Stay with the session, move on, okay. Lenovo Tab M7 I still don't think is connecting to audio unfortunately, so hopefully we can come back. I don't know again if we can get a message through, which means we go to M2. Oh no, sorry. My apologies. F5, you can go first on your views about how patient experience and expectations, and access.

F5: Can I just finish? I'm just eating at the minute. I'm just having something to eat before I take my medication.

GK: I can understand completely, F5. Okay, I will move to M2-, oh, M2's just disappeared. I was just going to ask-, no. He's there. You're moving around the screen, it's most entertaining. Okay. M2, would you like to give some views around patient experience, how patient experience could be improved, patient expectations, welcome packs, etc.?

M2: It's been great listening to other people's views and in terms of from the patient's perspective I do believe that GPs are doing an amazing job as well. It's not really easy catering for a community during COVID time when everyone is under pressure, so we

do appreciate our GP as well, not just given them all the things that are going wrong in the community, we do appreciate them. What I do believe from a patient perspective in terms of how to, kind of, hone (ph 01.01.50) our relationship, for the best engagement it would be in terms of I know that if there's so many software out there that they can use as an interpreter, they don't have to bring a physical interpreter into the GP practices. There's different dashboards that can do language interpreting for them, which probably will not cost a lot. So, it may be worth looking into an automated technology that's available there where they can just use a dashboard and people can pick up a phone and say what they say and the dashboard can interpret it automatically for them. It won't be perfect like being humans there but it will get the job done, the person will understand what they're saying. By kind of breaking that language barrier that improves confidence and trust because, let's face it, language barrier is one key element that doesn't foster trust. So, by being able to demystify the language barrier then trust is being built. We've talked about training, like, let's say, to me you can train people, like F5 said, if people are not ready to change you can't get them. So, I think the GP will have to step up as well because if the GP's doing an amazing job and there is a receptionist that is giving the GP a bad image then I'm sorry to say this, from a corporate standpoint I would probably have to either fire that person. So, the GP has to be bold enough as well to not make one person make the whole effort of an entire GP practice look bad. If the receptionist has been giving training and has been told what is expected of, then if they're not doing that then that person will probably need to be replaced with someone who loves their community because GPs are the heart of our community.

The third suggestion I will have from the patient's perspective as well is it's common sense really to show to other people that we care, if we need to read a book about that how to be humans, asking someone 'Are you okay? How was your day today?' With a smile on your face, simple things like that goes a long way, you know? Making people feel welcomed in the GP environment, itself alone actually cures people because 80% of diseases is nerve related. So, if someone is already getting hypertensive before getting to the GP practice, like F5 said she has to take medication, that is very scary. So, to me it's about being human and to treat people with respect because anyone who is being treated with respect then the relationship can start from there. Humans, we all will have our tendencies to biases, including myself, that is basis human tendency. The ability to know that whatever our biases are, I'm in a professional environment and I need to leave them behind. I've got a community to serve and I need to serve that community with trust and love. That's all that matters. That doesn't require training. Most of the receptionists probably have husbands and kids and they care for these kids every day. It's that same level of care and love that they need to bring to that community because they are part of that community.

GK: Thank you, M2. It's very interesting. I have to say on a point there, we have done some work before in GP access with registration and the three GP surgeries I have to say out of the 54 who did it right, they had all applied hotel quality customer

service training. Not one customer should be lost, that whole idea of how hotels, hospitality industry standards and not surprisingly they were considered, you know, when we did our review that they had the best customer service when you rang up, they had the best information. So, there is something that can be done I think around mindsets, which you talk about. Training can only go so far but it's got to be internalised and that's a very good point and thinking outside the point you're saying also about thinking of it as wider communities, that you're at the heart of the community. I mean, I know that GPs are officially businesses with taking a government contract, that's the very, sort of, contractual end of GP life but actually if they see themselves as hearts of communities there's a different-, there is something about the vision of how the GP sees itself and maybe some do but that's quite an interesting point. Thank you. F2, what would you like to add around patient experience, expectations, self-care, welcome packs?

F2: I mean, there's a few points really. I mean, my most recent experience I was referred to a physiotherapist through the GP, he's a physio that works in my GP. My GP's X Surgery in Croydon. So, he rang me up for my telephone appointment and he, sort of, asked me a few of my symptoms and we spoke about that and he said to me that he would send me some exercises to my email. This was Friday, I haven't received an email with the exercises. I haven't been, you know, perhaps shown on a video call maybe perhaps how to do these exercises. I just feel a bit fobbed off really, you know, I just feel a bit like, you know, don't really want to ring back. I feel a bit like I'm a nuisance. I just feel that, you know, that sort of-, and I didn't actually quite understand him as well. He spoke a different language which was fine, so I did say, 'Could you repeat yourself?' He did and he was pleasant, and he was kind. Perhaps he was doing his best but, you know, if it was the other way round would that be okay for him? Would that be okay for him to not receive his exercises, you know? So, yes, I just was reflecting on that and I was like, you know, 'Wow. I haven't even received the exercises.' Don't know how to do the exercises Then he said to me, 'Oh, you'll be alright within a month.' You know, so there was no, kind of, like, you know, 'Could we follow-up this again? Can I teach you how to do the exercises?' There was no sort of communication. I've heard a lot today about communication and communication is key when GPs are liaising with other professionals. Currently I'm in a situation where me and my daughter's father are separated so we both have PR. There's been a lot going on, we're going through quite a lengthy court proceedings at the moment and it's quite hard to get professionals to liaise with one professional for the right information in regards to my daughter, her health. You know, so I think that communications training, it is absolute, you know, key for GPs and the wider services that are working with GPs as well. I found it quite tough liaising with GPs around my mental health as well for my own experience. You know, I've had to self-refer myself, I haven't been signposted to get the right treatment that I need. I've, sort of, (TC 01:10:00) had to, like, do it all by myself, you know?

It's been tough. So, yes, what do I think needs to be proved? Better communication, definitely. If there's only one physiotherapist that's working within that GP, which I believe there is, perhaps he needs the right training to care for the patients adequately, you know, in terms of if he's teaching people how to do certain exercises. Well, I definitely wasn't taught how to do any exercises. Perhaps a follow-up call. I find that,

you know, there's no follow-up, you know, 'When can we meet again to see how you're getting on?' It's like, 'You know, okay this is the plan. Get on with it.'

RB: I don't mean to put words in your mouth, F2, but are you saying that, you know, you're willing to take responsibility for your health and your self-care but you're not really having the right information from the GP that's empowering you to do that?

F2: Yes, yes. I mean, I am willing. I have taken responsibility for my own self-care but that's what I mean. That's an example. I'm willing to take responsibility to do these exercises but had I been shown how to do them, you know, it would make things a lot easier. It's a bit like going to get a train ticket, if that's your first time for getting a train ticket from the machine and you don't know ,someone might have to teach you, you know?

RB: You need to be properly supported, properly shown and then you can go and do your exercises.

F2: Yes, that's it. Sorry if I confused everyone.

