AnalyticsCambridge

Evaluation of Peterborough GP Access Programme

Programme management and GPs at the Accident and Emergency service

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Draft	14/06/2014	Draft chapters numbered Qualitative assessment of GPs at the Accident and Emergency Service and Patient Views on GP at Accident and Emergency Service sent to Project Manager Rob Henchy.
Fd1	2/9/2016	Headlines from chapters on Views across the programme and Numbers and characteristics of patients attending GP at A&E service sent as PowerPoint slides. Discussed with RH on 2nd September.
Final Draft 2	5/9/2016	Considered at a final draft stage

Contents

Tables

Figures

Summary

1. The main conclusion from this evaluation is that key stakeholders interviewed consider that significant benefits have been achieved.

2. The second is that Peterborough is better placed to continue these improvements in the future. An important aspect the programme has been to increase partnership working within and between organisations to create the opportunities for this.

3. A number of lessons have been learnt which could help similar programmes starting up elsewhere. One is to recognise the management resource needed to carry out the implementation. But success has been achieved through the effort and commitment by individuals and organisations in assisting and being flexible in reacting to changes.

4. The wish to improve communications was raised by many. Given the complexity of those to be communicated with in terms of numbers, commitment and their differing roles this will be a challenge - but new methods are being tried out to assist. The function of patient representatives was particular praised with their engaged role welcomed.

5. There are a number of governance issues which should be explored as the programme matures and seeks to become more "business as usual".

6. The GP Service at A&E service was praised by many interviewed for the benefits it has brought in a variety of ways. As with any joint working more induction at the start would have helped, but issues are now seen to have been overcome. There is potential for this part of the programme to perhaps expand and change to deliver greater benefits.

7. A key measure is that the GP at A&E service has seen 2,979 patients in the period it has been operating to 3rd July 2016.

8. CFEP UK carried out a survey asking patients who had used the GP at A&E Service for their opinions. Three quarters of the respondents considered the respect for privacy at the hospital to be very good or excellent and close to two thirds (64%) of patients considered the length of time before consultation with the GP to be excellent or very good.

9. In looking at the characteristics of the patients who use the GP at A&E service they are younger than might be expected. It is possible that the availability of other services could be examined, for example to reduce demand.

10. The information on when the patients were seen was examined. This does show that there is no increase in the number being seen by the GP at A&E service.

11. The A&E service sees different numbers of patients arriving at different time – many of those interviewed stated that numbers could increase significantly in short periods. It is difficult to note the implications for resourcing the GP service as these patterns are clearly different to those that would be expected in a standard "by appointment"' operation.

12. Analysis was carried out of where the A&E patients lived or were registered. While most came from Peterborough it is significant that 450 came from the South Lincolnshire Commissioning

Group. This is the type of information which could be taken into account in ensuring the service is resourced by those by whom it is used.

13. The patterns on what patients were asked or recommended to do after seeing the GP showed strong links with community care ("allowed home") and the wider GP service ("to ring own GP if no better"). Comparisons with the patients of the rest of the A&E service could pick up possible changes which might build on the learning of other practices noted by those interviewed.

14. The GP Access Fund work in Peterborough through its programme and executive management is seen as green and on track, more so than other similar projects in the region. As with any programme of this scale there have been lessons learned in its implementation. But there is a wide belief that some of these have been overcome and there is plenty of opportunity and willingness to resolve the others.

15. The programme is considered to have taken Peterborough and placed it ahead of other areas in this work. The work will need to continue to maintain this but from the evidence gathered it is possible.

1 Introduction

1.1.1 The purpose of this report is form part of the evaluation of the scheme to transform Primary Care in Peterborough which comes through what started as the Prime Minister's Challenge Fund and is known know as the GP Access Fund.

1.2 Context

1.2.1 The Prime Minister's Challenge Fund was first announced as £50 million of resourcing to help improve access to general practice and stimulate innovative ways of providing primary care services[1].

1.2.2 To implement this NHS England invited practices to submit bids. And NHS England were also asked to oversee the programme.

1.2.3 The first wave of twenty pilots was announced in April 2014. Further funding became available in September 2014 and following bids in to this a second wave of thirty seven schemes was announced in April 2015.

1.2.4 The "Primary Care Transformation Programme Peterborough" was accepted as one of these thirty seven pilot schemes in wave two.

1.3 The Primary Care Transformation Programme Peterborough

1.3.1 NHS England have published a short summary of each of the wave two pilots[2]. This sets out the key elements of the Peterborough Primary Care Transformation Programme:

1.3.2 *"The 29 practices in this scheme have organised themselves into three hubs, serving populations of up to 100,000 patients, supported by the planned formation of a new "umbrella" organisation for primary care in the locality. The new system will offer extended and more innovative access to a patient population of over 252,000, using the latest technologies, including video consultations and mobile working solutions, in order to support effective collaborative working between practices, community teams and hospital services*.

1.3.3 This scheme, which went live in August [2015] *, will see 27 of the 29 practices provide increased access with appointments 8.00am-8.00pm on week days, ultimately available through direct booking of appointments via NHS 111. At weekends as well as bank holidays, 8.00am – 8.00pm primary care will be offered in front of the Emergency Department at Peterborough City Hospital."*

1.3.4 *The scheme is also looking to promote 24 hour access to primary care through the online service 'WebGP'*.

[1] For more detail see https://www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/

[2] https://www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/wave-two/about-wave-two-pilots/#25

1.3.5 This report is an evaluation of aspects of the programme. It covers two important parts. The first is the programme and management arrangements in place and how these have worked.

1.3.6 To do this interviews were carried out with 24 stakeholders to get their views on what had been achieved to date, lessons learnt and also issues of opportunities for the future. This is covered in chapter 2.

1.3.7 The rest of the report carries out an evaluation of the important aspect of the programme which is the GP at A&E service. This is reported in three chapters. The first of these is the views expressed through nine interviews with primary care and hospital staff working in and around the GP at A&E service. These were carried out in two day visits.

1.3.8 CFEP UK Survey had been commissioned to carry out a survey of patients who used the GP at A&E service. The findings from this are included in this report to bring the evaluation of the service together into one document. There is also some additional analysis of this work to put it into context.

1.3.9 Finally the data collected on patients who use the GP at A&E service has been analysed to pick out key trends and patterns which can be used as part of the evaluation of what is being achieved.

2 Views across the programme

2.1 Introduction

2.1.1 This purpose of this chapter is to summarise the views put forward in interviews with those who have been involved in setting up and running the programme to date.

2.1.2 In total 24 people have been interviewed. The aim has been to capture not only the benefits delivered but also lessons learned to date from the way the programme has started and works. An aim of this is to contribute to lessons that could be learned by other programmes also setting up.

2.1.3 In considering the benefits achieved it is clear that these not only include hard and measurable indicators but also "softer benefits" that would be well placed to facilitate future progress.

2.1.4 The way the information from the interviews is presented is by looking at the:

- Benefits from the programme,
- Lessons for other programmes, and
- Issues to consider going forward.

2.1.5 The next part of the introduction gives more information on how the interviews and qualitative information was gathered.

2.2 How were the views sought?

2.2.1 The interviews took place as meetings in a variety of contexts. Most were one to one meetings. Some were through meetings with two or more interviewees. There was also a session at the Greater Peterborough GP Access Fund Programme Board meeting of 21st July. After the views were expressed notes were written up and sent to attendees so they could add additional thoughts or make changes. Where interviews were conducted with more than one person present care was taken to check whether views were shared when comments were made. This was followed up through the notes from joint interviews being sent separately to those who took part. This allowed them to make their own changes if they so wished.

2.2.2 The interviews were qualitative in that there was no fixed set of questions asked. The aim was to ensure that those spoken were able to give their views in the ways they chose, which allowed their view of connections to be clearer. But to ensure that the issues of most value were covered, the following were prompts or checklist was used to ensure that those spoken to could give their opinions on:

- What do you think the Greater Peterborough GP Access Fund has achieved to date?
- If you wanted to pass on experience to others who might be doing something similar, what tips would you give them?
- What has worked well?
- What could have been done differently over the last year?
- Are there things that should be continued?
- Are there things you'd like done differently for the future?

2.2.3 Appendix 1 gives the names and *current* roles of the 24 people who were interviewed between 6th July 201 6 and 3rd August. The selection of interviewees was made through suggestions from the programme management but the positions covered were also checked to ensure that key roles were included. Those roles interviewed included those who were directly working on the programme exclusively but also those in partner organisations, including those with more of a commissioning role. This allowed a range of stakeholders views and from those not the direct employment of the programme. An example of this was the inclusion of discussion with the patient representatives on the Board.

2.2.4 A number of those interviewed had been engaged in the programme but had since moved on to other positions. These interviews carried out to allow learning from early stages of the programme to be included.

2.2.5 Fifteen of the 24 interviewees are those with wider, cross programme roles. The remaining (nine) interviewees were more specifically involved in the GP at Accident and Emergency Service. Some of their comments are as relevant and have been included in this chapter.

2.2.6 A key part of the agreement on the interviewees is that each was assured that what they said would be treated with confidentiality. While the points they made would be included in the report they would not be directly attributed to them. If it a direct quote was sought then they were asked if they gave their permission – with the understanding that they did not have to.

2.2.7 As with any qualitative work care has been taken to give an impression of the strength of the views expressed, though this is not as simple as with a structured approach. The main method used is that if the same views were expressed by more than one interviewee then this is stated.

2.2.8 The aim has been to put forward the views of those interviewed as they expressed them. There has been no specific attempt to exclude comments if others disagreed with them. There were a few occasions where a new process might be stated as being beneficial if it were introduced. Another interviewee might say that the process did exist. It has not been the aim of the work to return to check whether the process did exist. But this can show that as in any large organisation or partnership not everything is known perfectly.

2.3 Benefits

2.3.1 An important and key benefit is that access to GPs has been made better. The introduction of GPs at the Hospital A&E service (see chapter 3 for more detail on this) and the GP evening work is very successful and has worked well. The scheme is seen as benefiting patient care in Peterborough. And this is for Peterborough *as a whole*: seen as of significant value.

2.3.2 Those interviewed expressed the view that the programme had delivered a number of benefits and had been a "huge achievement". A range of these benefits were given and they ranged from outputs or things which might be observed directly be patients, but also in matters such as improved working together by the agencies and organisations engaged in the work. And this was seen as making future change more likely and with a better chance of delivering better results.

2.3.3 The point was made that the value of small benefits - such as patients being able to see GPs for 1.5 hours in the evening - should not be underestimated.

2.3.4 Though A&E work has been tried in other parts of the country, the view was expressed that real innovation from the programme in Peterborough programme would come through schemes such as integrated care which could provide care out of hours.

2.3.5 A key success was that the programme had given impetus to GPs working together. GPs have been given the opportunity to consider the issues and challenges they face and that things have to be done differently.

2.3.6 The start of the programme could be likened to having a blank sheet of paper. The aim had been to get GPs in Peterborough working more collaboratively and to attract resources which would allow this.

2.3.7 Key workshops were held in early January 2015 in which nearly very every Practice was represented. It was recognised that there was a political push towards GPs being available for 7 days a week. Applying to the GP Access Fund would help move towards this and, critically, in a way they could influence.

2.3.8 As with many emerging partnerships, the practices which joined could be described as being in three categories:

- ❖ Those who were most willing;
- ❖ Those who were concerned but wanted to be "in" rather than "out"; and
- ❖ Those who could best be described as "uninterested"

2.3.9 The process of putting the bid together gave an impetus to sitting down and. As well as this being the GP practices themselves, relationships with other Organisations have improved and the basis is there for this to continue. For example relationships with the hospital are seen as better (professionally and managerially).

2.3.10 The collaborative working mechanisms are allowing changes to be tried out such as 24/7 access to GPs through web system and schemes for mobile phone dictation.

2.3.11 Changes implemented have shown the value to GPs of seeing records held by other GPs.

2.3.12 Diane Siddle, the Contract Manager, NHS England – Midlands and East stated that the scheme is seen as on target and has been rated as "green" for a while. "Within Cambridgeshire, Essex, Norfolk & Suffolk the project would be in a minority seen as achieving".

2.3.13 One interviewee thought that the programme work had put Peterborough 6 months ahead of others in getting to where Primary Care needs to be - maybe a 3 to 5 year redesign journey?

2.4 Lessons for other programmes

2.4.1 Those interviewed were encouraged to reflect on the progress to date - in the first year of the programme. They were asked if there were any lessons that similar programmes starting in other areas could bear in mind when they set up. The replies and views they gave have been put under a number of different headings. These are:

- ❖ Preparing and managing programme start up,
- ❖ Development will take stages,
- ❖ Importance of communications,
- ❖ Importance of programme management for delivery, and
- ❖ Managing innovation

2.4.2 The programme in Peterborough is part of Wave 2 of the GP Access Fund projects across the country. As well as passing on the lessons that have been learnt here, there is perhaps a question on whether lessons from the Wave 1 programmes could have been made more available or their use encouraged.

2.4.3 The issues here are the ones which those interviewed noted. Some have been addressed and for some they are also picked up in the next section on those that can still be addressed. As in any management process there will be some topics which will always be on the agenda. The GP Access Fund in Peterborough has shown an ability to be adaptable and try new things to address some of the existing issues that were raised.

Preparing and managing programme start up

2.4.4 One important issue at the start of the programme – or in some ways before it started - was uncertainty caused by issues of timing and funding. Work on the programme started in May 2015 but the due diligence process through the NHS did not complete until June that year and the money was not released until after this. Original programme timelines assumed a start on 1st April.

2.4.5 As part of removing any uncertainty caused by the transfer of money to the programme being delayed it would help if there was advice on when *when money has to be spent* also changes as a result.

