An evaluation of the use of Healthcare Assistants at the Thistlemoor Practice, Peterborough

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Executive Summary

GPs at the Thistlemoor Practice in Peterborough have developed a radical model for the role of healthcare assistant in general practice. In May 2007 this role was evaluated by Sheffield University, funded by the NHS Working in Partnership Programme, which found it to be safe, effective and well liked by patients.

The Practice

Thistlemoor Road Surgery has one part time and two full time partners, six nurses and seven healthcare assistants. It has a practice population of 7,500 patients.

The HCA role

The practice operates an open access clinic for acute patients who can opt to see a doctor or a nurse. Those who request a doctor will first see an HCA who will update any outstanding health checks and take an initial history before preparing the patient for examination by the doctor. All work is guided by computer-based protocols and templates.

Using HCAs in this role had reduced waiting times in open access clinics from one hour to five-fifteen minutes.

The HCAs also have an extended role in chronic disease management, carrying out telephone checks for step one patients with a range of conditions. Using the practice database, they identify which patients need monitoring and call them for routine appointments, which they also carry out. They also carry out well person checks and obesity monitoring.

Success factors

The evaluation identified several factors that were necessary to support this extended role. They included:

* A vision of what the practice wanted to achieve
* A supportive learning environment
* Choice and gradual adoption of new roles
* Good infrastructure with sufficient consulting rooms and computer terminals

Conclusion

The evaluation found this to be a robust model. Extending the role of the HCA in this practice enabled nursing staff and GPs to use their skills appropriately. The practice was on target to meet all its QOF and access targets. Patients liked the model and were happy to see whichever staff member was appropriate to meet their needs. Making a success of this model takes time, skill and a commitment to training.

Download the full report at http://www.wipp.nhs.uk/hca-gpn

An evaluation of the use of Health Care Assistants (HCAs) at the Thistlemoor Practice, Peterborough. May 07

'I never thought I would end up doing this!'
55 year-old health care assistant referring to range and breadth of her current duties

Introduction

This evaluation report examines the experiences of staff and patients at the Thistlemoor Practice, Peterborough in the development of a novel model of primary care delivery. The evaluation looks at the development of the model and identifies possible learning for others who may be seeking different ways to deliver primary care services.

Context

Primary care services and staff are currently facing a number of competing demands and expectations. These come from:

- The need to provide an accessible and up to date service for the practice population
- The need to fulfil contractual obligations in order to receive payment
- The drive towards practice based commissioning implying a more collaborative approach with other practitioners, organisations and patients
- The shortage of staff to fill posts in primary care in all areas both geographically and professionally

One way of meeting these demands is to introduce and use skill mix effectively in the practice.

Briefly, the model developed at Thistlemoor makes the best use of resources with two full time and one part time partner and a skill mix of six nurses and seven HCAs extensively to deliver patient care. The practice has developed the role of the HCA as a key part of the model. The result is a 'doctor light' approach using two permanent GPs for a practice population of 7500.

The evaluation was commissioned by the Working in Partnership Programme (WiPP). WiPP has an explicit role in developing the role of the HCA in general practice. The imperative to develop this role comes from increased demands on general practice for more access to primary care and the need to address shortages of practitioners in all disciplines within the primary care setting.

The purpose of the evaluation was to:

- Gain further understanding of the impact of the introduction and expansion of the role of HCA
- Identify learning from the process including key success factors
- Identify elements that may be useful to other practices which are undergoing changing demands and workload

This report is divided into five sections

1. Description of the Thistlemoor model and its evolution
2. Development of the HCA role and the HCA experience at Thistlemoor
3. Identifying the learning at Thistlemoor
4. Discussion of implications for general practice
5. Identification of key success factors

The information used in the evaluation was gathered in two ways:

1. Written evidence of practice developments, training packages, publicity for patients and information for staff was requested from and supplied by the practice.
2. Interviews were conducted with staff over a period of three days. A one-day preliminary visit was followed by a two-day visit with semi structured interviews with staff from all teams within the practice and the patients at the practice.
   Most interviews were with individuals. A group of patients were interviewed as well as one group of staff. Thirteen interviews were conducted with 25 people in total.

1 INTRODUCTION OF THE MODEL AT THISTLEMOOR PRACTICE

This section briefly describes the introduction of the model at Thistlemoor.