GK: No, no. That's fine. I was interested in hearing the story and what elements came out for me that I think is interesting and I'd like to just get a little more insight on this is the expectations because also the communication of expectations. You know, you said that there's only one physio.

F2: Yes.

GK: There's no communication that you might not see him for a week or two weeks so at least you know. I guess you got referred to the physio but did they say how long or when he'd be in contact?

F2: Well, I mean, it was a telephone appointment that was booked through another GP. I had to go for a routine check up for something else and I explained to her the issues that I was having and she said, 'Okay, I'm going to refer you onto our physio. It might be that he'll invite you in if he feels it's necessary or he might just have a chat with you over the phone.' So, I gave him my email address and everything, so I guess the expectation of that is that, you know, for the doctor to do the right thing and send me the email and perhaps even discuss what might be my barriers about doing those exercises or how can I do those exercises. I might end up doing an exercise and it might cause me more harm, do you know what I mean? How do I know how to do these? Usually if we were in normal times then I would be, 'Okay, come in.' So, he hasn't actually physically examined me. It could be something underlying, it could be something completely-, that he didn't actually think, you know, what was wrong with me. So, it's just, sort of, like, a bit, you know, because I said I've been having these problems ongoing now for some time and it was sort of like a bit rushed, you know? It wasn't, kind of, like-, and, you know, fair enough. He might have to get me through and he's got other patients lined up but he didn't sound very informed himself about actually what he was trying to inform me of, if that makes sense.

GK: Yes. No, no. So, there are a whole number of areas there which I think could be considered. While I've got you because I know you mentioned earlier, you said

that you've been to a number of different GPs in recent years and there was a question that Sian asked about welcome packs and the welcome you get. I just wanted to ask you, F2, have you had any good experiences of being welcomed and what do you think could be learnt? As you've been to a number of different GPs, you might be able to give a bit more insight on the ideal welcome or what you think the ideal welcome could be.

F2: So, I mean, you know, so from the very beginning of growing up I had a GP for about twenty years. It's only over the last ten years that I've moved around and had different GPs. My original GP from growing up, you know, I always had the same doctor, knew my background, knew my family well. It was actually a family-run practice. Dr X his name was. I just remember, you know, my experience there. He knew my background and it was just quite warming to have that consistency. It's not like that today, you know, I see many different doctors which I find a little bit nerve-wrecking. I know that's just the way things are but just remembering growing up from my childhood having the same doctor, it was just helpful because they knew your background, they knew your history, the receptionist was always warm and welcome. Maybe it's just change, maybe I just didn't like change. I don't know.

GK: I'm just thinking because you said you've moved to different. Things like welcome packs, the way you were welcomed when you joined the surgery. Were there good examples of what you've had and have there not been some good examples?

F2: Sorry, Gordon, do you mean have I received any welcome packs?

GK: No, no. When you joined, I mean, you say you joined a few GP surgeries in recent years. What I just wanted to get an idea of that initial experience of being welcomed to the surgery, whether there have been some good examples or where you think it was done well or was it unfortunately not so well?

F2: You know, when I become a mum in 2017 I had my daughter in X in X. I remember the practice being, you know, the experiences were great. They cared for me and my daughter really well. You could always get an appointment. In terms of my experience from being out of London and being in London there was a big difference. I do remember when registering they did give me an information pack, they gave me all the information of local health visitor clinics, baby clinics and things like that. I remember being pregnant in London before I moved there, I don't remember receiving that sort of treatment in terms of being well-informed on different services for baby centres, children's groups and things like that. I noticed a difference there, if that makes sense. Sorry, I'm muddling everything up, aren't I, Gordon?

GK: No, no. So, what you got was a useful information pack and that was the difference between one place and another. So, that's great. We've got many other people that want to come in.

F2: Yes, sure.

GK: Thank you, F2.

F2: You're welcome.

GK: That's been very helpful. I'm going to go in reverse alphabetical, so F6. Do you have anything to add about patient experience, expectations, self-care, equity, tailored support?

F6: have made just a few points just from reading the pack. One of the questions I was going to ask is how much training the staff at the different GP practices have about dealing with different kinds of clients and the backgrounds they have, so their empathy and the way they treat them and greet them initially. How much training goes into that at different GP surgeries. The other point I was going to make is sometimes when people come from different backgrounds where they might not have English as a first language and they might have gone through different things before they arrive in the UK and they're not used to the healthcare system in the UK, do you have longer appointments or something? Those initial appointments just so instead of someone coming back time and time again do they allow for a longer appointment to begin with so that all the different issues that someone might have they can raise them at an initial appointment and they can feel comfortable to do so? The other thing I was going to say is I've noticed that-, so, this is quite current in COVID that even though there's lots of free resources a lot of them are only available if you have a mobile phone or Wi-Fi, or a computer. (TC 01:20:00) Are there a lot printed copies of resources available to people to send out from GP surgeries or give to people? Just in case they don't have as much data to always be going on the Internet or accessing things online. Also, if someone becomes quite comfortable with somebody within a GP practice, like a specific nurse or it might be gender, or it could just be someone who they've spoken to before and they feel quite comfortable with, is there availability to maybe have follow-up appointments with the same person so they can build a rapport and get to know someone who has got to know them? They might not want to disclose a lot of different issues to lots of different people and they would like to feel comfortable with a member of the GP practice and build a good relationship, especially depending on what background you come from.

I'm just going to give you an example of something that when it comes to access, so one of the GP surgeries that we're working with they had the capacity-, so, people can self-refer for online therapy, for talking therapies in different languages but the barrier was that the people that they identified that could refer to this wouldn't actually be able to go online. They didn't have the language to go online to actually do the referral, so we're stepping in and we're helping people to do that referral. In a way there is stuff out there but the access is blocked if you don't have the language skills to do it initially in the first place. Even though the talking therapies is in different languages, a lot of people who would like to refer don't have (audio cuts out 01.21.34).

GK: Yes, that is a very interesting point. It strikes me there's an element here around personalisation and really understanding the patient and its needs and tailoring, I mean, it's talking about tailored support but that seems to be a very good illustration, and what's a contrast is you can actually offer services but to refer it you've got to have a level of language which people might not have. It's also understanding I think again identifying patients that might need a different service. There were a number of points there which I think could be of interest of further exploration that understanding that a patient who doesn't understand how our health service works might need almost like an introduction to our health service. It's not just enough to give a welcome pack, with that welcome pack are you making a lot of assumptions that people already understand the system? Which you would do because for most of us we wouldn't want an explanation of how the NHS runs, although actually that could be helpful because with work we're doing with dentistry I have learnt a lot in the last five weeks about how dentistry is commissioned very differently from GPs. I assumed it was a bit like GPs, it's nothing like that and I've lived here all my life. We make a lot of assumptions I think that people will know this information. I think you also raise some very interesting points about variability. There's a lot of stuff on websites, there's a lot of information out there but if people don't, as you say, have a lot of data at home, we're making more assumptions that people have access. I think that's some very useful points. Was there anything else you wanted to add, F6?

F6: No, that's okay. Thank you.

GK: Thank you. No, that was very useful. F5, are you ready to talk?