2.4.6 One issue that was mentioned by a number of those interviewed was that more attention could have been paid to structures and mechanisms needed to run the programme from the start. Clearly in a bid the focus is in what is proposed as action. A theme that came through was that as well as consideration of innovations or proposals individually there needs to be a sufficiently resourced mechanism to co-ordinate and manage their implementation.

2.4.7 The advice was to consider what structures needed to run the programme when preparing the bid: *how* to do things as well as *what* to do. An example would be how the programme would be managed including practicalities such as an organisation to hold the money.

2.4.8 As is valid in improvement programmes, it was suggested that one reason why the bid was chosen was that progress could be made from a starting position where Peterborough was not recognised as a place where GPs worked together.

2.4.9 One view on the programme getting off to slow start was that the need for a suitable structure and governance to spend the money in an accountable way. There was a need to form a Board of Directors, have a chairman for that, have accountancy and legal advice, down to having someone who could sign the cheques. These need time to set up and can be seen as a delay.

2.4.10 Specific practices stepped in: the Jenner Practice handled CQC registration and Park Medical Centre took on “holding the bank account”. This assistance was helpful and welcomed.

2.4.11 It was felt that the work has needed the intense commitment of those who put forward the bid – the scheme has been dependent on a large cohort who have given up their own time to make it work.

2.4.12 It was said “it has been a bumpy and intense ride!”

Development will take stages

2.4.13 It was recognised by a number of those interviewed that the GPs in Peterborough had different views or commitment to the programme. It was felt that they could be put into three categories, those who were:

- Willing, saw the benefits;
- Concerned, but would rather be in than out, not sure of benefits;
- Those who would need more persuading to see the benefits.

2.4.14 As with any programme start up there are stages in reaching "maturity". Those described matched the classic model first proposed by in 1965[3] (shown diagrammatically in Figure 2). The four common stages in this model are:

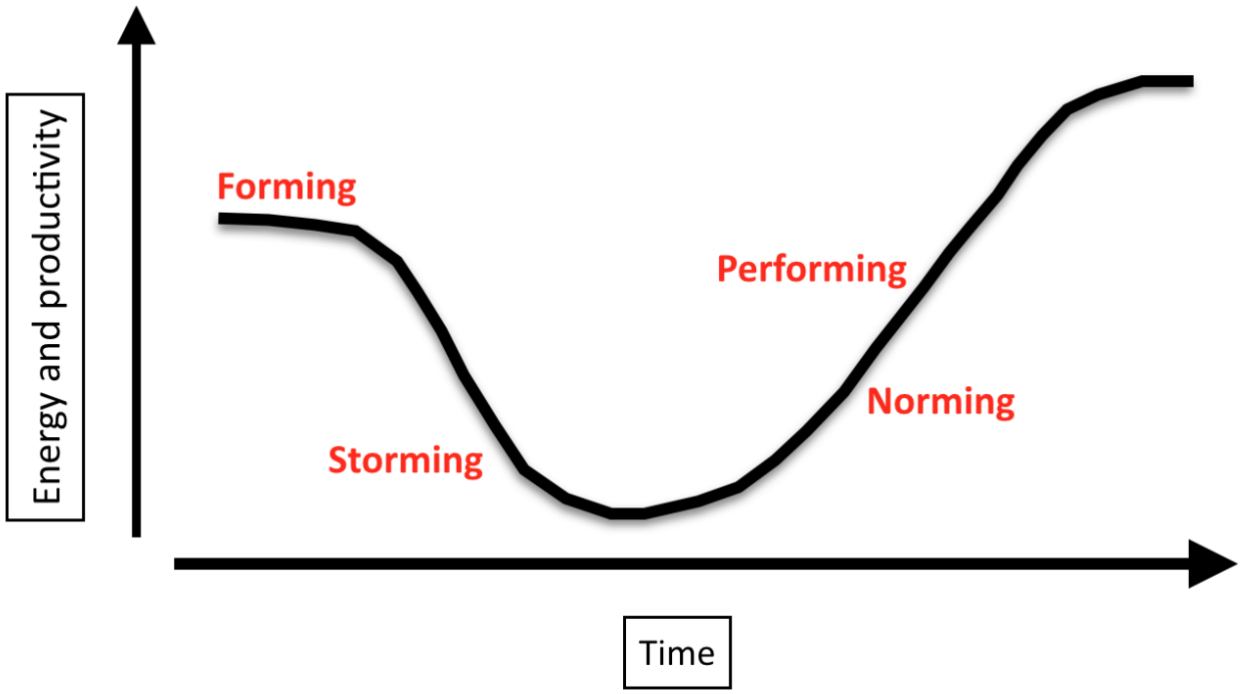
- Forming: the team meets and learns about the opportunities and challenges and then agrees on goals and begins to tackle the tasks. Team members tend to behave quite independently. For programmes such as this the forming stage can take place in the preparation of the bid.
- Storming: *"...participants form opinions about the character and integrity of the other participants and feel compelled to voice these opinions if they find someone shirking responsibility or attempting to dominate. Sometimes participants question the actions or decision of the leader as the expedition grows harder..."*
- Norming: *"Resolved disagreements and personality clashes result in greater intimacy, and a spirit of co-operation emerges".*
- Performing: *"With group norms and roles established, group members focus on achieving common goals, often reaching an unexpectedly high level of success".*

2.4.15 As a note on how the stages might have worked was a comment that progress improved after September as a better consensus developed. Giving examples of this one interviewee stated that the focus for July to September 2016 was the mobilizing the Extended Hours Service and the work on the "hubs". There were still "laggards" in this – coming from small size practices or those with a lack of commitment. As a result some practices have taken on the role for others.

2.4.16 The arrangements for the "hubs" (see 2.4.32) was done through practices agreeing to work together. There was a view that this had not (yet) arrived at a solution based on the needs of communities: but it was also recognised that the current position could be described as "interim". Another factor was the uncertainty on whether the money could be carried over into the next financial year.

[3]Tuckman, Bruce W (1965). "Developmental sequence in small groups". Psychological Bulletin. 63 (6): 384–399. The summary used is that from https://en.wikipedia.org/wiki/Tuckman%27s_stages_of_group_development#References

Figure 1 Tuckman's stages of group development



Source: the model shown is from Bruce W Tuckman, "Developmental sequence in small groups". Psychological Bulletin. 63 (6): 384–399. As drawn from https://en.wikipedia.org/wiki/Tuckman%27s_stages_of_group_development#References

Importance of communications

2.4.17 The subject that most comments were expressed as was on the importance of communication.

2.4.18 Some interviewees noted this in the early stages with the need to include those who were not directly engaged in the programme but whose opinion was important. It was suggested that there was a need to brief key stakeholders (e.g. local MPs) on the bid so they understood the benefits and aims. This should also keep people informed on progress and challenges so, for example any delays could be explained rather than simply seen as problems.

2.4.19 Praise was given by a number of those interviewed with the listening to patient groups. This was not seen as “lip service”. The members of patient groups have felt themselves as part of the wider group involved. Discussions had been easy to follow and this has enabled good reporting back to Patient Participation Groups (PPGs) and patient forums.

2.4.20 It was recognised that views may be expressed in different ways and times: not everyone may say everything at an "all practice event". There is a need to recognise and engage with people who have different functions: practice mangers and GPs are different. As another example, better communications could be developed for those most engaged with technical issues: such as whether to use Skype or Clinical.

2.4.21 The desire for more and better communication was raised by many and new methods are being tried to improve this, for example webinars. A variety of methods should and are being used. Changes are being introduced but need to continue and also to be resourced.

2.4.22 As well as comments that more could be done, there was also recognition there was better working between staff and organisations. There was now better understanding of different roles and the potential joint benefits from working more closely together.

2.4.23 There were very many positive comments about the improved relations between the GPs and the Hospital. One factor has been the build up of trust from assistance given to help in Junior Doctor's strikes. But other there were examples of improved understanding here at the planning and operational levels were also given (chapter 3 gives examples).

2.4.24 One issue that could be examined is the need to establish communications roles and messages e.g. what is role of Directors?

2.4.25 A message was of the need to maintain momentum on engagement. The start is not a one off event!

Importance of programme management for delivery

2.4.26 As well as the importance of communications another issue raised by many was the need to have the necessary capacity to do the work. A key lesson has been the need to invest in management. GPs have limited time themselves and not necessarily the right skills.

2.4.27 It was suggested that the amount of support to get the programme up and running was built up too slowly and that this might have lost "a couple of months" to the programme.

2.4.28 The project management on the work was seen by those interviewed as "enthusiastic and good". But clearly the amount that can be done is limited by the resources available.

2.4.29 The point was also made that there have been issues on staff turnover for programme team: a number of staff have only stayed for short periods. It is not clear whether this in itself could be due to insufficient management resources.

Managing (technical) innovation

2.4.30 Technical innovation is an important part of how the programme seeks to realise the benefits. It was noted that the start at Peterborough was good. It was also appreciated that there has to be some allowance (for change and timetable slippage) as innovative solutions are tested and made practical with deliverable design. For example, there were delays in getting SystmOne set up across practices, it was technically more difficult than had been estimated.

2.4.31 One approach which has been found and that other programmes could adopt with testing new technical innovations is to start testing with one practice and then roll out to a selection of others. This was seen to achieve better results than simply rolling the innovation out to all at once.

2.4.32 It was felt by some that there was too much flexibility on the "hubs" solution. As mentioned in section 1.3, a key element of the programme was that "*The 29 practices in this scheme have organised themselves into three hubs, serving populations of up to 100,000 patients, supported by the planned formation of a new "umbrella" organisation for primary care in the locality."*

2.4.33 The work with hubs is not simply technical, but was new in other ways. While there are suggestions that this is still "work in progress", practices have been prepared to work together to help achieve this. The work on the "hubs" has been felt to have a purpose or result in getting "people to see the bigger vision, a shared aim".

2.4.34 There have also been "outside" factors to take into account in the work: the proposal was to align the "neighbourhood teams" with the Hubs. With the "demise" of the UnitingCare Partnership[4] there has clearly been further work to develop neighbourhood teams.

2.4.35 If the work was being done again it was felt that it would help to have or be able to use guidance on the population size or number or practices which could be involved. Experience from Peterborough might assist.

2.4.36 Different types of area will have different solutions. Peterborough is an urban area. A rural area might need a different approach and way of working.

[4] The example is given of outside influences in the programme. As a summary, Cambridgeshire and Peterborough clinical commissioning group commissioned an innovative integrated contract with a budget of about £0.8 billion to provide older people's and adult community services from UnitingCare Partnership (a limited liability partnership formed from two local NHS foundation trusts). The five-year contract started in April 2015 but was terminated after only eight months because it ran into financial difficulties. See National Audit Office report, 13 July 2016

2.5 Issues to consider going forward

2.5.1 Many of the issues raised so far have been those which have been classed as "lessons learned" and to some extent the time for addressing them has passed and also solutions have been found. Considering them would have value for other programmes. It was also the case that comments were made (and encouraged) on issues that were still "active" and that could be addressed as the programme continues.

2.5.2 These have been set out under four categories:

- Developing a vision and plan,
- Role of Board,
- Specific issues, and
- Opportunities.

Developing a vision and plan

2.5.3 It was felt that the Greater Peterborough Network does not yet have a clear vision for the future. It would help to develop this and then work from this e.g. produce a business plan.

2.5.4 There will be issues in having one plan that suits all with different appetites for change and views on the risks. But it was recognised that the process of producing the plan could help the move forward.

2.5.5 In terms of Board structure and management it was recognised that different models had been tried and are being tried. While this work was being carried out a Chief Executive Officer position was advertised. An "away day" for the Board executive is planned but this had not yet been given a date.

Role of the Board

2.5.6 The question was raised on the extent to which the role of Board members need might need to be developed?

2.5.7 The Board members have a number of roles in the nature of the work. These include:

- Acting as a commissioner,
- Being a service provider, and / or
- Being a member of a federation

2.5.8 This can leave issues around how decisions are taken. Broadly the issues would fit in the category of "declarations of interest".

2.5.9 Some interviewed felt that it would help to have more clarity on the power the executive might have to take decisions. Is there agreement on when all GPs should be consulted or the executive has the power to do things?

2.5.10 Another question on the way the Board works could be also be headed under 'terms of reference". This would be how the Board should handle decisions if not every member attends? Clearly there is a balance between the amount of time gaining agreement between different parties and the speed in making decisions and their authority. It is possible that taking more time to get agreement can be more positive than a simple "imposition from above". It is also possible that the developing partnership working may allow more executive power.

2.5.11 Complementary to the executive power is how decisions and ideas should be checked or scrutinised. How can decisions be made on whether the ideas are worthwhile? There is also the issue of determining that operational activities meet the aims and procedures that were put in place when they were set up. The example was given that commissioners are buying additional slots from Hubs and the key role is that these provide access to patients from other practices. The question then is: is this being achieved?

Specific issues

2.5.12 Although there is inevitably a degree of repetition with comments noted previously, a number of specific issues were raised where future action was thought to be important.

2.5.13 As has been mentioned, a number of interviewees considered that the position of the "hubs" was worth further consideration. A number had recognised the current solution as temporary but one arrived at by compromise between what might be considered better on paper and what was possible in the current state of the joint working. One view expressed was that the location was not logical. There has been much debate on this including having one Hub and a seven day rota.

2.5.14 When the programme started vacancy rates for GPs and nurses was high. It was stated by one interviewee that there was a 20% GP vacancy and a 25% practice nurse vacancy rate in Peterborough. Although a simple of measure of whether this has changed is not essential, it would be useful for the programme, or the service as it progresses, to determine to see that it is "on track" in delivering a resolution to this.

2.5.15 There was an appetite to use the progress made to date to continue to explore improvements. One which was specifically mentioned was future (joint) work between primary care and hospital staff.