The current model of working in Thistlemoor practice was introduced gradually over four years through planning which was both general and specific and has been enabled by three main factors:

1. The vision of the partners
2. The premises and physical resource development e.g. IT infrastructure
3. The change in primary care contracting legislation (e.g. PMS)

The vision of the partners

The practice has had a developmental approach to its work with patients and staff from the time that the current senior partner took over the practice in 1994. The vision of the partners was to design a work environment which was open, friendly and devoid of barriers between staff and management.

> 'Creating systems and organising the practice were the key concepts, and from the outset, we developed policies and practices that were formed with consensus, but all staff were expected to follow them once we decided to adopt them.'
> *GP interview*

The doctors believed that there is a huge waste of resources within the NHS, especially when it came to nursesí skills. They believed that nursesí skills were underutilised as traditionally they were not given a chance to work to their full potential. Nurses were taught consultation and communication skills and to conduct consultations as first point of contact, and reception staff were taught technical nursing skills.

Providing a high standard of care through very organised systems has always been a core part of the vision and introducing a team with a different mix of skills was seen as a way to achieve this vision.

> 'Our vision is of working as a team to provide the highest standard of healthcare, when the patient requires it, and delivering this by the most appropriately trained professional.'
> *GP submission to WiPP*

The partners realised the possibilities presented by and necessities required by the changing demands on general practice both by the practice population and the local primary care trusts. Their view was that on the one hand patients use their primary care team for a widening range of problems, physical and social, long and short term. On the other hand the commissioners require an 'acute' primary care service along side a service that monitors and manages chronic conditions.

Developing team work and skill mix was believed to be the way of meeting the requirements at their practice. Hence staff roles were expanded to the limit of their boundaries and an ethos of education and development was introduced within the practice in order to achieve its goal.

Premises and IT infrastructure

The practice was developed physically with additional space added to a small surgery. When considering the development of the practice infrastructure, an emphasis was placed on having as many consulting rooms as possible and introducing an Information Technology system that could 'source/capture, organise/store/retrieve/share/transfer and use/reuse knowledge with protocols and templates, teaching and training material available to all members of staff on a network available at their work stations'.

(Submission to WiPP)

Investment in premises and equipment had the effect of producing an efficient working environment that enabled the practice to develop a learning culture.

Change in contractual arrangements

Using the PMS contracting arrangements 'gave us the freedom to make alterations in our staffing ...We have moved away from the traditional restrictive boundaries and encouraged staff to move towards a flexible multi-skilled approach to their roles.'

(Submission to WiPP)

In 2002 the practice introduced the role of the HCA to make more use of the time that patients spent at the surgery. HCAs carry out clearly defined tasks and roles that are governed by protocols and templates (see appendices 1 & 2). Much of the routine work previously carried out by more highly trained professionals, usually nurses. Thus routine collection of patient information, recording of physiological measurements (blood pressure, height, weight) and taking blood samples for testing was removed from their workload and more effective use was made of their time. With the introduction of the HCA role, the opportunity presented by the patient's visit to the surgery was maximised to ensure updating of records and opportunistic interventions. Therefore, the process that initially started to increase capacity has been further refined to improve the range of services and access for patients that come through the door. The practice aims to make each patient visit a one-stop service so that examination, investigations such as minor surgical procedures, ECG, dopplers, photographs, blood tests, etc. are all available to patients at the same time.

The HCA role was developed within the practice as an iterative process as at the time, there was no external training available. One of the partners within the practice undertook the training of the staff, using her own clinical experience, outside specialists and encouraging nursing staff to develop their teaching roles.

This investment in education, training and mentorship has meant that the practice has gradually built up expertise in the development and management of HCAs. The role of the HCA is now well established so that new members of staff do not find it surprising and indeed expect to learn from and be taught by HCAs. This investment is now paying dividends in flexibility of staff, staff morale and increased capacity in the practice.

Currently the practice's work is delivered by three teams, formed around chronic disease management, with receptionist, HCAs and nurses in each team. Patients have open access to appointments, are seen initially at reception and move through the system from HCA to nurse or doctor when necessary. There are high levels of satisfaction reported from staff and patients from this system. Full details of the role of the HCA can be found in appendix 1.

2 THE DEVELOPMENT OF HCAS IN THE PRACTICE.

In this section we examine the personal and professional development of HCAs at the Thistlemoor practice.

A consistent theme emerging from the evaluation was the development process experienced by those employed to undertake the HCA role.