F5: Yes, I'm here. I'm here. I mean, I think all the points are very valid, each person contributing and it makes a whole. I think that, yes, and your point just now about assumptions. I wouldn't particularly want to be given a welcome pack because I've lived-, well, yes, given a welcome pack but it would have to be with specific information because I have lived in the UK since I was age fifteen so telling me about how the NHS works is not going to be something that I'm particularly interested in. However, now we know that the health service has changed a lot and is just an amalgamation of community agencies that are coming together to form one agency, which is going to be managed by the NHS I think. So, yes, a lot of people may not be aware of that but I think for people like my sister as well who are dyslexic, when she goes to the doctor and she's given a form, you know, she just takes it and puts it in her bag because she's unable to complete it until she returns home to me. So, those are the kind of things in addition to as has been highlighted, assuming that people have got access to computers and they will then of course have enough data to tap into the services. We just need to rethink the whole package that we are putting out there before we're able to get it right. Now, for me in terms of self-care and self-management I think that we have to be very careful with that because as services are being reduced and we can get into a situation where all of the public is pushed towards self-care management, which then

takes the responsibility away from the government and etc. to provide us with the correct services that we need, yes? So, across the board a lot of work needs to be done and that's why a forum like this is extremely important. I mean, another thing that I believe in the practices, the GP is at the head of the realm and GPs need to take more responsibility for their actions as well. For example, I've been to the surgery when I've been on a tight schedule and my appointment is, for example, ten o'clock and I've been sat there waiting until 10:45 and then the GP comes out smiling or my name goes up on the sign, you know, the thing next and I go in and I've said to her, 'Why have you kept me waiting?' She then says, 'I apologise but the other patient took a bit longer than I expected.'

Well, yes, fine but you could have sent a message to the receptionist to inform the receptionist that you're running late and give me the option to decide whether or not I wanted to wait but you just kept me sat here. The thing that annoys me about that is that I don't have the option to leave because if I'm late you tell me I was more then five minutes late or I was more than ten minutes late so therefore I can't be seen but you can keep me waiting and I'm supposed to just accept it, and it doesn't go like that in my book. You and I are going to go down the road and it's going to get very vocal, and then when I get very vocal you're going to tell me, oh, I'm being aggressive because I'm a black woman and my character and personality are different from yours. There are lots of things that we need to get right in this so-called multicultural society, yes? So, I shall stop there.

GK: Thank you. Now, you brought up a very (mw 01.27.42) again about managing expectations and, yes, that expectation of time, that there's a two-way side to this as well. Sometimes it's hard to manage but there must be ways of doing things and I'm sure that there are ways-, again, it seems striking, it's a big element that's coming out of this and it's come in every single piece of work I have done in the five years I've worked with Healthwatch, that communication is always a key issue here but thank you, F5. So, let me see who we-, F1, would you like to give some views on patient experience and expectations, and self-care?

F1: Okay, thank you again. Well, most of the things have already been said by the participants. All of what they have said makes sense and it's very important as well. Yes, as for me English is not my first language, I'm just trying and I'm a student as well. I'm trying. Yes, what I found out about the GPs, you know, trying to, you know, for example, liaise with other healthcare workers. My own experience with it is with my child, as I mentioned earlier on, I have a child who was diagnosed with autism and, you know, there were lots of processes we had to go through before it was diagnosed but what I don't understand is any time, for example, I will talk to the occupational therapist, which they have to liaise as well with the GP. I found that the occupational therapist will not do nothing about it and when they will send me a letter the letter will state from the occupational therapist that this letter is (TC 01:30:00) going to be

sent as well to your GP, so I was expecting the GP to follow-up with the occupational therapist as to what my child needs and how they can, you know, help me fast so that my child will access those needs. I don't have none of it. So, for me, like all the participants were saying about our background, they don't take into consideration with that. I just felt that, you know, a lot of things have not been done to help us, you know, we come from different backgrounds. If I can say especially the black background, you know, they tend to ignore us. Sometimes when you go to the GP, you know, they want to talk to you fast, 'Okay, yes. How can I help you? Okay, yes. Okay. You will just take this treatment, try it again.' No, it should not be like that because sometimes maybe I don't want to talk because I will just feel refused from them, maybe they don't want to help me so I would tend to just stay quietly and don't talk, however I will be having lots of problems or issues at home. So, I think they need to help people, you know, will other backgrounds to bring back the translation and not everybody, you know, are computer literate. Some people are not. If, for example, like now if I did not have a type of education I would not be able to access the Internet, you understand?

So, lots of people are struggling because if I go to the Internet, I want to fill out a form, I don't know how to go about it, I'm not computer literate. How can I do them? Maybe some of the words are so huge or too a big task for me, I cannot understand so I think they have to simplify it. Not only for the minority backgrounds, also for people with needs, you know, like F5 said. Some people are dyslexic and they can't read some certain words, you understand? I think they have to prioritise that particular part of the GP practice, you know, and try to understand that we come from different backgrounds, that doesn't mean we don't understand. It's just that we are brought up from, you know, maybe we don't have that quality of education or even if we have it English is not our way of speaking. So, they need to understand and, you know, try to work on that. That's my own take, yes.

GK: Yes, thank you and you raise again, this theme seems to be coming out quite strongly, understanding the individual patient's needs both in help but in also their understanding and their circumstances of whether they have phones or whether they can use the Internet. So, we're stating to see a full circle of different aspects, not just about health. It can be to do with health conditions but it's actually to do with your ability, education background and I think that area inequity covers that but it's really trying to look at people and then identify, and then creating a service that can work for them. It might be longer appointments for those that need that extra time or it might be a different kind of appointment or maybe video works, or that kind of thing. So, yes, thank you F1. That's been very interesting.

F1: Thank you.

GK: So, let me see. F4, do you have anything to add or different aspects, of course, on this area of patient experience and expectations?

F4: Yes I really would like to say thank you because I have a very good experience of a GP myself but my problem is the asylum, they can't speak English at all and especially in this time it's really, really difficult for them. I know, I supported a family. They live in London, the family. They called me and they said, 'We called GP,' they had lots of problems and the husband, and some suspect of the COVID-19 and the wife was ill and she said, 'We called the GP.' The GP said, 'We don't have an interpreter available,' and she asked me, 'Please call and ask my problem.' I called the GP, the GP said to me, 'You are next to her?' I know it's their role. I said, 'No, I can't in this situation,' but they said, 'Sorry, we can't accept you because you are far, not next to the family.'

GK: **Next of kin, yes. Okay, yes.**

F4: Yes. Oh, yes, and I asked many of the volunteers for an interpreter and I found many are willing to be a volunteer for interpreter, volunteer not for pay. I think in this situation maybe the GP may take it more easy and accept, for example, when I call for their illness and accept my telephone, for example, because I know it's a very, very difficult time at the moment.