2.5.16 Some patients seen by GPs at A&E come from outside Peterborough, for example 450 from South Lincolnshire. This is covered more in chapter 5. This is an example of an issue which would needs to be addressed for future funding arrangements for the work

Opportunities

2.5.17 During the interviews a number of specific opportunities coming up were mentioned. It was felt that these could be taken advantage of by the programme in developing its work. Those mentioned included:

- If practices are close to closing how might their patients be absorbed by other practices,
- How might practices work with new housing development,
- Possibility of joined up services with councils,
- Looking at and possibly expanding work with the Hospital.

2.5.18 As with any programme an end strategy is needed. Mechanisms need to be made and agreed that will take the programme as it is - testing out possible alternative and innovatory ways of working - and make arrangements so that the work can be run as "business as usual".

2.6 Conclusions

2.6.1 This chapter has examined the views of key stakeholders across the programme on its achievements to date and potential actions for the future. The issues recorded include some which are considered dealt with as these may be useful for other programmes establishing themselves.

2.6.2 There are two key conclusions from this section of the evaluation. The first is that those operating across the programme consider that significant benefits have been achieved. These views are from a range of stakeholders including those directly operating in the programme but also including those with more "external" or advisory positions.

2.6.3 The second conclusion would be the view that Peterborough is better placed to continue these improvements in the future. One impact of the programme has been to increase partnership working within and between organisations to create the opportunities for this.

2.6.4 Key lessons for similar programmes and those engaged in them would be to consider the *implementation* of programme ideas as well as the ideas themselves. This will allow a quicker start up time. It should also help aspects of risk management if there are delays in funding coming through.

2.6.5 An important part of the implementation planning is to recognise the management resource needed to carry out the implementation. Many of those interviewed recognised that progress would have been quicker if more had been put in place earlier one.

2.6.6 A significant element in the programme's success has been the effort and commitment by individuals and organisations to assisting and being flexible in reacting to changes.

2.6.7 There is a recognition that not all organisations share the same energy or commitment. This is inevitable in any new partnership. But there is credit in the progess which has been made and the effort put in to bringing organisations "on board". The expression "herding cats" was used by a number of those interviewed.

2.6.8 The wish to improve communications was raised by many spoken to. Given the complexity of those to be communicated with in terms of numbers, commitment and their differing roles this will be a challenge. New methods are being tried out to assist.

2.6.9 There are some governance issues which should be explored as the programme matures and seeks to become more "business as usual". The arrangements for what can be termed a start programme with additional resources will be different to more "routine" management. Speed is achieved through the less formal arrangements. But it is recognised that Board members have conflicting roles and elements to balance this could be put in place. Some aspects of performance management and "scrutiny" could be adopted.

2.6.10 The function of patient representatives was particular praised with their engaged role welcomed. This has developed through a two way process including effort from the programme as well as work from the patient representatives themselves.

2.6.11 What the programme has carried out has been largely set by the plans formed in the bidding process. As innovations are tested and implemented then there was a view that a new plan and vision should be adopted and confirmed as a way of assisting with the continuation of the work.

3 Qualitative assessment of GPs at the Accident and Emergency Service

3.1 Introduction

3.1.1 This purpose of this chapter is to look at the GP at Accident and Emergency (A&E) service through issues and comments made by those interviewed in two visits made in July.

3.1.2 In the two visits six interviews were carried out to obtain the views of nine people who work directly in the service. Those interviewed have been not only those who provided the GP at A&E service but also those who provided the Hospital side of A&E services. This has allowed both perspectives to be seen. Those interviewed included GPs and Consultants, nurses and receptionists. In addition to views from these nine interviewees, the evaluation as a whole – at this stage – has had views from an additional 15 interviews. Where these have expressed views on the GP at A&E service they have been included.

3.1.3 Observations from the visits - seeing it in action - have also made a contribution to the report.

3.1.4 In order to provide context for the views, the chapter starts by explaining how the GP at A&E service works. The chapter then summarises the key issues and suggestions raised by organising these into three sections. The first looks at any issues experienced when the service started up. These can provide any similar programmes elsewhere with issues to consider before they start.

3.1.5 The chapter then summarises comments and issues related to how the service operates now. These provide ideas and opportunities on issues that could be considered and – if appropriate – change now.

3.1.6 One of the issues raised by a number of those interviewed was that patients might come to the GP at AE service specifically to see a GP; rather than attend the A&E service. The section "GP service and numbers attending A&E" brings together a number of pieces of data to look at trends and reasons for A&E attendance at Peterborough.

3.1.7 Some of the suggestions made have been on potential larger changes to the service that could be considered for the future, but might take a number of years to implement. These are put together in the section on potential longer term improvements.

3.1.8 The summary at the end of the chapter brings together the key findings.

3.2 How does the GP at A&E service work?

3.2.1 The service has been set up to work in the following way. When a patient arrives at the "front door" of the A&E service at Peterborough Hospital there is a reception desk[5]. This desk is staffed by both the nurse (whose role is a "streaming nurse") and receptionist who work for the GP at A&E service. The GP part of the reception desk is closest to the front door and receptionists are primary care employed. One window down are the reception staff employed by the Hospital Trust who welcome and handle patients who will go on to A&E.

3.2.2 For the sake of clarification it is probably helpful to state at this stage that the A&E Service is that provided by the Emergency Department at Peterborough Hospital. However we are using the term A&E as it is a generally more familiar term.

Figure 2 Peterborough Hospital, Emergency Department

Source: http://jlif.com/portfolio_investmentportfolio.php

3.2.3 When the patient arrives at A&E they are spoken to by the streaming nurse who is part of the GP service. The streaming nurse is the person who makes the initial decision as to whether the person should see a GP or go to Accident and Emergency. If they are directed to A&E then they move to the next window down.

[5] Figure 2 show the location of the Emergency Department in the hospital buildings

3.2.4 If the patient is assessed as appropriate to be treated in primary care then the GP receptionist asks them for their name and date of birth to confirm their identity. They are then asked if they give permission for their medical information to be transferred from the GP they are registered with to the GP who will see them at A&E. They are then directed to the GP or placed in the queue to see them.

3.2.5 Two computer systems are used. System One is used for the GP services. The patients who see the GP are booked in on this system. A&E use the E-Track System. This system is used by A&E to show the health condition of patients and also how they have been prioritised. GPs can log onto this and view this information.

3.2.6 All the patients who come in are recognised as being in the overall category of A&E patients. If they are seen by a GP information is passed on to A&E who add this to the A&E System. They are not charged for under the hospital tariff system.

3.3 The start up of the service

3.3.1 A number of the interviewees expressed the view that when the service started there were issues on how to work with the reception service which already operated at A&E. A number of interviewees suggested a lack of communication or engagement with the existing A&E receptionists had led to a feeling that their roles were being "taken over". However it was felt that this position had improved since the start.

3.3.2 The introduction of the GP service brought together nurses who had differences in their roles and how they worked. A nurse at A&E would prioritise having the most ill patients seen soonest. Nurses who worked with GPs were more familiar with patients being seen in the order in which they arrived.

3.3.3 More explanation before the start of the roles of staff and the services they were to offer would have improved the understanding of the different roles.

3.4 Comments on how the service operates now

3.4.1 A number of comments were made on the different approaches between GPs and Junior Doctors at A&E and how sharing understanding of these can be beneficial. For example if a patient came in and was seen by a Junior Doctor on the minor injuries side of A&E the Junior Doctor might recommend they have a bed overnight "to be on the safe side". However a GP might be more inclined to "send them home" as GPs are more comfortable with people in the community.

3.4.2 It has been noted that the GP service is for patients arriving by "walking in" through the door. Patients arriving by ambulance were excluded from the service. It was suggested that there could be a role for GPs (and nurses) in seeing some patients who arrived by ambulance.

3.4.3 The current location for the reception can be quite noisy. There is an area close by where young children wait and play. This would be an issue for both A&E reception and the reception for the GPs at A&E service.

3.4.4 There are issues with how the reception desk(s) function. There is no clear signposting for patients: it looks like there are two windows for one reception service. In busy times a patient may go to the window that is effectively the A&E reception window. They might then be told that they should go to the GP reception window. If other patients have arrived while this is happening it can give the impression of "being sent to the back of the queue". The suggestion was made that there might be closer working together between the two reception teams.

3.4.5 The view was expressed that the timings of the service by GPs might be handled more flexibly. If a patient arrived 10 minutes before the official start time of the GP service then they could be asked to wait. Although it is not clear who would make this decision if the primary care nurse had not started working.

3.4.6 There can be issues for GPs logging on to the Etrack System. It's a system they only use when working with this A&E service and some introductory on-line training had been made available. However they might only use the system every few months. The Hospital IT support does not seem to operate on Saturdays or Sundays so it's not clear where technical or security help can be obtained.

3.4.7 There are benefits from the GP service here if the GP wants the patient admitted to hospital. Hospital staff can be "bleeped" so that this happens quickly.

3.4.8 From a patient perspective there can be an issue on where to obtain medication if the GP has prescribed it. One GP noted that he told colleagues who came in for the Sunday afternoon / evening shift that it helps if they find out where Chemists are open on Sundays so they can tell patients. One place where medication can be obtained is at the Sainsbury's at Bretton[6] - half a mile away[7]. But this is not open on Sundays after 16:00.

3.4.9 If patients admitted to the Hospital can obtain medication there, then access by patients who see the GP service should be considered.

3.4.10 There are still some issues on how the services operate together. It was noted that for some complaints made at A&E (and there had been only a small number) it might need to be explained to the complainant that it was the GP service which had been responsible (if this was the case). The suggestion was made that when a patient had been seen by a GP it should be made clearer to them that this is what had happened (i.e. that they had been seen by a GP). The comment was made that patients could be could be issued with a leaflet to explain that service. This does already happen and simply illustrates the point of continuing to work together to develop an understanding of the existing processes.

[6] Flaxlands Bretton Centre, Bretton, PETERBOROUGH, PE3 8DA. See https://stores.sainsburys.co.uk/2716/bretton

[7] As a simple straight line distance

3.4.11 It was felt that there would be advantages if there were regular catch up meetings between the teams – perhaps just 30 minutes every month – to discuss issues and improve communications.

3.4.12 Questions were raised about the contract that GPs are on when they worked on this service. For example it is based on seeing six patients and hour but it was not felt to be clear what happened if the number of patients seen was greater or less than this (chapter 5 gives more information). A related point to the contract is that it was stated that the Minor Injuries Centre[8] works more on the basis that it carries on until everyone has been seen[9], but this is not generally the way that the GPs at A&E Service operates.

3.5 GP service and numbers attending A&E

3.5.1 A number of those interviewed commented that the GPs at A&E Service might be responsible for the increase in the number of people attending the Accident and Emergency service. In November 2015 8,342 patients attended the A&E services of Peterborough and Stamford Hospitals NHS Foundation Trust. By June 2016 this had increased by around 590 to 8,931[10] (a 7% increase).

3.5.2 The evidence around this is mixed. Figure 3 compares the number of patients attending A&E services for England as a whole and for Peterborough & Stamford Hospitals NHS Foundation Trust. The comparison is from November 2015 (when the GP service started) through to June 2016 (the latest data available). As can be seen from the graph the patterns of change are very similar. This might simply imply that what is happening in Peterborough is what is happening in other parts of the country implying that the GP at A&E service is not driving the increase.

3.5.3 If the number of patients coming to Peterborough Hospital A&E had increased at the same rate as England then there would have been an additional 340 patients attending in June 2016. The increase was 590, slightly more. This might imply that the effect of patients coming to see a GP was increasing the numbers attending A&E. But one factor that needs to be taken into account is the number of people living in the area: and Peterborough's population has grown faster than England's. From 2011 to 2015 England's population increased by 3.2% while Peterborough's increased by 5.1%. This larger growth in Peterborough's population could explain most of the difference in the increase in numbers attending A&E.

3.5.4 Another source of information is the survey of patients who attended this GP service carried out by CFEP in July (more details are given in the next chapter, chapter 4).

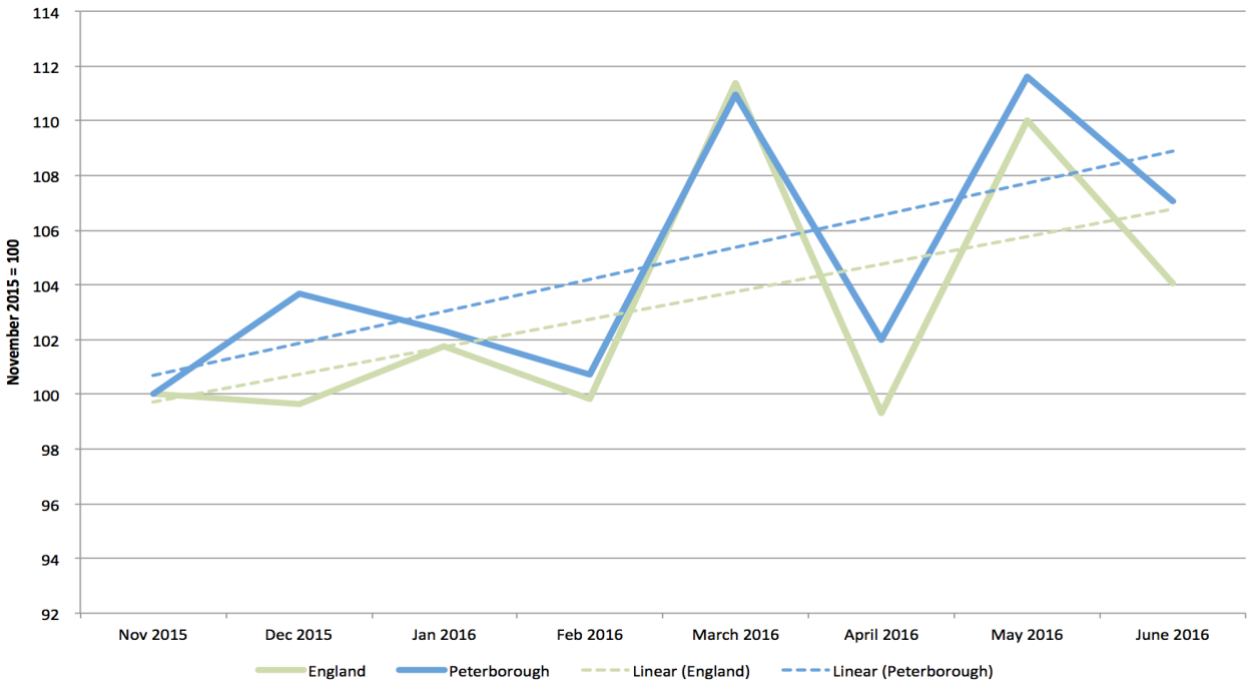
[8] For the location of this see Figure 4

[9] This may to be more an expression how the staff work there rather than a completely "guaranteed" aspect of the service.