The experiences of HCAs at Thistlemoor Practice, Peterborough show a definite pattern of development. Many of the HCAs were initially employed in a basic role which has developed to suit the needs and aspirations of the individual and the needs of the practice team. This shows the importance of an effective selection procedure to a clearly defined role while retaining the possibility of developing individuals according to their strengths. Indeed at Thistlemoor the ethos seems to be 'now we know you can do this, what else would you like to do...?'

This was not always foreseen by those individuals undertaking the role e.g.

> 'I never thought I would be doing this.'

But they generally welcomed this development:

> 'I have developed a lot and at the beginning would not have imagined that I would be where I am now. I have achieved all I wanted to achieve and I am happy where I am. That is a high point.'
> *HCA interview*

> 'I will stay here till the end of working life and itís been terrific'.
> *HCA interview*

After a 'shaky start' the HCAs have developed into confident competent members of a highly effective team. When asked how they felt when they started working at the Thistlemoor Practice, the HCAs have reported:

> 'I was really nervous because it was my 1st job. I was really panicky about working in a surgery and dealing with the public.'

Now they have moved to a position where they feel:

> 'I have become a confident person. The more you learn the more confident you get...and are able to do the job confidently and competently.'
> *HCA interview*

Those joining the team from outside the world of primary care medicine said the system appeared confusing and daunting at first. A sense of this being a job that had serious implications and consequences for the patients who use the service was very strong. However, HCAs felt that they were being supported with their learning. For example:

> 'The doctors, they tell you how to do it properly and it is important because it is for the good of the patients.'
> *HCA interview*

The transition from this to competent team member began immediately but progressed over time. Each interviewee remembers a time when they were able to shadow and to learn on the job. There was no pressure in the first days on the job. Gradually responsibility was assumed by the newly appointed person. A number of techniques were used to aid the development of the HCA:

- Shadowing. Being able to observe and ask questions.
- Questions being accepted as part of the norm. HCAs report never feeling foolish for asking a question
- Dummy patients on the computer and opportunities to practise on the IT system
- Support from the senior partners to enable the HCAs to identify their strengths and areas for potential development
- Choice and gradual adoption of new roles.

Professional development for HCAs

Staff development is integral to Thistlemoor Practice. Philosophically it is based on a model of a learning organisation, explicitly set out by Dr Nalini Modha. After being appointed to a role at Thistlemoor, it is the norm for this practice to identify the potential development opportunities for its staff and invest in this development. Staff development is a very active process rather than a response to a need to 'be up to date'.

Staff report that both of the senior doctors are good at spotting talent and encouraging the person to develop this talent. This has resulted in the practice having:

- HCAs who have developed professionally and personally
- A practice team with competent motivated staff
- Patients who are seen quickly and efficiently.

'I went on a nurses training day on Spirometery. I didn't feel out of place, there were no raised eyebrows. When I described the role of the HCA in the practice the nurses were saying 'I want one!'.'
HCA interview

3 LEARNING FROM THE PROCESS AT THISTLEMOOR

This section looks at areas of learning emerging from the use of the model.

Impact on other areas of the practice

Impact on nurses

Nurses are clear that the HCA role is complementary to the nursing role and that responsible delegation is important to making the model work safely. The impact of this shift in role does not appear to cause the nursing staff to feel threatened or that they may become superfluous. This is demonstrated by the comments from the practice nurses:

> 'They have a lot of knowledge...they help us set up trolleys and also with what to put on the computer. I might have been an annoyance to them initially, continually asking. I think there is mutual learning here.'
> *Group interview with practice nurses*

It is clear that nurses have a triage role which requires different skills, knowledge and specific training for the role. The interpretation of results and delegation of tasks is taken very seriously by all members of the team.

> 'We are not missing out by not doing the HCA tasks, we have enough to do. HCAs have learned how to do tasks and do them well but don't know the implications and itís very clear they donít interpret (results).'
> *Group interview with practice nurses*

> 'It [delegation] is a two-way process - they teach us as well as us assessing their competence.'
> *Nurse interview*

Impact on medical practitioners

For the medical practitioners at the practice the change in role is explicit and a part of their vision.

> 'I am not bogged down in my room - I have created time to step back and have a good overview. A lot of time is spent doing other things such as organising and teaching.'
> *GP interview*

> 'The old model of doctoring means getting your head down and getting through the surgery - leaving you not able to do anything else.'
> *GP interview*

Doctors are always available to consult with patients and staff in a clinical role. Their time is also available to develop other aspects of the practice internally with staff meetings, educational inputs to nursing and medical staff, and externally where they are engaged with other professionals and other parts of the local health economy.