GK: **Yes, that's an interesting one and it could be that there are issues to do obviously with GDPR, you know, and data protection. Oh, Sian says no. That's good. It's not good but it's good that-, so, Sian, just to clarify, there shouldn't be an issue then when, you know, if someone said, 'I'm not the next of kin but I can speak on behalf of this person,' that should be allowed to happen, yes?**

SH: I think practices need to use their judgement and be flexible. I must admit, I've always worked in a very multicultural area and I have always had access to interpreters, usually over the telephone. It's not ideal but it's better than nothing but I'm horrified that people would not-, you know, sometimes you take what you can get. It is not ideal to have a family member, we know that. We certainly don't like to have husbands translating for women on their own, that type of thing but when push comes to the shove you can find out what you can you find out or you find out nothing. You make a judgement call and you find out what you can find out and if that means having a twelve-year-old translate it's absolutely not ideal but if that was all I had and otherwise I could hear none of the story then you make that judgement call. I think there is perfect practice and then there's good enough and sometimes we have to accept good enough rather than say, 'No, I've got to have somebody who's separate and in the room,' because actually that's not realistic. I'm really sorry that you've had that experience and I'm slightly horrified by some of the stories I'm hearing today about lack of access to translators and we will stress that in the guide. We can't force people to do things differently, we don't have the resources to do that but what I'm certainly going to do is strengthen the need for advocacy and translation in the guide. I'm, kind of, quite shocked.

F4: Yes.

GK: **There must be some examples, I guess Sian, of good practice as well that could be put in the guide because I think a lot of these things is that I feel for GPs and we**

found this out when we did our work. So, they get knocked about by all these wonderful case studies in different parts of the country that are going on but if there's a really good example where someone's done it and it wasn't a big surgery or it wasn't a resource intensive thing but it's just, you know, as M1 said earlier, a way of thinking, thinking differently that I think that's, you know, people want to see where it's actually possible.

SH: Well, it certainly is possible. In my practice we have a number and it's tedious and I don't like it, and it feels disconnected, but actually if somebody speaks Romanian and they haven't got anyone to translate, I phone up, I put a code in, I then phone the patient, we have a Romanian three-way conversation. Of course that's not ideal, of course I'd like the patient sitting next to me, of course I'd like to have the Romanian advocate there in the room but I can't and we muddle through, and that's quick and easy to use. It does take longer and then it gets really complicated about how general practice is financed and it's very interesting to hear of the story of better experiences outside London than inside London. I think part of that reflects a funding formula that does not reflect the need of (audio cuts out 01.39.16) communities. So, I'm not making excuses for general practice but the funding formula is not fair so it does make it easier to provide a good service in a more affluent area than in a poorer area, and that gets into all the complexity of language and increased social need. That's a whole other thing. This is a practical guide to say, 'Look, this is what you can do within your resources,' but we will certainly strengthen the translation part of it because I am really disappointed in some of the stories I'm hearing today.

GK: Great, thank you F4. Do you have anything else to add? F4, the-,

RB: You're on mute, please unmute.

GK: (TC 01:40:00) Yes. Sorry, I should have said that. Thank you, Robyn.

F4: Thank you. Oh, sorry. The second one, please, investigation and test the asylum seeker. I supported a lady, I met her at the last June. She was okay and she was a cancer, she had cancer and July when I met her she had a stomach ache and she was worried about her cancer and she gave to the GP all of her documents and she said, 'I'm worried about the cancer returning,' but they don't unfortunately believe her. Her stomach got big and big, and suddenly November she was hospitalised. Her cancer is back and it's spread in her body and she's now in hospital for chemotherapy. Yes, please believe them and for the investigation. Thank you.

GK: I'm sorry to hear that story.

F4: Yes, it's so sad.

GK: It illustrates the challenge, that challenges that are going on. I'm sorry to say that's not the only time, I have attended other sessions in London with similar challenges with asylum seekers and I have heard unfortunately another couple of stories of that as well, similar issues. Thank you for sharing that.

F4: You're welcome. Thank you.

GK: So, F3. Thank you, F3 and M1 for being so patient. F3, what do you feel you would like to contribute around patient experience and expectations, and self-care equity?

F3: Yes, well I was going to say the one that just finished, this lady, F4. It's to do with my son, he wasn't diagnosed with the virus, Coronavirus, and when he started having pain, can't walk to the toilet because of breathlessness I said to him call his GP, his wife and him called the GP The GP said, 'When you have a test then-,' and it's nothing to do with colour because this is a black doctor, right? So, they're not all out there saying that it's only white doctors because some of them are not able to speak English or things like that and communicate, and I'm being frank with this. However, he said, 'Oh, if you get the test then I'll send you to the hospital for an x-ray.' I think to myself, 'What's going on for this challenging time with this virus going on? He's saying things like that?' However, my son deteriorated and one day it was overbearing and he said to me, 'Mum-,' which he would never talk to me like that because he thought he had the flu and then he said at the back of him it was like something digging into him. I said, 'Okay, then. Dial 111.' He dialled 111 with his wife, so they told him to take ibuprofen. What I'm saying is I called the doctor myself, spoke to the receptionist. The first one was really good, she said, 'Get another doctor,' and the other doctor was out on visit, however when I called back it's another one with attitude, which sounds like a black person anyhow. I'm not being discriminated here, I'm not being prejudice but it's annoyed me and she said, 'Oh, well you've got to go to your son's house,' because I know about GDP because I had training in that. So, therefore I said, 'How can I go there and he's not well? I'm 81. How can I go there to get this infection?' So, however that was it. He blathered on, I told him what to do, the remedies and whatever for our (mw 01.44.37) service, so that was one. Then what I really wanted to say is that is this coming to the PPG as well, Gordon? Can I do a bit about that?

GK: You can, yes. I think PPG, it's the ideal time to talk about PPG. You're on a PPG?

F3: Yes, I am. The voice chair.

GK: Okay. So, just to say by the way, for clarification because we don't want to move into acronym zone here. A PPG is a patient participation group. It's a group of patients that help the doctors in each surgery, each surgery is supposed to have one. In my experience in Croydon I think about a third do, and of that maybe twelve are really active and do the role they're supposed to do, rather than just, with all due respect to Sian, do what the doctors want them to do, and so there's a variability in what they're supposed to do, which is really be a channel between patients and the GPs about the quality of their experience. Go on, F3. Thank you.

F3: What happened is we have a treatment sessions are formed, our meeting, and the doctor came in and he said, 'What can I do, about these older people they keep coming, they don't really need anything. They're lonely and things like that. What can we do?' so I recommended, I said, 'Give it to F3 now.' I said, 'I felt that if we try and get Age UK involved, because they have different services,' so what the GP did, he put a banner outside, it cost them £80, with the information that they can contact,

but at the same time we met with someone, because I knew the person, from Age UK, and they decided to take referrals, so the people who are going in, so it made it lessen for the GPs to have a person coming in who doesn't really have a pain, just wants attention or something. That's the story. I feel like if education, communication, especially to do with engagement and the different things that, the treatment, patients can communicate an example, they can share letters. It's the monitoring and things like that we don't get. Especially, I went to the GP. I had a blood test, he said, 'I think you're on the border of diabetes.' He said, 'Come back in six months' time.' I said, 'No. Please refer me to the meetings that they have the preventative measures,' and that's what I had, then go back to my GP and it's all gone. I'm under control. Sometimes medication, and they sent me home for six months, I can develop it more. Only because I was aware of those services, not a lot of people know about those services, so when I look at the monitoring, we need that. We also need-,

GK: **Moderator: When you say monitoring, sorry, F3, you mean checking letters that they're useful to the-,**

F3: Yes. The letters. I've got letters here, yes.