[10] The source for these is Provisional Accident & Emergency Quality Indicators for England by provider. See https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areasae-waiting-times-and-activityae-attendances-and-emergency-admissions-2016-17/

3.5.5 The survey allowed patients to give reasons for their visit and in total 51 answers were given. Of these, 17 were most relevant to the issue of access to the GP service. These are shown in Appendix 1. Around one third of those surveyed indicated that they were attending because they were unable to see a GP at that time. But this is not the same as saying they had come specifically to see a GP. It is possible this may change in the future.

Figure 3 Number of patients seen at A&E: England and P'boro & Stamford Hospitals NHS Trust



Source: NHS A&E Attendances and Emergency Admissions 2015-16 and 2016-17

3.6 Potential longer term improvements

3.6.1 Many of those interviewed spoke of the advantages that would come from bringing existing facilities – particularly the Minor Injuries Unit - on to the Hospital site.

3.6.2 One interviewee expressed the view that if this happened possibly fewer GPs might be needed. If the Minor Injuries Unit was brought to the Hospital Site then it could take the suitable patients coming to GP service at Accident and Emergency. On this basis they did not think that this facility would then need three GPs (the two currently at the MIU and those at the A&E Service).

3.6.3 Peterborough Hospital was located at Thorpe Road and moved to its current site and was opened there in December 2010[11]. In Thorpe Road the Hospital was close to the Minor Injuries Unit. When this was the case people who came to A&E and could be treated by the MIU would then go there. But with the new location of the Hospital at the Bretton Gate people are more likely to stay at A&E when they have arrived.

3.6.4 The distance between the Hospital and the MIU is around 3 miles and might only take 15 minutes driving: though this ignores the time to walk to and from a vehicle to the reception, and other issues such as the time it might take to register again at the MIU. There might also be additional car parking fees form parking at two locations.

3.6.5 It was also suggested that the Out of Hours Service could be brought to the Hospital location.

3.6.6 One view expressed was that the service could run every day of the week. The example given was that if a shift took 15 patients out of A&E then that helps A&E. If services such as the MIU were brought to the Hospital site then that might be one way of achieving this.

Figure 4 Locations of Peterborough Hospital Accident and Emergency Service and Peterborough Minor Injuries Unit

Source: via Apple Maps

[11] See 2012 National Audit Office Report: Peterborough and Stamford Hospitals NHS Foundation Trust, https://www.nao.org.uk/wp-content/uploads/2012/11/1213658es.pdf

3.7 Conculsions

3.7.1 The purpose of this chapter has been to examine the views on the GP at Accident and Emergency service as put forward through the interviews carried out. They are summarised here and put in the form of recommendations to be considered.

3.7.2 As the service was set up there might have been more work with the teams who would be working together in the same space and essentially dealing with the same people. This could have improved understanding of the new service and how it might work with the public / patients. It would also have increased the opportunity for staff to suggest ways of working together.

3.7.3 Some mechanism for meeting together, perhaps for a short time every month, would allow greater sharing of experience between staff from both teams. Understanding the differing perspectives is seen as beneficial. It would also allow discussion on any issues for joint resolution: for example to give clarity on what might be done if a person reports to the "wrong" reception window or makes a complaint.

3.7.4 A decision could be taken as to whether the GP Service might have a role with patients arriving by ambulance.

3.7.5 If it was possible to reduce the noise at the reception area this would help patients and staff.

3.7.6 Greater IT support would be welcome for GPs using new systems.

3.7.7 There would be benefits for patients in increasing the ease with which they could obtain medication, particularly on a Sunday evening.

3.7.8 Although the number of patients attending A&E has increased since the GP at A&E service started there are other reasons why this might have happened other than the GP at A&E service encourages patients to come to specifically see a GP.

3.7.9 For the longer term there was considerable support for bringing other treatment centres for GP services closer to the Hospital. It was felt that this would increase the ability to offer alternatives to the A&E service.

4 Patient Views on GP at Accident and Emergency Service

4.1 Introduction

4.1.1 The purpose of this chapter is to add to the evaluation report results from the survey carried out by CFEP UK Surveys[12] in July. CFEP was established in 1995 and since then has gained considerable experience and expertise in providing patient and colleague feedback to healthcare professionals in primary and secondary care settings across the UK.

4.1.2 A fuller report on the survey is available[13].

4.1.3 The questionnaire used in the survey asked patients using the GP at A&E service 12 questions. Two were about the service provided: the respect for privacy and dignity at the hospital and the length of time before the patient had a consultation with a doctor. There were then five questions about the consultation with the doctor. These asked about the ability of the GP to listen to the patient, their explanation to the patient, the extent to which the patient felt reassured by the GP, the time given to the consultation and the overall satisfaction with the doctor. Patients were asked to respond by ticking one box for each of these questions to indicate whether they considered the service to be poor, fair, good, very good or excellent.

4.1.4 There were then two questions one of which was whether the patient might use the service again and the other was whether the patient would recommend the service to family and friends. The answers sought for these were questions were a simple “yes” or “no”.

4.1.5 Additionally there were two questions or opportunities for patients to give comments: firstly on why they had chosen to come to Accident and Emergency on that day and secondly a space to make any other comments.

4.1.6 This chapter first examines some general issues on how the answers to the survey questions can be interpreted. This is done by looking at the number of respondents and how their gender and age compared to the patients seen. It then summarises the patient views on the service provided through by GPs at A&E that are of particular importance to an evaluation of the service.

4.2 Comparing survey responses with patient characteristics

4.2.1 In starting to look at the potential use of the survey data, it is worth knowing that it had responses from 63 patients. An opening question is what how the results might be interpreted when this is considered as a sample.

[12] https://cfepsurveys.co.uk/

[13] Available from Rob Henchy, project manager

4.2.2 Chapter 5 examines the information collected on the patients who have seen the GPs at the Accident and Emergency Service. There have been 2,979 appointments for patients with the GPs from when it started in November 2015 to the start of July 2016 was. This data records the number of visits from patients but does not record data about the patients themselves (which would allow them to be identified as individuals). This could be taken as the "population" to which results from the survey sample could be applied.

4.2.3 If the survey is considered as a sample from a population of 2,979 then the statistical error levels for an answer of 50% to a question would by + or – c. 12%[14]. This would mean that an answer from the survey respondents given as "50% say X or Y" should be interpreted more as between 38% and 62% of the total patients might have this view. Error levels would be lower for values less close to 50%. For example, if six people in the survey answered a question in the same way this would be 9.5%. At the 95% confidence level the answer would lie between 16.8% and 2.3%, with the error level being 7.25%.

4.2.4 The production of the error levels should be considered only an approximation of the confidence for the survey. As with most survey responses those who answer are unlikely to be representative of the population as a whole (with the term population used to mean those who have used the service).

4.2.5 The last three questions in the CFEP survey asked those responding to indicate the age group they were in, their gender and ethnicity. Having this information allows a comparison between those who responded to the survey and the patients who used the service. The comparisons are shown in Table 1.

4.2.6 As Table 1 shows, the comparison between survey respondents for gender and the gender of patients recorded through the patient log (those who have seen a GP at A&E) shows these are similar – close to half the patient are male.

Table 1 Comparing gender of patients from CFEP survey and patients who have seen a GP at A&E

Gender	CFEP Survey		Those who have seen a GP at A&E	
	Number	Per Centage	Number	Per Centage
Female	24	47%	1,454	53%
Male	27	53%	1,286	47%
Total	51		2,740	

Sources: CFEP patient survey and patient data log

Note: missing data (without gender) is 12 records (14%) from survey and 223 (or 7%) from patient log

[14] This is the error level at the 95% confidence level

4.2.7 A comparison between the ages of the survey respondents and those of the patients seen by GPs is given in Table 2 and also Figure 5. This shows that the respondents to the survey are older than the patients who saw GPs. The patient log (of those who have seen a GP at A&E) shows that close to half the patients (48%) were aged under 25 while only 22% of the respondents to the survey were in this age group. So clearly the answers to the survey are more likely to reflect the views of older patients.

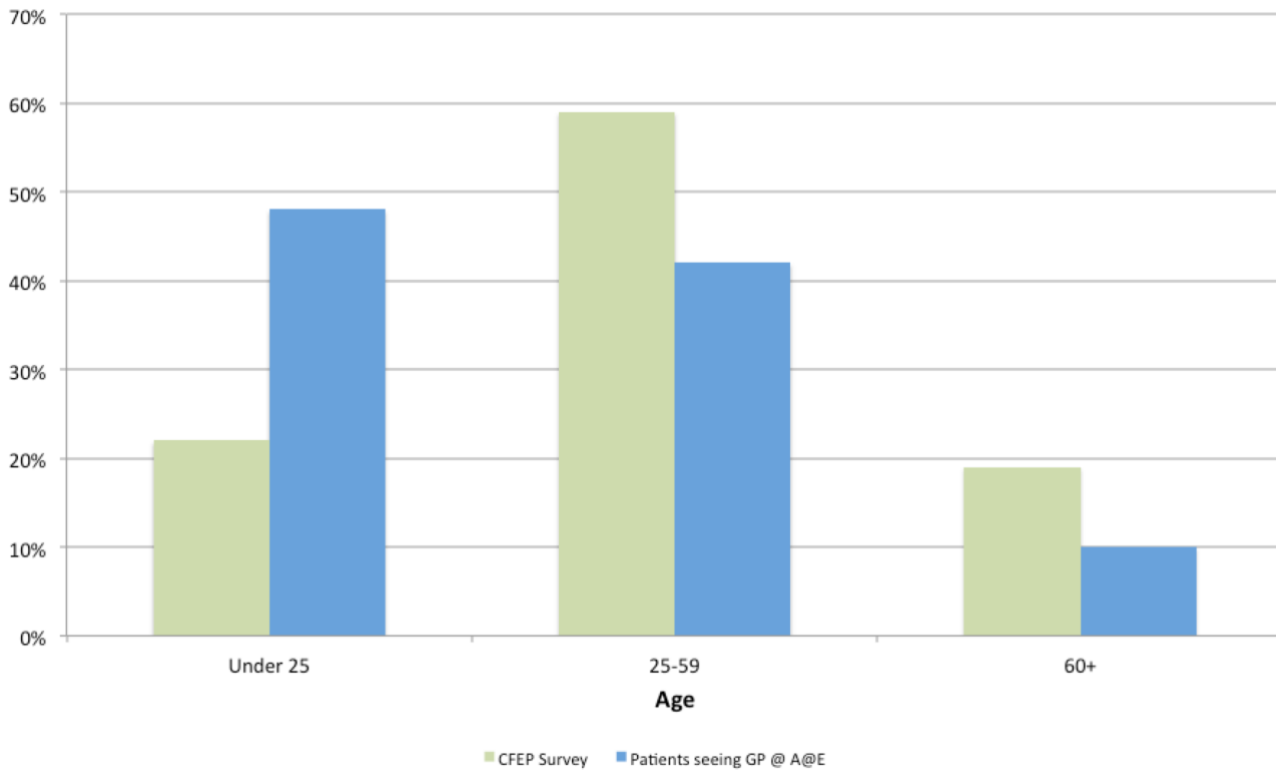
Table 2 Comparing ages of patients from CFEP survey and patients who have seen a GP at A&E

Age	CFEP Survey		Those who have seen a GP at A&E	
	Number	Per Centage	Number	Per Centage
Under 25	12	22%	1,325	48%
25-59	32	59%	1,151	42%
60+	10	19%	281	10%
Total	54		2,756	

Sources: CFEP patient survey and patient data log

Note: missing data (without ages) is 9 records (14%) from survey and 239 (or 8%) from patient log of those who have seen a GP at A&E

Figure 5 Differences in age between survey respondents and patients seeing GPs



Sources: CFEP Survey and Peterborough GP @ A&E patient log data

4.2.8 Both the CFEP survey and the patient data from those who had seen a GP at A&E record details which are labelled as ethnicity. However it is not possible to provide a comparison between these. This is because the patient log data has categories of which some are nationality and some are ethnicity and it is not possible to produce information from this which is *only* ethnicity.

4.2.9 There is potential bias towards a good ranking or score from the CFEP survey results because of the codings used for the answers. In many for the CFEP survey questions the respondents are asked to indicate whether they find that aspect of the service either "poor", "fair", "good", "very good", or "excellent". Out of the five categories three are good or above. Many customer satisfaction surveys also have five categories for answers but with a middle balanced category. One example this might be "How satisfied or dissatisfied would you say you are with the way the National Health Service runs nowadays?" With the answer categories being: "very", "quite satisfied", "neither", "quite unsatisfied", very dissatisfied[15]. It could be argued that the answer categories in the CFEP survey are biased towards positive satisfaction measure.