Impact on patients

> 'With the help of HCAs and nurses we are able to see up to 100 patients in a morning surgery. Waiting time has been drastically reduced from up to one hour to five to 15 minutes of arrival at the surgery.'

> 'Using skill mix to see patients helps us to meet the governmentís access criteria by being able to see patients when they want/need to be seen.'

> 'We have been able to continue to operate open access surgeries despite an increase in list size because of the use of skill mix, patients do not need to make appointments to see a doctor, and when they do attend, we make sure they are dealt with efficiently and quickly. The waiting time in reception is from 5-10 minutes, and then everything is done to make it a one-stop service.'
> *GP interview*

The changes being introduced into the health care system means that patients and professionals are being required to adjust their views, expectations and habitual patterns of using the system.

For patients at Thistlemoor there is awareness that something is different and while the detail is may not be clear the perceived benefits are keenly felt. For example:

> 'Now I see the nurses first. I donít know which is a nurse and which is a HCA. I donít know what an HCA is - I don't know grades. I think it is someone 'not quite qualified' but Iím not bothered about whether it is an HCA or a nurse.'
> *Patient interview*

> 'I feel lucky to be a patient here. When you feel poorly you just come and you donít have to ask. All the people are very professional here.'
> *Patient interview*

Patients gave the impression that they were very satisfied with their experience at the practice. While they were not exactly clear about the 'grade' of person they were seeing, they were very clear that they felt the person was competent and that they would see the right person according to their needs.

Using unqualified staff and maintaining patient safety

Unqualified staff in the acute and primary care sectors perform tasks that were previously the domain of health care professionals with many years experience and training. This is a trend which has been increasing over the past 10 years . Tasks which have previously been performed by medical staff but have been devolved to either specialist technicians or generalists from other disciplines e.g. nurses. Nurses have developed extended roles, subsequently normalised and now incorporated into the role of the nurse. This is not without risk:

There will also need to be a rethink of education and training as health workers are increasingly engaged in work which was not part of their original mandate. Several studies have already identified the lack of appropriate courses for those taking on innovative roles that cross historical boundaries. Where nurses take on the work of junior doctors, for example, there may be no supporting educational programme. Under these circumstances health workers themselves report considerable stress, and the danger is that patient care will sometimes be compromised

(Reshaping the NHS workforce Doyal l BMJ April 15 320(7241): 1023-1024

The Thistlemoor Practiceís use of HCAs pushes this forward in two ways. Not only are the tasks devolved even further down a hierarchy of professionalism, the HCA is now the first point of contact for many patients who visit the surgery. This represents a major shift from a task being devolved to another after sanction from another professional to an unqualified member of the health care team initiating interventions.

For example here is a patient pathway attending a morning surgery:

Open morning surgery

In an open morning surgery we are divided up into 3 teams, each team is headed by a doctor working with 2 nurses and 2 healthcare assistants (HCA's). Each team works in the same way.

When a patient presents to reception they are asked to specify who they would like to see. Any patient requesting a nurse is called in by a nurse who will ask for a doctor's input if required. Any patient requesting a doctor is taken in for preliminary checks by the HCA.

The HCA takes history of any presenting problem and carries out basic checks such as pulse, blood pressure and temperature for all patients presenting with acute symptoms. The HCA also:

- Updates health screens including smoking status & alcohol consumption
- Does urine checks for all patients with abdominal pains
- A large number of templates are available to aid history taking with guidelines for investigations. The HCA takes history of the presenting problem and records it using templates where available. The HCA initiates templates for history taking for such problems as:
  - Abnormal weight loss

- Excessive sweating
- Heavy periods

- The HCA prepares the patient for examination including gaining consent for physical examinations/photographs) and setting up of any required instrument trolley.

Working this way with templates that trigger off suggestions for possible investigations she can make preparations for interventions while waiting for the doctor to come through. The HCA then acts as a chaperone during examinations, assists with physical examinations or minor surgical procedures such as injecting a frozen shoulder, tennis elbow, etc.

The HCA scribes for the doctor, takes any blood samples for tests ordered, fills in forms, takes any photographs for documentation, makes choose and book (C&B) appointments with the patient. The HCA also helps by producing any prescriptions requested by the doctor.

HCAs are also available to undertake emergency ECGs, nebulise patients, etc.

Monitoring of chronic disease undertaken by HCAs

Hypertension, hypothyroidism, epilepsy, and asthma checks over telephone for step 1 patients are all carried out by HCAs. Other checks include pill checks, obesity monitoring, and new patient / well person checks.