GK: **So, communication, it's a role that PPGs can have in testing them. Okay. Yes.**

F3: Yes. Sharing, yes, instead of medication, and I think we are self-sufficient. We can manage our health. We don't have to have tablets all the time. Before, years ago, we had dieticians at the surgeries, who will enable us how to do things, but it's something like that, we need to say-, some of the GPs, then, really, we talk about communication

, you can't even understand what they're saying, so you have to keep checking, 'What did you say?' Again. You understand?

GK: **In appointments, in an appointment context.**

F3: Yes, in appointments. When you go into the GP surgery itself and talk to the GP. We have a different variety of GPs out there. We don't just have English GPs, we have a mixture of GPs. That's what I would like to say.

GK: **Thank you very much, F3. M1, who has been extremely patient. M, that's M1, that is, M.**

M1: Here I am.

GK: **I imagine this is an area which I know you have a great interest in. Go on, give us your experience or things of what could be done to improve patient experience, etc?**

M1: I've been writing notes down here, and what our group has been saying here. Text messaging, yes, I think this, to the surgery, would be, for those people that have a mobile phone, (TC 01:50:00) to be able to liaise instead of having to phone and stay in a queue, I find this so much better nowadays. I can send a text, it doesn't mean I've got to wait. The person, the receptionist or whoever is dealing with it at that end,

can come back in their own time and let you know what the answer is rather than just hanging on and hanging on, on the phone. That's all I had to say about that. Data collection. I noticed it at one point in the text, it's measuring your activity. At the moment the GP spends a lot of time looking at the rules, and often I find that those rules that they're looking at are now on the video on the website now, so you could almost do the doctor's job themselves by doing self-diagnosis on the website without having to sit with the doctor doing it for you. The other aspect I picked up on measuring your activity, I think you're expecting the doctor to do categorisation of the individual appointment and the excess or otherwise of that thing. I don't think that's really a good use of the doctor's time in the surgery. When you have identified a problem I think that ought to be done on a data capture, on a sample basis, so that you can go back and discuss that sample in depth, away from the doctor's coalface, as it were. What was the next one? PCNs and ICNs. We already have identified this in Croydon, about taking the people that use the 20/80 rule, the people that are demanding lots of appointments and really only need psychological comfort, really, and the ICNs, I believe, Gordon, you'll confirm this, that is what they were set up to do.

GK: **Yes. I'll hold there, if I can just, because, again, another acronym, so PCNs, primary care networks, they are a new relationship between NHS England, who contract GP services, so each GP surgery has its own private-, it's a private organisation that takes an NHS contract, and the relationship is now managed. It used to be individual GPs direct with NHS England. Now we are groups of GPs in similar neighbourhoods, and that's a PCN, and I think roughly it's about 150,000 people, is it, Sian? What's the average size of a PCN?**

SH: There's some variation, but it's usually around 50,000 for PCNs.

GK: **Yes, but you can get larger ones.**

SH: You can get larger ones, some places have done it differently, yes.

GK: **Yes, 30,000-100,000 I think it was.**

SH: 30,000-50,000 was the starting point, yes.

GK: **Yes. Then, on top of that, and Croydon's leading the way in this, there's an ICN, which, with PCNs it's just the relationship between the GPs and NHS England, who fund them, ICNs are bringing in the wider health and social care services that are being offered by the council and by voluntary sector, and it's quite a complex thing to explain in some ways, but it's all working together, and teams of people working together, again, at this sort of neighbourhood-sized level. I just wanted to clarify that, because we have used those terms again, but M1, you were going to make a point about the role of PCNs and ICNs?**

M1: The thing is, from this document, it's the coordination of those two different types of organisation, now, and I believe some of the ICNs are a part of PCNs and things like this They're all aiming for the same goal, to look after the patient, and maybe the same analysis, really, to a large extent, has already been done in Croydon, it just needs to be implemented.

GK: That's a good point, but it is a role that different parts of the system have, and I think that's an, actually, very important point to emphasise, that we've been talking very much about the individual GP here, but actually, the individual GPs are no longer working in silo, they're working in PCNs, they're working in ICNs. There's a whole aspect about working across with the hospital or the voluntary services, which we have raised here today, in continuing care, so actually, I think that there is a role about when it's something that the particular GP needs to do, when it's something that needs to be done within their groups of GPs, when it's something that needs to be done in the wider system, and those, because you wouldn't want someone going off in a direction which might affect other parts of the service. Robyn's been very good at keeping an eye on the time. I will come back to you, M1. I was just going to say, we have got to twelve o' clock. Now, it doesn't have to end here, we have got a little bit longer, and I know M1 definitely has got things to say, but I am aware that some other people need to leave at twelve o' clock, so if you need to leave, I would like to know any other comments you have. I think the conversation has been very vibrant, and I think we are covering a lot of what we wanted to get out of this, but if anyone has got to leave, can you say if you want to leave and if you've got any other final comments you want to add, because I don't want to miss your opportunity. Then, if you bear with me, M1, we'll come back to you. I just don't want anyone to miss out having something to say. Has anyone got anything else that they would like-, put your hand up if you want to say anything to round up if you've got to go soon. M2 first, and then F1.

M2: My problem is that I've-,

F3: I have to go at 12:00pm.

GK: F3 as well.

M2: : I've got to go into a meeting now. My final thought is just to say thank you to everyone that have put all their minds out there. It's been quite educating for me as well, actually. I didn't know it was that serious in terms of what people face, but also we do also need to strike a balance and give credit to our GPs as well, because I'm very sure that I might have had a terrible experience in my local GP, but that might not be the same experience, but all the people in other counties, it's not that doom and gloom that is out there. One lesson I would take away today is we want to see a GP that serves our community, that is part of our community and feels as part of the community, not just a business that is there to make money out of the community, so thank you for the opportunity, Robyn and Gordon and everyone. Nice to meet you all.

RB: Thank you, M2.

GK: Thank you, M2. I know that, sorry F1, I was going to bring you in here, but I noticed that F2 said she needed to leave, and I'm sorry, I know a lot of you may need to leave, but F2, did you have any final comment? Then you, F1.

F1: Okay.

F2: No. I think everyone's covered quite a lot. I've covered what I've needed to say. Thank you, everyone, for your input. It's been really good to listen to everyone's experience. Hopefully we will be able to put some of the things in place moving forward to improve.

GK: Thank you very much, F2. Thank you for your contribution. Yes. That's the intention. Thank you very much, and we will get feedback, as well. I meant to say at the end, and when Sian has completed this work she is going to feed back to us about how what you have said today has changed the guide. As she said, maybe not everything gets in, but this is not the only piece of work I'm sure they're doing, so it will help feed other areas, but we will get some feedback, so we will feed back to you. Thank you, F2. F1?