4.3 Patient views on service provided by GPs at A&E

4.3.1 The survey asked patients for their views on the extent to which the service respected their privacy and dignity. The answers given are shown in Table 3. Three quarters (75%) of the respondents considered the respect for privacy at the hospital very good or excellent. The definition of privacy and dignity is not made explicit and impressions might relate to many factors. These could include physical aspects such as how waiting areas and rooms are managed. The response might indicate that there is little concern over the sharing of information from the GP with whom the patient is registered with the GPs at A&E. As was set out in paragraph 3.2.4 patients are asked if they are give permission for this information to be shared

Table 3 Survey views on the respect for privacy and dignity at the hospital

	Poor	Fair	Good	Very Good	Excellent	No response
Numbers	1	2	12	20	27	1
Per Centage	2%	3%	19%	32%	44%	

Sources: CFEP Survey, General Practice Out of Hours Report, page 2

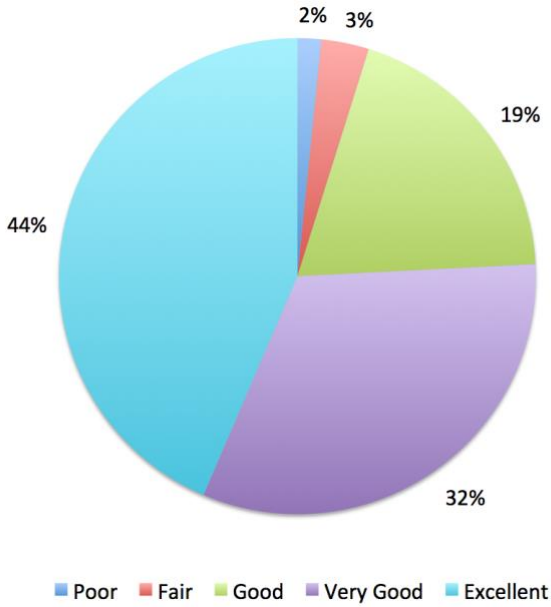
Note: per centage excludes questionnaires where there was no response to that question

4.3.2 The CFEP survey report provides some comparison with similar surveys which have been carried out. This shows that the level of satisfaction with privacy provided at the GP at A&E survey is similar to those from other surveys[16].

[15] Kings Fund, http://www.kingsfund.org.uk/blog/2012/06/public-satisfaction-nhs-plummets-2011

[16] The average (mean) score for this was 78% while the average (median) score from other surveys was give as 77%.

Figure 6 Respect for privacy and dignity at the hospital



Sources: data from CFEP Survey
Note: answers from 62 respondents

4.3.3 The CFEP survey also asked patients for their views on the length of time before consultation with the doctor. Table 4 shows the results (also shown in Figure 7). These are that 64% of the respondents consider the length of time before consultation with the doctor to be very good or excellent. Although this is a lower proportion than that seeing the respect for privacy and dignity was good or excellent, given the sample error levels the results could be similar.

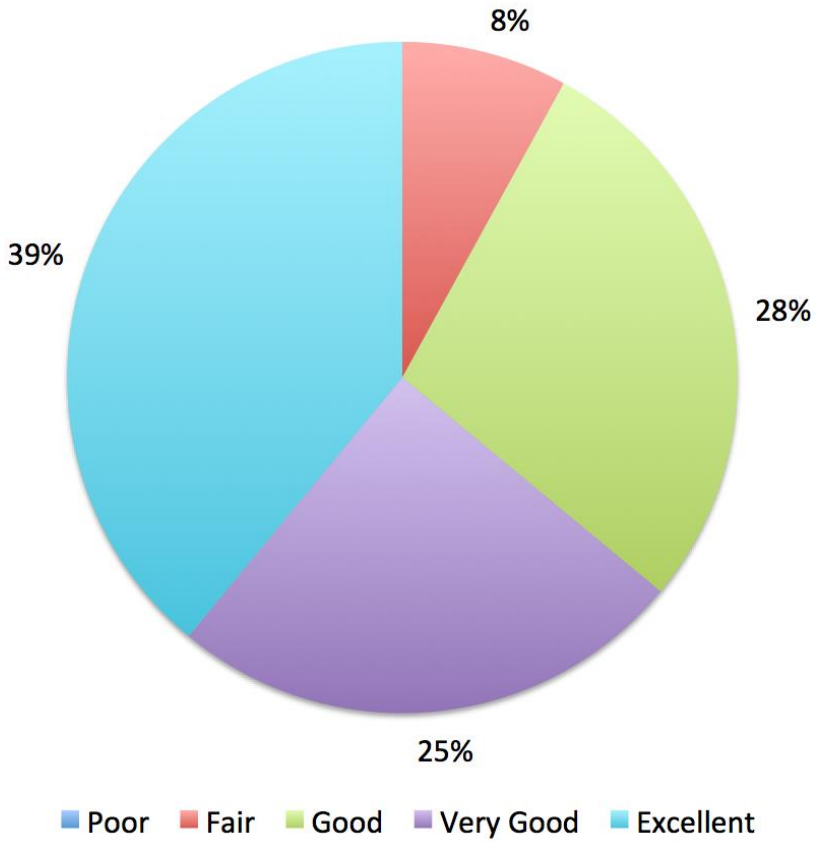
Table 4 Survey views on the length of time before consultation with the doctor

	Poor	Fair	Good	Very Good	Excellent	No response
Numbers	0	5	17	15	24	2
Per Centage	0%	8%	28%	25%	39%	

Sources: CFEP Survey, General Practice Out of Hours Report, page 2
Note: per centage excludes questionnaires where there was no response to that question

4.3.4 As with the previous question on respect for privacy and dignity at the Hospital, CFEP also provide a comparable satisfaction levels from other surveys they had carried out. These show that the average (median) satisfaction level from the patients at Peterborough is 74% while that from these other surveys is lower at 61%.

Figure 7 Satisfaction with the length of time before consultation with the doctor



Sources: Sources: data from CFEP Survey

Note: answers from 61 respondents, no one rated service as "poor"

4.3.5 One of the issues raised in the interviews with stakeholders about the GPs at A&E service was the extent to which patients might be coming specifically with the purpose of seeing a GP. This was examined in more detail in section 3.5. The CFEP survey allowed patients to respond to the question "why did you chose to come to Accident and Emergency today" by writing their own answers (as opposed to being ask to chose from preselected options).

4.3.6 Fifty one answers were made to this question[17]. are shown for this question in Appendix 1. Of particular relevance to this issue is that 17 of these responses (around one third) indicated that they were attending a GP at A&E because they were unable to see at GP elsewhere at that time. For example the answer "GP closed" was used four times. However, as previously noted, it cannot be assumed that the patent had specifically come to the GP service at A&E to see a GP. It is possible that they came to A&E simply because their GP service was closed.

[17] These comments are listed individually in the CFEP survey report though it is not clear whether some individuals made more than one comment.

4.4 Summary

4.4.1 This chapter has reported on key results from the CFEP survey of patients using the GP at A&E service in July.

4.4.2 Answers were received from 63 respondents. Using standard error measures this number would give the answers expressed as per centages a potential variance of plus or minus 12%.

4.4.3 Those who answered the survey were more likely to be the older patients.

4.4.4 Three quarters of the respondents considered the respect for privacy at the hospital to be very good or excellent, similar to other surveys CFEP have carried out.

4.4.5 Close to two thirds (64%) of patients considered the length of time before consultation with the GP to be excellent or very good. This was given as better than other surveys CFEP had carried out.

4.4.6 There should be some caution in comparing the results of this survey with other ones as the categories for answers were more likely to show positive results.

4.4.7 Around one third of patients indicated that the reason they visited the GP at A&E service was because of a lack of access to their current GP. However this could simply be that their current / local GP was closed and so they came to the A&E service (so the conclusion cannot be made that they had come specifically to see the GP at A&E).

5 Numbers and characteristics of patients attending GP at A&E service

5.1 Introduction

5.1.1 The chapter examines characteristics of patients seen by GPs at the GP at A&E service by looking at trends and patterns from the data collected through the "master logs" and stored by the project management team.

5.1.2 It looks at key characteristics which could assist planning and prioritising in a number of ways. One example would be comparisons with the wider A&E data and those of patients seen by GPs at their practices.

5.1.3 Initially there is a short examination of the data quality as this is fundamental for drawing opinions from subsequent analysis. There is then a look at the gender and age of patients. These are compared to national values. This section also includes a summary of the "ethnicity" of the patients seen.

5.1.4 Trends in when patients are seen are looked at according to various measures such as by day and by "shift" (which approximates the length if time the GP service is available on the days it is "open").

5.1.5 There is then an analysis of what might be termed the "geography" of the service – looking at where patients who use it have come from. The CCGs and practices they are associated with as well as the Local Authorities they live in.

5.1.6 The final section summarises some of the information on what happened to the patients after being seen by the GP.

5.2 Data quality

5.2.1 Data used in performance management should be relevant for purpose – so that it can measure or contribute to the measurement of the activity. It should also be collected through the most efficient means possible. An introductory part of the analysis was to look at the data in the "master log" files and carry out elementary checks on missing data. This is shown in Table 5.

5.2.2 Some of the data in Table 5 does contain relatively high amounts of data where value are not known. Though, as the comments column in the table shows, this is not necessarily significant in every case. Improvements could be made in the recording of the times of the Clinically Assessed start time and end times. This should improve the resultant waiting and assessment time data.

5.2.3 The above comments are not a more formal audit of the data set. There has not been an estimate records completely missing or where data is coded wrongly.

5.2.4 To give a comparison, information on unplanned attendances by A&E department type in A&E (2014-15) published by NHS England[18] has data classified as unknown for 0.2% of the total records reported on.

Table 5 Information on patients using GP at A&E service

Column Name in Data Table	Data is about	Number of missing values	Missing values as per centage of total	Comments
RegisteredCcg	Code for Clinical Commissioning Group	130	4%	
RegisteredPracticeCode	Registered Practice (but also named in other column)	90	3%	
RegisteredPracticeName	Name of registered practice	230	8%	This can be determined through the registered practice code.
PatientWalkedIn	Date and time (with minute of arrival)	50	2%	
CoreActivity		10	0%	
FollowUps	For example: "To Ring Own GP If No Better"	10	0%	
Ethnicity	Some of the classifications are ethnicity and some are nationality.	660	22%	
PatientAge	Given as weeks for under 1 year old, years and months for under 18, and years and months for older	10	0%	
PatientGender	Male or female	20	1%	
Town	Settlement rather than simply Local Authority or other administrative geography (e.g. Bourne, Sleaford)	1,330	45%	Aspects of patient location can be determined through the Registered Practice code.
DefinitiveClinicallyAssessedStart	Date and time	280	9%	

18 http://digital.nhs.uk/searchcatalogue?productid=20143&q=title%3a%22accident+and+emergency+attendances%22&topics=0%2fHospital+care&sort=Relevance&size=10&page=1#top

Column Name in Data Table	Data is about	Number of missing values	Missing values as per centage of total	Comments
DefinitiveClinically AssessedEnd	Date and time	310	11%	
Waiting Time	Calculated between "patient walked in" and ClinicallyAssessedStart.	330	11%	
Assessment Time	Calculated between DefinitiveClinically AssessedStarted and End	370	13%	
PrescribedMedication	Medication and amount where prescribed	1,450	49%	An implication of what is counted as "missing data" is that medication is was not prescribed. However there may be cases where it was prescribed but this has not been recorded.

Source: data from master log files supplied by programme team (information from PAC monitoring at Peterborough Hospital)

Note: the number of missing values is expressed as rounded to the nearest 10. The percentage of missing value is of the unrounded number. There was a minor technical issue that the number of records in this data set was 2,961 which is 19 or 0.6% less than he data used for some analysis. It is not considered that this difference is significant for the purposes of the analyses in this chapter. For reference this data set is labelled as D2.

5.3 Number of patients seen

5.3.1 The data on the number of patients seen by GPs at the Accident and Emergency (Emergency Department) at Peterborough City Hospital used in this covers the period from the 7th November 2015 to 3rd July 2016[19]. Over this period 2,979 patients were seen. The term patient is used here to cover the appointments offered in which patients were seen. This is not precisely the same as the number of individuals as clearly some patients might have come back on more than one occasion. Indeed the measurement of repeat visits might be useful information to examine.

5.4 Characteristics of patients: gender, age and ethnicity

5.4.1 The data made available includes the age and gender of the patient as well as information labelled as ethnicity.

[19] Including both these dates.

5.4.2 The gender of the patients has been referred to in chapter 4, Table 1. 53% of the patients at the GP service were female and 47% were male. At a national level the gender of attendees at Accident and Emergency Services was effectively 50% female and 50% male[20].

5.4.3 Section 4.2 compared the age of the patients attending the GP service with those who answered the survey. For the comparison patients were grouped into the three age groups: under 25, 25-59, and 60+ as these were the age groups available from the published survey data.

5.4.4 Table 6 shows the age of the patients attending the GP at A&E service in more detailed age groups. This was compared with the proportions attending A&E in England. The data for England includes information from major A&E departments but also minor injuries units and walk in centres. The general observation from is that the proportion of patients aged 1-5 is much higher for Peterborough than for England (10 per centage points higher). And the proportion of patients aged over 41 is higher for England (generally higher in the older age groups from 41 onwards). This information is also shown graphically in Figure 8.

5.4.5 It is possible that one reason for the difference in the age of those attending the GP at A&E service is that the population In Peterborough are younger than the England population. The per centage of people in Peterborough Local Authority and England are both shown in Figure 9[21]. This shows that while Peterborough's population is younger, there is still a significant increased likelihood of the patient seen by A GP at the A&E service being under 6 than would be expected simply from the age structure of the population.