F2: ?? First of all I would like to say thank you to Robyn and Gordon to give me the opportunity to be on this platform to participate about the GP and how it will transform, maybe later. Yes. I'm glad to be here. As a student, I have learned a lot of things today and I will continue to learn. It's my pleasure to give my own views about the GP practice or the healthcare system, how it works, so thank you once again, and thank you, everyone, for your input. Thank you.

GK: : Thank you, F1, for yours, as well. As it says on this pen, your voice can make better services, so we do what we say on our pens. Thank you. Thank you very much, F1, and I hope we continue the conversation in other areas as we move on, so thank you, F1. As I say, any other comments that anyone who's got to go, because I know that M1 will have a few more comments and we're prepared to stay, but are there any other comments that anyone wants to add?

F5: Can I say, I have to leave. I'm going to try to hold on until about 12:15-12:30pm, but I need to go to a tutorial.

GK: If you can hold on until 12:15pm then I just want to check if there's anyone who's got to go now, because I know, M1, you're okay for a few minutes, are you?

M2: Yes. I've got all the rest of the life.

GK: We might (TC 02:00:00) still be here at three o' clock. No. So, F3, F6, do you have any, if you've got to go? F3 said she needed to go, so F3, do you have any other final comments you would like to make? You need to take the mute off.

F3: Which F3 is it? You have two F3's?

GK: Sorry?

F3: Have you got two F3's?

GK: Moderator: No, just one F3. One F3 is-, there can only be one F3.

F3: I'm not leaving.

GK: **You're not leaving? I thought you said you were. That's fine. So, F5's staying. F6, are you staying? Are you okay to stay for a while?**

F6: No. Unfortunately I need to go, but thank you for the opportunity. It's been really interesting.

GK: **Our pleasure. Thank you for your comments. Do you have anything else you wish to add?**

F6: Not at the moment. Thank you very much.

GK: **Thank you, F6. It's been great to have you here. F4, are you staying on, or do you need to go? Come off mute. You're on mute.**

F4: Yes. I would like to stay.

GK: **Brilliant. So, everyone else here can still stay for a little while longer. M1, sorry, would you like to continue where you had left off?**

M1: Yes. I find it interesting. Obviously this document is a London-wide document, I don't really know what other areas of London, and now we have found the South West London Partnership Board and things like that were consistent. Well, there is an inconsistency from the original boroughs that have joined. I mean there are, is it six CCG groups, all doing variants on their own thing? I don't know what other parts of London are doing, but are only really familiar in a vague kind of way with their own part of London, and we have this two-pronged attack. All of sudden the money came through in about 2019 from the chancellor. They were all told to form groups of about six or eight surgeries into PCNs and organise themselves, so I feel there's a bit of a disconnect there between the two organisations within the borough.

GK: **Moderator: I think that's a very good point, and now the next change is the plan towards ICSs, and I guess that's something that-,**

M1: (Inaudible 02.02.56).

GK: **Yes, which is an integrated care system, which, again, I don't want to go into too much detail on, but it does have an impact in the consideration, bearing in mind, I guess, Sian, you're going to roll this out by April, within a year from now there's going to be a new way that the NHS is delivering services, and it's a question. I know it's a bit like a funnel. That will be at the top end of the funnel, working down to the GP surgery, but how might that affect? You raise a good point, M1, about inconsistency, because the idea that six boroughs were coming together, that was a thing that we had to get in terms of the difference in services between those,**

so I think there's a question about consistency, isn't there, which I guess this guide is trying to achieve?

M1: Each area has a different-, as we said, the care service you get down in Guildford is completely different from what you get here in Croydon, and across the south-west London patch you have enormously different expectations in each of those areas, and patches of expectations, and I know for a fact, because my GP's surgery, the service I get there is probably totally-, you know I've been with this six or seven years, I've done-, I've walked round every GP surgery on the patch. I've been in there. I know what they look like, and the consistency of what you get is a very wide bandwidth. You get the little cottage one door with a front room surgery all the way from a whacking big hall with about 50 or so seats to sit in the waiting room. It's terrifically different expectations as to what you're going to get.

GK: There's an element there, in the how you manage that consistency across that range, and issues of resourcing, which I certainly-, although that's not always-, from the research we found, of course, there was also the fact that actually, it was the smaller-scale surgeries could deliver things, so you think that larger scale can work, but I guess that's a challenge that they need to conjure with, so this guide has got to work for all settings, hasn't it?

M1: One of the things that I realise about these PCNs is, and this was emphasised recently when I participated in that survey on the dentist's, a lot of doctors now were in the process of grouping their practices together. I won't name names, because this is the thing, but group practices of about twenty GPs are operating in this borough now, and I've got a long industrial history behind me, but one of the things that I know from that is that all the things like human resources, pay clerks, legislation, health and safety, all those aspects cannot be dealt with in a single surgery or in a small business, and eventually a lot of these small businesses have all got together, and only just recently, local to me here, a dentist said to me, 'We wouldn't have survived this pandemic if there hadn't had been a large amount of money come in, bought the existing practice lead out, and now I'm part of a group of about ten dentists now,' and this is the way right across industry now, all getting this. You see, if you're just a practice manager actually doing the job, you haven't got time for all this analysis which is in this document. It's only when you get to about five or six, probably even more, surgeries, then you've got enough capital and resources that somebody can actually spend the time reading this document and doing the analysis in the content section.

GK: That's a good question, the viability. I guess that's something that maybe, Sian, actually, when you were thinking of putting this together, what did you have in mind, because of course there is such a variety, isn't there, of GPs and their different contexts? What did you have in mind when you were putting this together?

SH: We had very much in mind, still, the individual practice, and although PCNs have come along and practices are working more collaboratively, not only within themselves,

but ideally with the wider community and social care. The main contract is still with GP practices, individual GP practices, so the PCN sits above that. This guide is really about getting individual practices to get as good as access as they can, and to recognise the parts of access that they can improve on. I think M1's absolutely right. A lot of this is beyond the scope of a very small practice, but at the moment practices are still the main contractual mechanism for delivering care, and that brings advantages because you get that personalised care, you know your GP, but it also brings disadvantages, because it's very difficult in the modern world for a small practice to be able to do everything that we're suggesting. We have developed the guide jointly with the LMC, which is the union of GPs, and GPs are very keen to hold on to the individual contracts within GP practices, and the PCNs are only happening as something in addition to, over and above, but the core contract still sits with the practices. That's why the guide is focused at practices, because I think quite a bit about the responsibility of the leadership within GP teams, and you're quite right, it's the GPs, or the partnership, which may include practice nurses or practice managers, but it's usually the GPs. They take the income for the practice and they decide how that income is going to be spent. If we want to encourage GPs to invest and support their front desk teams in training we really need to get them onboard in this change, and so what we're trying to do with this guide is signpost the leadership within individual practices, 'This is what good can look like. This is where the resources are to find it. Here are some small steps that you can take to achieve that,' so they don't feel completely overwhelmed and think, 'This is something I can't do.' What we have tried to do is say, 'Look you're doing well. You can do better. Here are some steps. Pick the bit that's right for you and for your practice,' and we talk about the (TC 02:10:00) jigsaw.