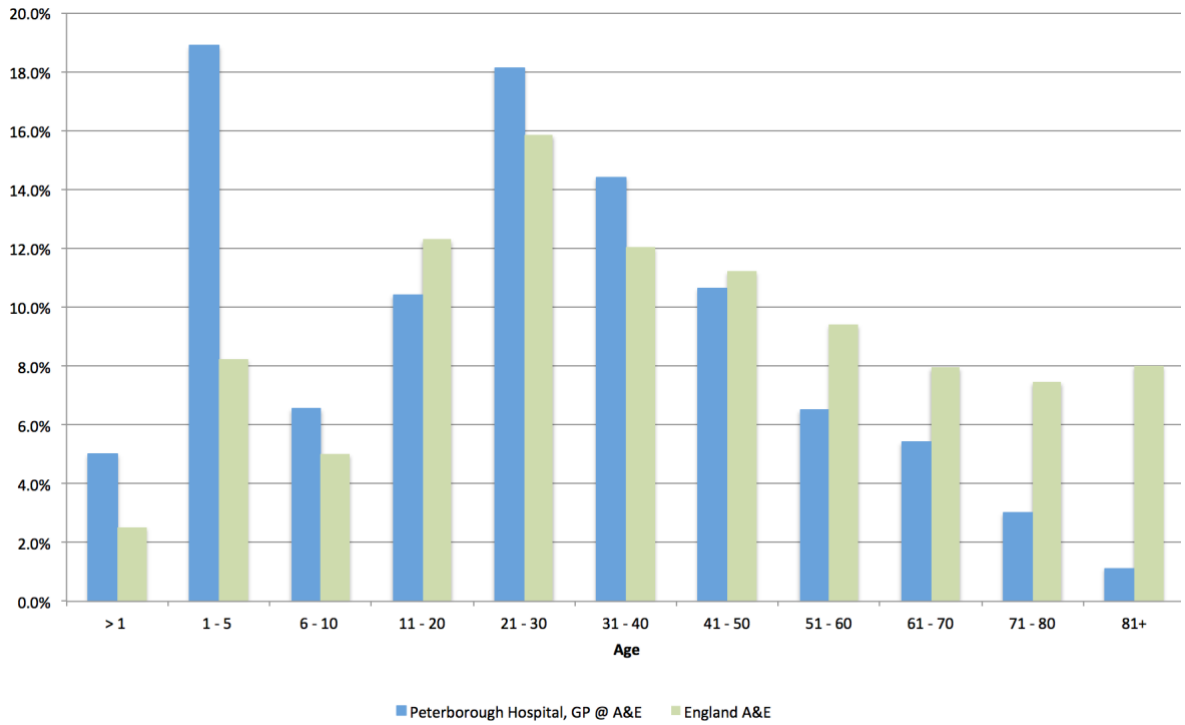
Table 6 Age of patients attending GP at A&E service

Age	Number	Peterborough	England	Difference
		Per Centage	Per Centage	(per centage points)
> 1	138	5.0%	2.5%	2.5
1 - 5	520	18.9%	8.2%	10.6
6 - 10	180	6.5%	5.0%	1.5
11 - 20	287	10.4%	12.3%	-1.9
21 - 30	499	18.1%	15.9%	2.3
31 - 40	397	14.4%	12.0%	2.4
41 - 50	293	10.6%	11.2%	-0.6
51 - 60	179	6.5%	9.4%	-2.9
61 - 70	149	5.4%	8.0%	-2.5
71 - 80	83	3.0%	7.5%	-4.4
81+	31	1.1%	8.0%	-6.9
Total	2,756			

Sources: from PAC monitoring at Peterborough Hospital and Accident and Emergency Attendances in England
Note: age data missing for 223 or 8% of patients in P'boro data, England A&E data also adjusted for missing data

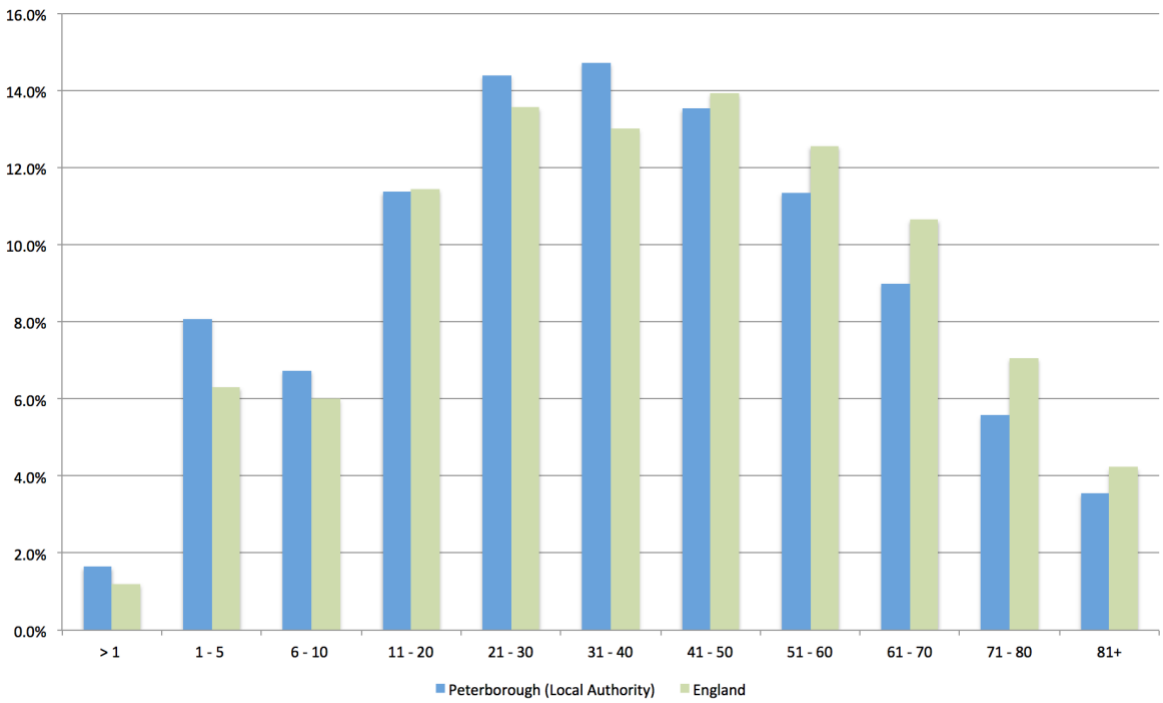
[20] Source: NHS Accident and Emergency Attendances (England), 2014-15, Table 5
[21] These are Office for National Statistics 2015 mid year population estimates. The figure for Peterborough is that for the Local Authority.

Figure 8 Per centage of patients by age group seen at Peterborough GP at A&E



Sources: information from PAC monitoring at Peterborough Hospital and Accident and Emergency Attendances in England

Figure 9 Age of population: Peterborough Local Authority and England, 2015



Source: Office for National Statistics Mid year Estimates

5.4.6 Information on the ethnicity of patients is recorded in the data captured. Though as noted in Table 5, data is missing for over one in five of the records (22%). The coding system used is that employed in other NHS data sets. There are issues in this NHS coding system is as it mixes ethnicity and nationality.

5.4.7 The "ethnicity / nationality" of the patients seen by GPs at A&E are shown in Table 7 and Figure 10. The significant majority are described as white or British. This would include those who are described of British nationality but with a different ethnicity (e.g. Indian or Pakistani). The coding system used does not indicate the ethnicity of those who are Polish (for example). Further work might be useful to compare the ethnicity of those attending the GP at A&E service with those on the GP Practice registrations (allowing for age and other factors). This could be used to examine potential demand.

5.4.8 The way the numbers in the different ethnic categories have been treated does show 423 (or 18% of those coded) in other categories. These patients have been allocated to 65 other different categories, each of which has perhaps one or two patients in them.

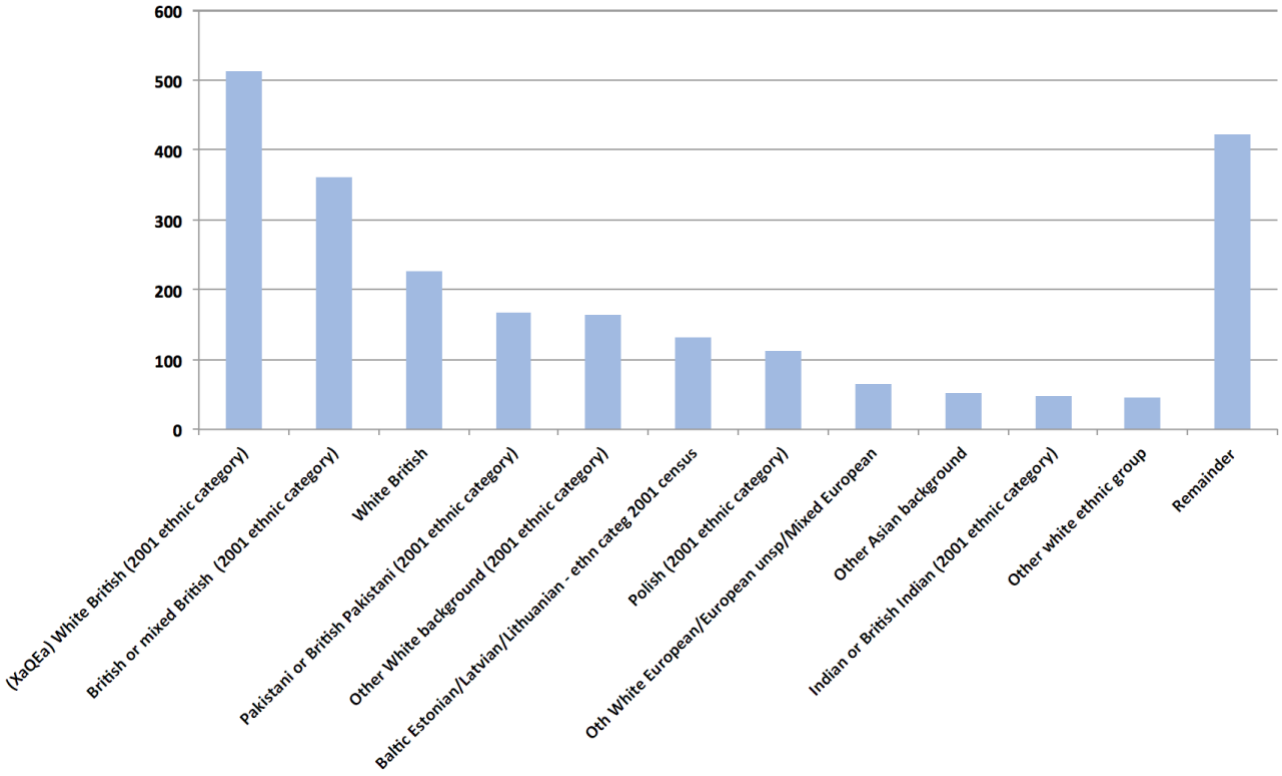
Table 7 Ethnicity of patients attending GP at A&E service

"Ethnicity" Codes used	Number	Per centage
(XaQEa) White British - ethnic category 2001 census	514	22%
(XaJQv) British or mixed British - ethnic category 2001 census	361	16%
(XaFwD) White British	227	10%
(XaJR3) Pakistani or British Pakistani - ethnic category 2001 census	166	7%
(XaJQx) Other White background - ethnic category 2001 census	165	7%
(XaJSF) Baltic Estonian/Latvian/Lithuanian - ethn categ 2001 census	131	6%
(XaJSE) Polish - ethnic category 2001 census	112	5%
(XaJSP) Oth White European/European unsp/Mixed European 2001 census	64	3%
(XaJR5) Other Asian background - ethnic category 2001 census	52	2%
(XaJR2) Indian or British Indian - ethnic category 2001 census	48	2%
(XaFwF) Other white ethnic group	45	2%
Remainder	423	18%

Source: information from PAC monitoring at Peterborough Hospital

Note: ethnicity data missing for 423 or 22% of patients in Peterborough data (D2)

Figure 10 Ethnicity of patients attending GP at A&E service



Source: information from PAC monitoring at Peterborough Hospital (through Data set 2)

5.5 When are the patients seen?

5.5.1 A starting point for looking at the number of patients seen is to do this for each day the service has been available. The service started on Saturday 7th November 2015. It is still in operation and the latest data used in this analysis is for Sunday 3rd July. The service operates mainly on Saturdays and Sundays and also bank holidays from 09:00 through to 21:00. For staffing there are two shifts (of equal length).

5.5.2 There have also been some days when the service has operated on a weekday, for example to cover the industrial action by junior doctors. On these days only one shift has operated in the evening and it has operated from around 18:30 for four or six hours. The four hour shifts are associated with days impacted by the junior doctors' industrial action.

5.5.3 Table 8 shows the numbers of days (by type) on which the service has operated to date. Close to one in five days (so far) has been a week day (excluding bank holidays). However, as mentioned previously in relation to support during the Junior Doctors' strikes this is not "routine".

Table 8 Days on which GPs at A&E have operated (to 3rd July 2016)

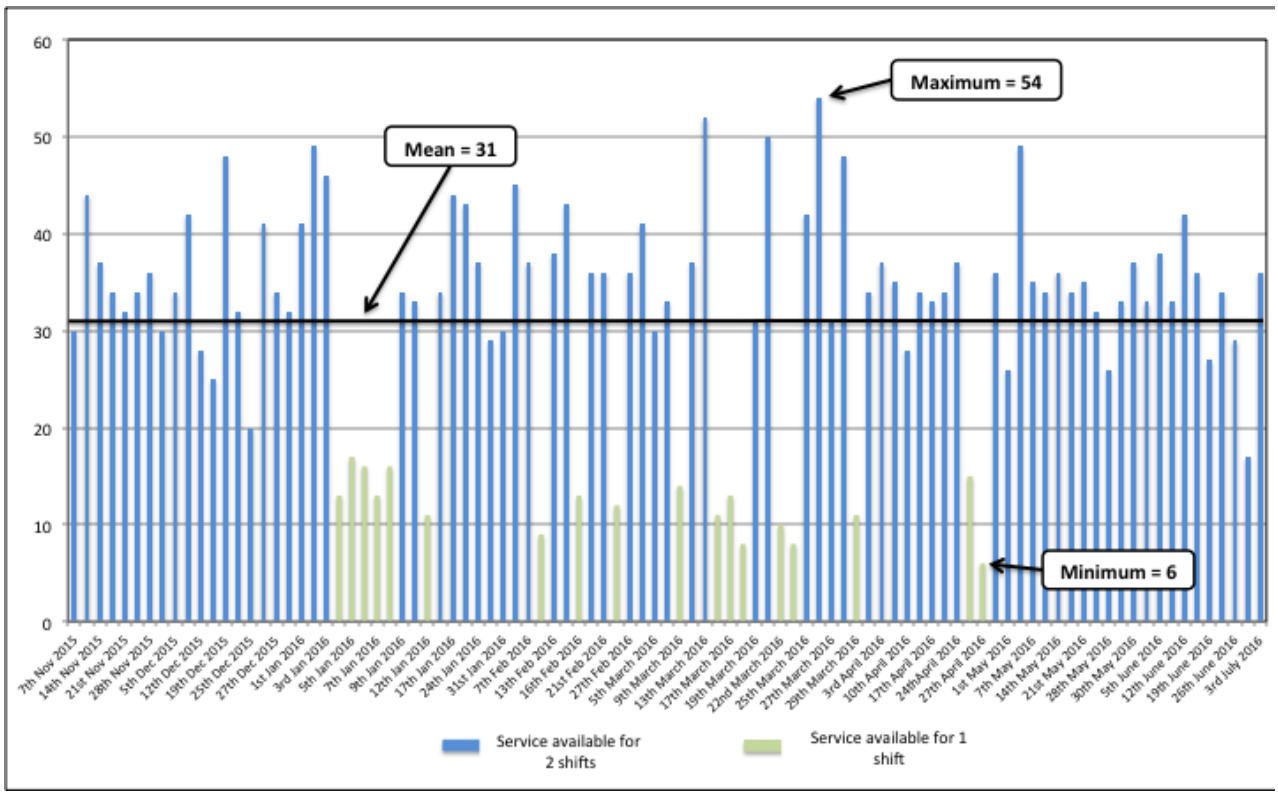
Days	Number of days	Per centage
Saturday	35	37%
Sunday	35	37%
Bank holiday	7	7%
Week day	18	19%
Total	95	

Sources: information from PAC monitoring at Peterborough Hospital (through data set 1)

5.5.4 The number of patients seen for each day the service has operated is shown in Figure 11. The data points are marked up to show on which days one shift has operated and on which two have operated. The average (mean) number of patients seen per day is 31 with the maximum being 54 seen on Easter Saturday 26th March. The minimum was 6 patients seen in the four hours on the evening of Wednesday 27th April.

5.5.5 One thing that the data does show is that the number of patients seen has not risen since this aspect of the programme started in November. The eight two-shift weekend days in November have an average of 35 patients seen every day. If the last eight weekend days are compared then the average for these is 32 patients per day.

Figure 11 Number of patients seen at A&E by GPs, by day of shift



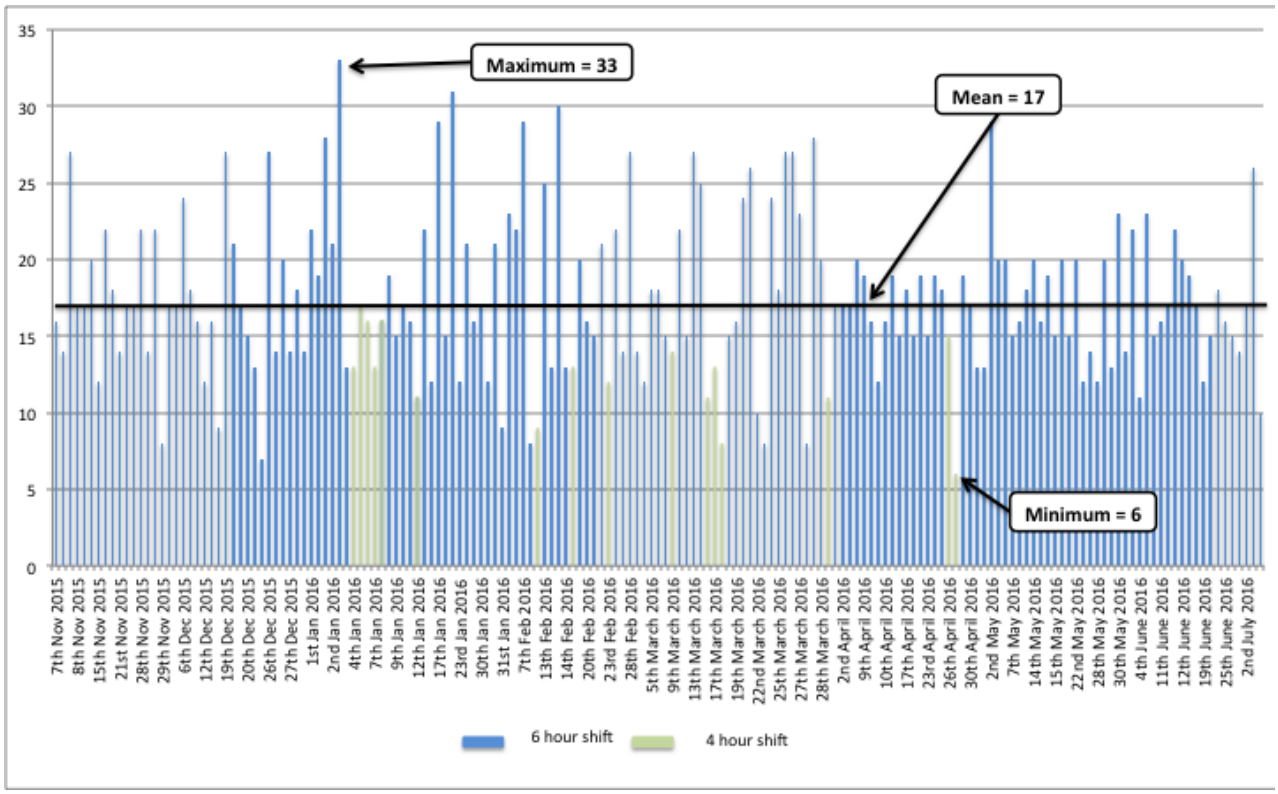
Source: information from PMCF monitoring at Peterborough Hospital (through data set 1)

5.5.6 As mentioned, when looking at the data by day some aspects of performance can be missed as the service has been open for different numbers of hours on different days (for one in five of the days the service is open for one "shift" only). The service has been open for 171 shifts from the start in November 2015 to 3rd July 2016.

5.5.7 Figure 12 shows the number of patients seen *per shift*, to take account of the fact that while most days have had two shifts a number have had just one shift. This shows that the average (mean) number of patients seen per shift has been 17, with the largest number being 33 and the smallest number being 6. This shows no trend for a growing number of patients seen over since the programme started.

5.5.8 153 of the 171 shifts (close to 90%) have been six hour shifts, while just over 10% (18) have been shorter – approximately four hours[22].

Figure 12 Number of patients seen at A&E by GPs, by shift



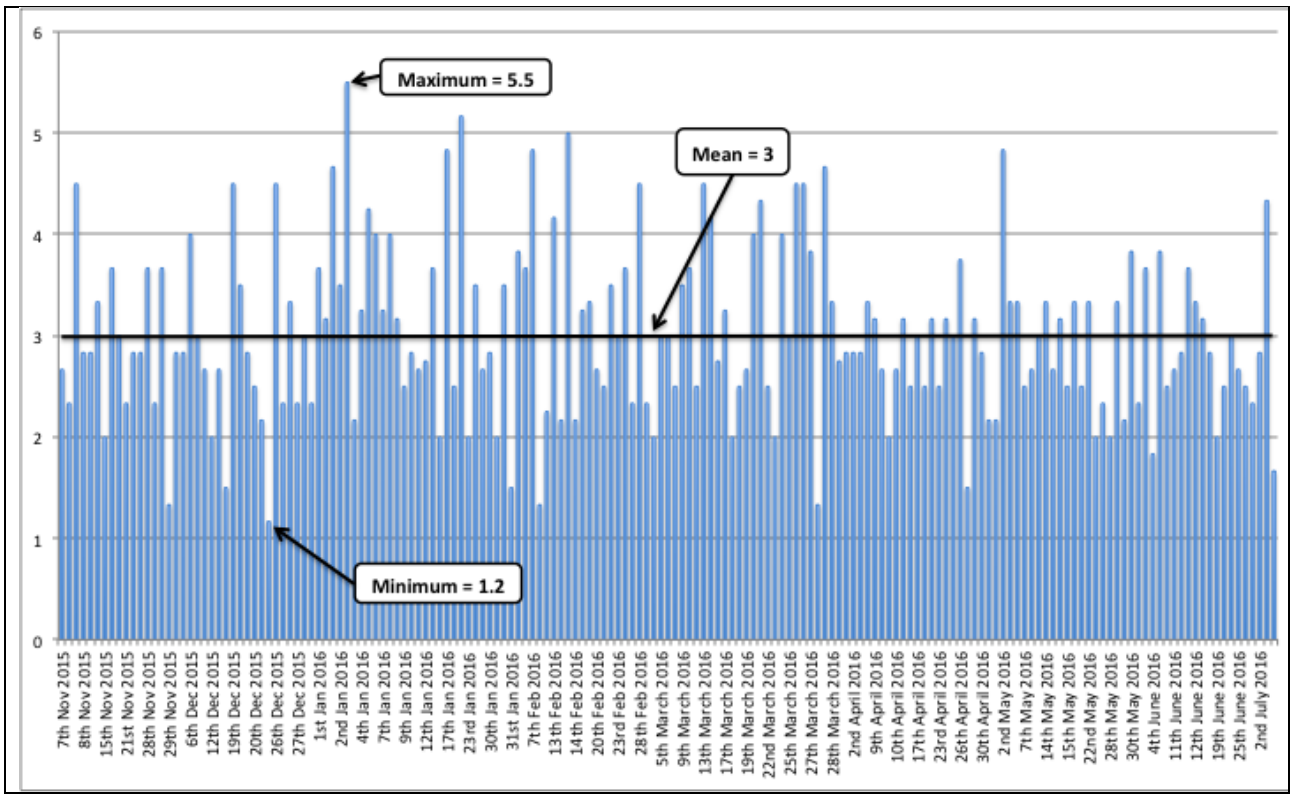
Source: information from PMCF monitoring at Peterborough Hospital (through data set 1)

[22] The exact length of the shorter shifts has been estimated from the times the patients were seen and so is to some extent approximate. For example if the earliest patient is seen at 19:10 it is possible that the shift has been running since 18:00 but no patient arrived before 19:10. Similarly if the last patient was seen at 22:48 the assumption has been made that the shift finished at 23:00, when it might have been later, but with no patients being there. While the estimation of the four hour shifts is an estimate from the times patients were see, it is clear that the length of shift was shorter.

5.5.9 As a further examination of patterns over time, the data was broken down into estimates of the number of patients seen *per hour*. The estimate is that the service has been available for 990 hours. In this time 2,979 patients have been seen. This represents three patients an hour. Nationally GPs spend an average of 8-10 minutes with each patient[23].

5.5.10 It could be argued that this does indicate that the shifts could see more patients and there is that possibility. However what must be taken into account is the arrival of patients is not a steady stream (as it would be more likely to be through an appointment system). This point was made by a number of those who worked on the service when they were interviewed – arrival patterns of patients varied greatly.