It's all these different bits, and you can't get the jigsaw right in one go, and some practices are doing really, really well and some practices have a really long way to go, and we know that when we walk through the door. As M1 says, you walk through the door of one place and another, you're getting a completely different experience, so what this guide is trying to do is say, 'Look, this is what good can look like. This is what is happening in other places. Here are the resources to help you to try and deliver some of this,' but it's not going to solve many of the problems which have come up today, because these are deeper-rooted issues around how we're organised, how we're paid, and things, but it's hopefully a positive step on that journey, but the richness of what I've taken from today is fantastic, and I'm already thinking about how we're going to change certain bits of the guide to reflect some of this patient experience, which is what good access is all about, really. Sorry, that was a bit rambling.

GK: **Thank you, Sian. Now, I was going to say, just a couple of points, Sian, I'm aware, by the way, we're at 12:15pm. We can go a little bit longer. I want to check that F4 and F5 might have additional points, and F3 as well, and then M1, if you've got any final comments I'd like to include those. I just don't feel-, if people have got to leave. Just a point which you were saying, Sian, which is important, is the ever-changing nature of how-, it's making sure this is future-proofed as well, and understanding these. Also, I think what was missing, if only from reading the guide**

myself, is that there weren't case studies. There were references to case studies, and I don't know if it's too late in the design. I think if we could have a paragraph, 'At this surgery they did this and it did this and it got this result,' because we did do that in our-, I'm going from the experience that we had. We had some case studies in ours and it really did help, and they were ones that were local as well. We did say it was a surgery. Actually, I think in this case we did name the surgery, because we believed in giving really good practice, and we actually did a little bit of promotion on that, and they didn't mind, and when you're telling good news, that's great, but I think if you can say, 'A surgery in-,' or even, actually, name the surgery, because then if they're wiling to-, usually where there's good practice going on they're willing-, there's an openness, actually, to share their good practice with others, but I do know that sometimes, and it's not exclusive to GP surgeries, some get, sort of, knocked about a bit by these really good examples somewhere else, which are out of context. When it's happening in communities near you, when they're only a few miles away, or in London, then I think if you can draw those out it will really help explain how the different bits come together. Hearing what's going on in here I think that's something that's missing from the guide and the wider booklet as well, although I know you've got space to consider. Before I come back to M1, because I know you've got a few things, F4, F5, F3, do you have any other things you would like to add as we're rounding up?

F5: Yes, just a final thank you, and, you know, to our GP who has been taking onboard all our woes and criticisms, and they're coming from a good place, all criticisms, and I know that you accept that, and that it is all about trying to do our bit to have a better world. I had experience several years ago of being a patient at the most fantastic surgery that I think there ever is, and I think it was the Lewis Grove that was in Lewisham, where we as patients had access to our medical notes. It was open, a large room, you went in, you made tea and coffee, you sat on the sofa. You just interacted with the doctors and other patients. What I particularly liked was having access to my notes. I was absolutely horrified when I had, written, some of the remarks previous doctors had made about myself, and some of them were very inconsistent, and certainly not accurate. I learned a lot from that experience, and it would be very nice if that service was replicated in other places along with some of the things that we have identified here as being contributory to the way forward. My final word, and I'm really very sorry that I have to go, but I'm a first-year student on a public health degree course, and today was our first day back at university. I took the opportunity to be here rather than to be in class, but I got a message to say that tutorials are starting at one o' clock, so I really have to push off, okay.

GK: Thank you for your time, F5, and I hope you can share what you have learned today, or what you think, and I hope that helps you with your studies in some way.

F5: F1 and I, we should have been on our first tutorial back, but we wanted to be here. So, thank you very much and I shall wait for more feedback.

GK: Thank you, F5. F4?

F4: Yes. Thank you. Before I go, because I have to go, I would like to share my personal experience about my GP. I really appreciate my GP. They are great. Just one thing, they have two or three receptionists. When I call and one receptionist answers I'm getting a heart attack because she is very direct and she is very angry, and I don't know why. I thought that even my name, when she asks me, for example, date of birth, I think, 'Just, please, a little bit more kind and calm.' That's it. Thank you so much for this opportunity. Thank you.

GK: Thank you very much, F4. I hope we can work together soon. Thank you again. Thank you. Bye.

F5: Thank you very much. Bye.

GK: Thank you, F5, as well. Thank you as well. We will work together, as you're a student, and we hope we can find other ways of working over the next few months and years. M1 and F3, do you have any final comments you would like to make?

F3: I just want to say, F5 mentioned about Lewisham and this hospital and involvement with patients. I was in a community group there as well. We looked at different areas, we looked a training, how we interact with each other and communicate. I wish things can happen like that again, but I know the GPs are very busy. That's the trouble. I'm on this group called the specialist group, where we met with Tom. We will meet the first Wednesday of each month, and we have the CCG, which is the commissioning team, we have a person from the hospital who will give feedback what's going on in the hospital, how many COVID patients. Then we have someone who will come and talk about the cuts in services. When we're looking at all these different aspects of a GP, it can affect, because of the money, where they're cutting some of the frontline services. My thing was that I was looking more at carers. When they cut frontline and the carers, is there some way guarding that carers will be involved in these projects, I mean, in your findings?

GK: Moderator: I think, yes, that's an aspect that I know Sian is talking-, obviously we're talking to patients today. We have tried to get a good representative sample, and I think that has been achieved, but of course we couldn't speak to everyone, and carers are a very big aspect. It occurred to me, Sian, I could probably put you in touch with-, we have a good relationship with the Carers Support Centre, and if you want to get a carer's insight on GPs, which we haven't been able to represent, we have had, obviously, a representative of a mother who has got an autistic son, so that's an aspect, but if you feel there are others you want, we could probably potentially put you in contact with the Carers' Information Centre. You might even just get a viewpoint from their manager about the challenges. They actually did a report only about-, on GP access, or the use of the GP, actually, I'll try and send it to you, Sian, that they did about a year-and-a-half ago. We worked with them a

little bit on it, but I'll see if I can find that, but also if you want a further conversation, we realise we haven't represented that today, but that's a very good point, F3. Thank you.

F3: We have got older carers and we have younger carers, because I found that when I was a school governor, how I got to get the carers to talk about caring, when teachers (TC 02:20:00) said, 'This child is coming in late,' the mother was in a wheelchair, so therefore it's a lot of what I call lack of service in the community, and awareness.

GK: It's context, and indeed the carers need help with health, as well, and that's a thing that's also forgotten, that the carer's own health gets sometimes overlooked because they're concentrating on the person they're caring for, and they can have health issues, as well. Okay, we've only got about six minutes left.

F3: I just want to say a big thank you and appreciation for what you are doing now, to get us involved, to talk out what's in the community, because it's not all the time the NHS people know what's going on out there, so therefore I'm really pleased you and Robyn and-, what's her name, sorry?

SH: Sian.

F3: From the health, from National Health, and as an ex-social worker I really, really appreciate that you involve the community in this decision. Thank you.

GK: Moderator: Thank you, F3. Keep well. Thank you. Just to say, we bid for this, and we were the lucky winners of the bid, so we bid, NHS England put some money out to the Healthwatch network, and we were the successful bidders, just to give you a bit of context there. M1, I know you probably still have a few things to say, but go on. You've got about five minutes.

M1: Five minutes. Here I go, then. Gordon was saying, and I thoroughly agree, with the examples. I remember when we were trained in all this we had two big volumes, and we were taken to a hotel in Eastbourne, and I thought, 'That's a load of rubbish,' and it remained in the bottom drawer, but what I didn't know was that our senior managers were very much able to use this, and used it to great effect to reduce our organisation from 250,000 workers down to 120,000 when the new digital equipment came in in '92.

GK: I hope that this guide won't be used in quite the same ways, but particularly about the changes to the guide.

M1: Let's get on, Gordon. Gordon was saying about examples. There was a Channel 4 series about the GP's surgery, and it was very much to the highlight there how the GP has a ten-minute clock to actually deal with the patient and give their full attention and deal with whatever comes through the door and get them out in ten minutes. Yes, a good practice GP can actually do that, but I'm fully aware when I go to my own thing,

that he will overrun, and it's for a damn good reason, and I'm only too willing to sit there and read a book until he is able to see me. The other thing which I wanted, and it's an old thing of mine, is a shout-out to people and to the GP to recommend is rheumatism and sciatica and shoulders, like that, the exercises on NHS Choices and the videos are absolutely top-rate. Go home, do those exercises, don't take the pills, the pain goes away. Thank you very much. Thank you, Sian.

GK: **That's good to know, but I think the question sometimes is access to that, isn't it? There's a big issue around that, I think, and if it's all online, and it is true, it's great that everything's online, it's on apps. I've seen a particular tendency now for stuff now even to be online but on apps, and it's sort of like, an app you've actually got to download onto your phone, and there are lots of questions around consent and sharing information and you think-, I mean, we all do it, don't we? We all go, 'Alright, then,' but some people are very cautious, some people are quite anxious. 'What am I giving my data away to? Is it a third party?' and it comes along with, 'This app is run by some digital company based in California,' and you think, 'Should I be doing this?' but you do because you want access to that, but it can be a barrier for some, and I think for what seems to have come out here is it's great for those, like F5 and F3, and in fact probably everyone who was here, who are willing to stand up for their rights and be a bit vocal, they might get the change they want, but I am aware that there's a whole group of people who have a number of barriers, from personal, just don't want to be able to be-, who don't have the confidence or don't have the language barrier, or don't have the cultural connection, or might simply get ignored because of who they look like or how they present themselves, that there are barriers there, and that's something that needs to come out, I think, and be perfected here. Have we got any other-, we do need to finish. Any final comments?**

M1: No, that's it. I've said my say.

GK: **That's it. We're done. Well, I'd like to thank you.**

SH: Can I just say a really big thank you? I'm sorry that some of the people went. Do you know, it's so helpful, and what we do in our rushing world, rushing from meetings, and rushing to see patients, and F3's absolutely right. We don't stop and we don't always listen, and one of the things we have said in the guide is, 'Stop and listen to your patients, and actually act on what they have told you.' I think we have to take that as an example from today, so thank you. Atiyah and I will go away and really reflect on what you've told us, and we will act and include some of that in the guide to start in the way that we should all be working, so thank you. I really appreciate everyone's thoughts and comments.

(END OF EVENT).

Quality assurance

Does the research ask questions that?

Are pertinent? Yes, these were questions about the relevancy of content for a GP Access Guide to be shared eventually for 1200 GPs across London.

Increase knowledge about health and social care service delivery? This research helps those at NHS England and Improvement Healthy London Partnership to make changes to the guide in response to patient insight.

Is the research design appropriate for the question being asked?

a) Proportionate: The specifications suggested 4 to 8, we recruited 8 Croydon residents.

b) Appropriate sample size: Has any potential bias been addressed? As above. They were varied in gender, age, ethnicity and life experience

Have ethical considerations been assessed and addressed appropriately? The event would be recorded, but names of participants would be removed to ensure anonymity.

Has risk been assessed where relevant and does it include?

a) **Risk to well-being:** None.

b) **Reputational risk:** That the data published is incorrect and not of a high-quality standard. We publish the full transcript and show where we have made inferences, based on what was said.

c) **Legal risk:** Have appropriate resources been accessed and used to conduct the research? There was no need to refer to legal resources for this research.

Where relevant have all contractual and funding arrangements been adhered to?

This has been funded by a grant from NHS England and Improvements' Healthy London Partnership after a competitive bid process. All contractual and funding arrangements have been adhered to. We received £2,466 to complete this work.

Data Collection and Retention

Is the collection, analysis and management of data clearly articulated within the research design? This was a focus group, the recording was transcribed and highlights draw out.

Has good practice guidance been followed? Yes.

Has data retention and security been addressed appropriately? Yes.

Have the GDPR and FOIA been considered and requirements met? Yes.

Have all relevant legal requirements been adhered to ensure that the well-being of participants has been accounted for? ie the Mental Capacity Act. None required for this research.

Has appropriate care and consideration been given to the dignity, rights, and safety of participants? Yes. Participants were recruited and supported throughout the process, including access to the guide and preparation and support from Volunteer Lead to ensure that they could participate fully in discussions.

Were participants clearly informed of how their information would be used and assurances made regarding confidentiality/anonymity? These were made clear throughout the process.

Collaborative Working

Where work is being undertaken in collaboration with other organisations have protocols and policies been clearly understood and agreed, including the development of a clear contractual agreement prior to commencement? There was a clear contractual agreement with NHS England and Improvement Healthy London Partnership on what was expected and when. They needed to provide necessary information and also participate in the event. We also needed to provide a draft transcript within 2 days of the event.

Have any potential issues or risks that could arise been mitigated? These are shown below:

Risk factors	Level of risk	Contingency
Cannot get enough participant	Medium	Look to recruit more - 4 was minimum required by contract

Question set does not work with group	Low	Questions and themes were considered an and issues shared in preparation so expectations could be managed
Guide might not be understood by participants	Medium	Explanations of aspects in preparation for event and introductions to each section on the day
Data is seen as being out of date	Low	**Report to be completed within two months of insight undertaken.**

Has Healthwatch independence been maintained? Yes, this research is shared with Healthy London Partnership before publication for their comment, but only factual inaccuracy would be reviewed. This does not affect the comments of experiences we receive.

Quality Controls

Has a quality assurance process been incorporated into the design? This was a simpler process, assessing a guide, running an event and producing a report, but necessary quality assurance as described above was included.

Has quality assurance occurred prior to publication? Data collection was checked and re-checked.

Has peer review been undertaken? No peer review was undertaken. It was not required for this research project.

Conflicts of Interest

Have any conflicts of interest been accounted for? This project was an agreement between Healthwatch Croydon and NHS England and Improvement Healthy London Partnership.

Does the research consider intellectual property rights, authorship, and acknowledgements as per organisational requirements? The research is owned by Healthwatch Croydon, who are managed by Help and Care. Other organisations support has been recognised and suitably referenced.