Figure 13 Number of patients seen at A&E by GPs, number seen per hour



Source: information from PMCF monitoring at Peterborough Hospital (through data set 1)

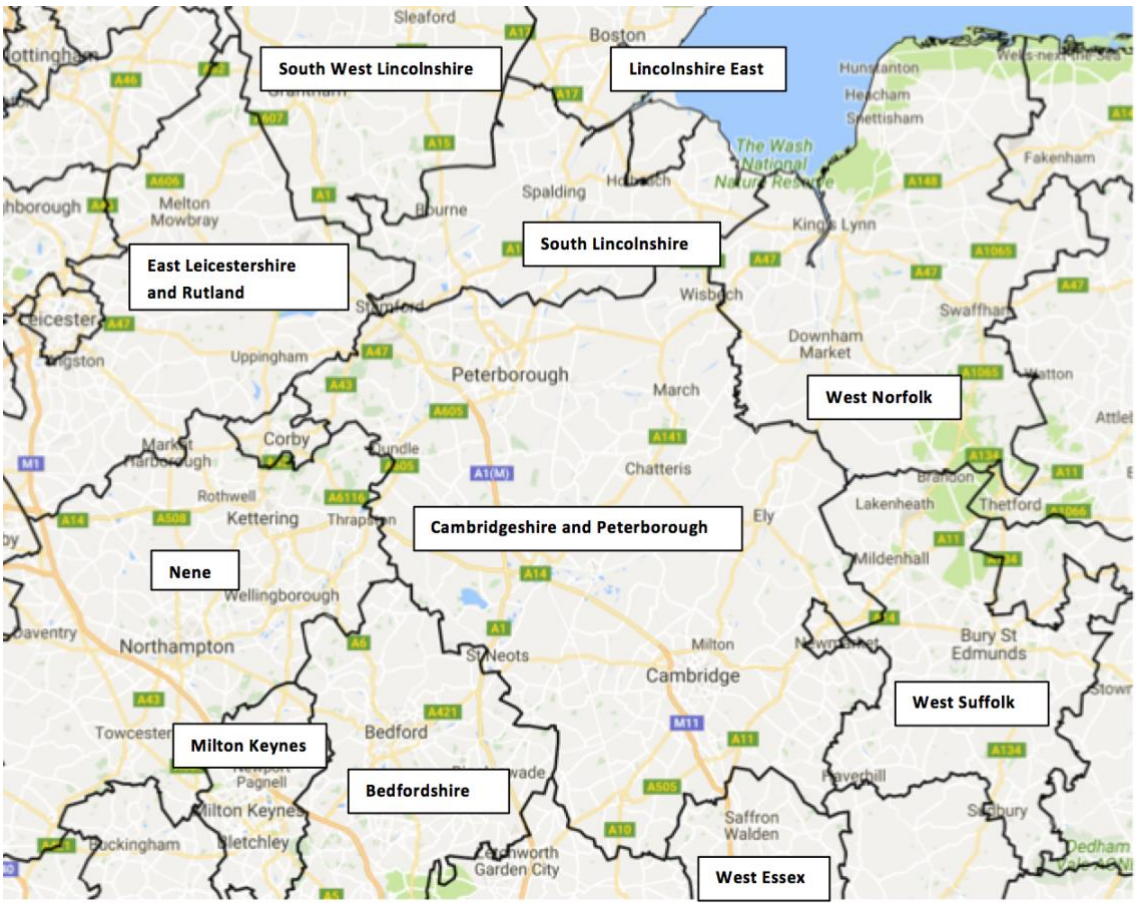
[23] http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/gp-appointments.aspx

5.6 Where are the patients registered?

5.6.1 The information collected about the patients using the GP service at A&E also shows the Clinical Commissioning Group at which they were registered (with their local GP). Table 9 shows the results of this. Over three quarters of the patients (78%) are from the Cambridgeshire and Peterborough Clinical Commissioning Group. There are also 450 patients (of those whose CCG is known) who come from the South Lincolnshire CCG. These form 16%, or over one in six, of the patients seen by the GPs at the A&E service. Between them these two CCGs account for 94% of the patients seen. There were also 56 patients (around 2% of the total) in this period from East Leicestershire and Rutland CCG.

5.6.2 The issue of the funding for the services of GPs and the location of the patients they serve may need some examination if the funding comes to the Cambridgeshire and Peterborough Clinical Commissioning Group but patients who live outside this area are benefiting.

Figure 14 Clinical Commissioning Group Boundaries



Source: https://www.england.nhs.uk/resources/ccg-maps/

Table 9 Clinical Commissioning Groups areas from which the GP @ A&E patients have come

Clinical Commissioning Group	Number of patients	Per Centage
Cambridgeshire and Peterborough	2,207	78%
South Lincolnshire	450	16%
East Leicestershire and Rutland	56	2%
South West Lincolnshire	16	1%
Coastal West Sussex	12	0%
Other	101	4%
Total (where CCG known)	2,842	

Sources: information from PAC monitoring at Peterborough Hospital (through data set 1)
Note: there were 137 records where no CCG was given, these have been excluded from the table

5.6.3 A more detailed geographical analysis is given by examining the GP practice at which the patients attending the service are registered. A GP practice code is given for 2,897 patients (i.e. it is missing for 82 patients). So this information is available for 97% of the total number of patients seen.

5.6.4 For those where the Practice Code is given, there are a total of 193 GP practices from which the patients come. For most of these practices there are only a very small number of patients: there are 135 practices where only one or two patients who have used the GP at A&E service are registered. And only 147 patients (5%) have come from these. These GP practices are from what would be considered significant distances from Peterborough[24] which would rule out issues such as: the patients live in these places but work in Peterborough. These are probably friends or family members who are staying in the area while on holiday or on a visit.

Table 10 GP practices and Local Authorities from which the GP @ A&E patients have come

Number of Patients seeing GP at A&E	Per centage of total	Practice	Local Authority
288	9.9%	THISTLEMOOR MEDICAL CENTRE	Peterborough
223	7.7%	BOROUGHBURY MEDICAL CENTRE	Peterborough
170	5.9%	WESTGATE	Peterborough
156	5.4%	MILLFIELD	Peterborough
120	4.1%	THE DEEPINGS PRACTICE	South Kesteven
116	4.0%	PASTON HEALTH CENTRE	Peterborough
107	3.7%	BRETTON MEDICAL PRACTICE	Peterborough
87	3.0%	NEW QUEEN STREET SURGERY	Fenland

[24] To give some examples:

Number of Patients seeing GP at A&E	Per centage of total	Practice	Local Authority
85	2.9%	NENE VALLEY MEDICAL PRACTICE	Peterborough
82	2.8%	PARK MEDICAL CENTRE	Peterborough
75	2.6%	YAXLEY GROUP PRACTICE	Huntingdonshire
72	2.5%	OLD FLETTON SURGERY	Peterborough
72	2.5%	HAMPTON HEALTH	Peterborough
67	2.3%	WESTWOOD CLINIC	Peterborough
58	2.0%	THOMAS WALKER	Peterborough
55	1.9%	DOGSTHORPE MEDICAL CENTRE	Peterborough
54	1.9%	ST.MARY'S MEDICAL CENTRE	South Kesteven
54	1.9%	HEREWARD MEDICAL CENTRE	South Kesteven

Sources: information from PAC monitoring at Peterborough Hospital (through data set 1)

Note: there were 82 records where no Practice Code was given was given, these have been excluded from the table

5.7 Actions and advice after patients have seen the GP @ A&E

5.7.1 This section describes some of the actions which were recommended to patients after they had seen a GP at the A&E service. This type of information could be used in wider work to examine potential partnership working with other organisations, community care and possibly even costs of this service overall.

5.7.2 Many of those interviewed in the study spoke of the role of GPs in working with 'care in the community". What is shown in Table 11 is that 90% of the patients seen by GPs at the service were "allowed home". Clearly that should also be the case for patients who leave the A&E service having been seen through the Consultant / Junior Doctor aspect, though they would have different conditions or reasons for being there.

Table 11 Activity after seeing GP at A&E service

Activity after seeing GP	Number	Per centage
Allowed Home	2,658	90%
Transferred to ED	140	5%
Transferred to other Hospital Dept	75	3%
Transferred to Paeds	54	2%
Left without being seen	23	1%
Transferred to ACU	8	0%
Other	2	0%

Sources: information from PAC monitoring at Peterborough Hospital (through data set 2)

Note: data on "CoreActivity" is missing for only one record from data set 2.

5.7.3 It is worth noting that some (5%) of the patients seen by GPs were transferred to the A&E (Emergency Department). It is inevitable that this will occur to some extent though it would be worth seeing if the number could be reduced: or at least thinking of the potential consequences if there were delays.

5.7.4 Further information is available on the follow up recommended to patients after they have seen the GP at A&E. This is shown in Table 12. Close to half of the patients (49%) were recommended to "To Ring Own GP If No Better". For one quarter the recommendations was that "No Follow Up Required". And for 15% it was recommended that the patient seek a "routine" appointment at their own GP. Together these follow up recommendations accounting for close to 9 out of 10 of the patients seen.

Table 12 Recommended patient follow up after seeing GP at A&E service

Follow Up	Number	Per Cent
To Ring Own GP If No Better	1,447	49%
No Follow Up Required	712	24%
Own GP: Needs routine appointment	445	15%
Own GP: Needs Urgent Appointment	120	4%
To Ring Own GP If No Better;No Follow Up Required	115	4%
Own GP: Needs routine appointment;To Ring Own GP If No Better	79	3%
Own GP: Needs Urgent Appointment;To Ring Own GP If No Better	10	0%

Sources: information from PAC monitoring at Peterborough Hospital (through data set 2)

Note: data on "CoreActivity" is missing for only one record from data set 2.

5.8 Conclusions

5.8.1 The purpose of this chapter has been to examine the data held on the patients who have used the GP at A&E service. This can play an important role in determining the results of of the programme as it runs. It also has the potential to assist with further development and changes to the programme.

5.8.2 The quality of the data is suitable for purpose, though there are aspects where it could be improved. No work was carried out to look at the effort of capturing the data and this should be born in mind.

5.8.3 A key measure is that the GP at A&E service has seen 2,979 patients in the period it has been operating to 3rd July 2016.

5.8.4 The patients seen are younger than might be expected. It is possible that the availability of other services could be examined, for example to reduce demand from this.

5.8.5 The data on ethnicity is given but again further work would help make comparisons with other data coded using these NHS codes - to determine any key differences.

5.8.6 The information on when the patients were seen was examined. This does show that there is no increase in the number being seen by the GP at A&E service. Again this is an issue which could be examined further. The analysis carried out section 3.5 showed that the numbers of patients attending the A&E service in Peterborough had increased – comparable to England as a whole. The question then is why the numbers seeing the GP at A&E service have not increased. It could simply be that the increase is in patients with more urgent conditions and who should be seen by A&E.

5.8.7 The A&E service sees different numbers of patients arriving at different time – many of those interviewed stated that numbers could increase significantly in short periods. It is difficult to note the implications for resourcing the GP service as these patterns are clearly different to those that would be expect in a standard “by appointment”’ operation.

5.8.8 Analysis was carried out of where the A&E patients lived or were registered. While most came from Peterborough it is significant that 450 came from the South Lincolnshire Commissioning Group. This is the type of information which could be taken into account in ensuring the service is resourced by those by whom it is used.

5.8.9 The patterns on what patients were asked or recommended to do after seeing the GP showed strong links with community care (“allowed home”) and the wider GP service (“to ring own GP if no better”). Comparisons with the patients of the rest of the A&E service could pick up possible changes which might build on the learning of other practices noted by those interviewed.

Glossary

Abbreviation	Meaning
CCG	Clinical Commissioning Group
cfep	Client-Focused Evaluations Programme (CFEP UK Surveys)
CHD	Coronary Heart Disease
GP	General Practice
LCG	Local Commissioning Group
MIU	Minor Injuries Unit
NHS	National Health Service
PMCF	Prime Minster's Challenge Fund
PPGs	Patient Participation Groups

Appendix 1 Why patients chose to come to Accident and Emergency – answers given relating to availability of GPs.

Sunday, felt like I do not have anywhere else to go.
I can able to see the doctors if they need to see.
Feel more comfortable with our out of hours GP.
Could not get doctor's appointment.
GP closed.
Because I am due to go on holiday in 2 days time with an 8 hour flight and wanted to know if ok to do so, with reassurance. Doctor helpful and reassuring.
GP closed.
GP closed.
GP closed.
Need emergency prescription.
It's Sunday and no GP.
It is a weekend (Saturday) so surgery was closed.
Had difficulty breathing which was becoming increasingly worse. Called 111, advised to attend A&E.
Past experience.
Could not see own GP.
Advised by GP.
The walk-in centre was closed so I was advised to come here.

Source: CFEP survey, General Practice in Out of Hours Report.

Note: these are as written by the survey respondents

Appendix 2 Individuals Consulted or Interviewed

Name and key role	Date of interview
Dr Mark Attah, Chair of Greater Peterborough GP Access Fund Programme Board, Bretton Medical Practice	19th July
Alison Bacon, Patient Representative, CHD Programme Board, Cambridgeshire and Peterborough Clinical Commissioning Group	21st July
Bruce Bonar, Practice Manager, Jenner Health Centre	21st July
Lisa Burbidge, Board Secretary, Greater Peterborough Network	6th July
Dr T Charles Coxon, GP at A&E and also Old Fletton Surgery	10th July
Judy Dame, Streaming Nurse with GPs at A&E	10th July
Kallie Dickens, Project Officer, Greater Peterborough Network	6th July
Dr Gary Howsam, GP Partner at New Queen Street Surgery, Whittlesey and Stanground Surgery	14th July
Martin Horvat, Receptionist with GPs at A&E and administration at Ailsworth Medical Centre	10th July
Rob Henchy, GP Access Fund Project Manager	Various, esp. 28th July
Alastair Jones, Consultant, Emergency Department, Peterborough and Stamford Hospitals NHS Foundation Trust	2nd August
Anita Jackson, Director CIP & Transformation, Peterborough and Stamford Hospitals NHS Foundation Trust	2nd August
Catherine Mitchell, Local Commissioning Officer, NHS Cambridgeshire and Peterborough Clinical Commissioning Group	29th July
Dr Gordon Porter, GP at A&E and also Old Fletton Surgery	10th July
Chris Rowland, Programme Manager, GP Access Fund	28th July
Margaret Robinson, Patient Representative: Healthwatch	21st July
Diane E Siddle, Contract Manager NHS England - Midlands and East (East)	3rd August
Michael Southwood, Interim Lead Nurse, Emergency Department, Peterborough and Stamford Hospitals NHS Foundation Trust	2nd August
Wendy Spencer, Deputy Chair, Borderline and Peterborough LCGs Joint Board Patient Forum	21st July
Debbie Tarrant, Streaming Nurse with GPs at A&E, also Westgate Surgery	10th July
Linda Toma, Receptionist with GPs at A&E	10th July
Anthony Whitaker, IM&T Project Manager (Older Persons Programme), NHS Cambridgeshire and Peterborough CCG	27th July
Joanne Walker, Emergency Nurse Practitioner Leader, Emergency Department, Peterborough and Stamford Hospitals NHS Foundation Trust	2nd August
Dr Sanath Yogasundram, Board Director, Greater Peterborough Network Ltd., GP at Nene Valley Medical Practice	21st July

Note: key role term is used to represent that individuals may have more than one role and may also have changed role since engaged in project