Appointments are managed by HCAs who identify those in need of monitoring. The patient attends for a routine appointment and is seen by an HCA in a consulting room. HCAs take the appropriate personal and clinical information, recording this onto the practice system. HCAs always follow protocols for the appropriate condition. If the check is satisfactory then records are updated and appropriate advice given. If the patient has further queries of if the results trigger referral to a health professional, the HCA will ensure this takes place.

Use of protocols and templates

HCAS use protocols and templates for all procedures that they carry out. Not only do they provide a facility for immediate access to medical staff for ill patients but they are also one way of ensuring patient safety. The practice updates and revises all templates and protocols regularly.

> 'The template system we developed minimises risk as well as teaching and use of systems.'
> *GP interview*

HCAs at Thistlemoor Practice are very clear that they do not interpret results or discuss them with patients, but that within the protocols they can assess the next level of care very quickly when necessary. So someone who is attending for routine screening can be seen by a HCAs and leave the practice with out seeing another practitioner. As soon as it falls outside the limits of the protocol, the HCA will trigger the next intervention.

> 'When a result is 'outside the limits' I can feel uncomfortable but then I contact a doctor or nurse and ask ëwhat do you want me to do?' I'm not qualified to

judge clinical things.'
HCA interview

Thus the protocols and templates offer safety.

Accessibility of qualified staff

Another safeguard is the accessibility of team members. Staff consistently commented on the availability of another professional with whom to consult.

'I don't feel worried because I can ask. I will always ask.'

'You can go to their consulting room at anytime and I feel like I can ring the doctors at home if I need to. I do this about once or twice per month.'
HCA interview

'We all work together ñ not ëI'm a doctor here'. Everyone mucks in together. Team work has to come from the top. Nobody is unapproachable.'

The evaluators were very impressed with the default position of:

'I will always ask because it's expected of me and it is always ok.'
HCA interview

Yet another safeguard is the monitoring of activity by the doctors, who see it as part of their role to spot check HCAs. This is welcomed by the HCAs who expect it to happen.

'We are always monitored ñ not a problem at all. It feels like a good back up system. I know Mrs Modha would go into the IT system to check on things. I feel ok about this. [There is] 100 per cent support and part of this is someone keeping an eye on you.'
HCA interview

A further safety resource is the growing skill of the HCAs themselves who were able to use their growing awareness of when help is needed or when patients need to be seen elsewhere.

From the point of view of the qualified nurses the system appears to be working well and the doctors appear to have absolute faith in their staff and the system.

'We approached the MDU [Medical Defence Union] before we introduced skill mix at the practice and explained what we were proposing to do. The defence union reminded us our responsibility in relation to delegation but were very supportive of the model. They provide indemnity for all staff and medical liability has not increased using this system.'
GP interview

It is important that any development of role and any new role introduced into the practice needs to be risk assessed so that the individual, the team and the organisation are confident about them. They need to be able to stand up to the scrutiny of medical defence organisations.

Job satisfaction

Staff continually reported high levels of motivation commitment and enthusiasm during the visit. There were concerns among the evaluators about some of the staff being over worked and taking on more than one role, for example having a clinical as well as an administrative role. However, the staff seemed to relish in their dual roles. One reason could be because they are rewarded financially for taking on more responsibilities such as being in the human resource team and feel that this is recognition of their potential.

The introduction of new roles can have an unsettling effect on professionals who may experience a sense of threat to the value of their role. This was not apparent during this evaluation and indeed there was some relief that the workload could be shared.

> 'We are not missing out by not doing the HCA tasks. We have enough to do. HCAs have learned how to do tasks and do them well but don't know the implications and it's very clear they don't interpret (results).'
> *Group interview with nurses*

This has been modelled in many ways ñ everyone is encouraged to do what they can within their own limits. That is not to say there is a freeñfor-all with people doing what they like. On the contrary, there are clearly defined roles within the three teams. However individuals are constantly appraised and encouraged to take on new areas. An example of this is the use of photographic equipment for recording and teaching purposes. Expensive photographic equipment has been purchased and is used often during consultations. Rather than be the preserve of a technician or senior member of staff, all staff are able to use this equipment, thus bringing the philosophy to life.

The promise of constant supervision and support

Supervision and support area necessary part of effective health care and safe professional conduct. If responsibility is to be delegated it is essential.

Clause 4.6 sets out the Nursing and Midwifery Council's standard for delegation. This states:

> You remain accountable for the appropriateness of the delegation, for ensuring that the person who does the work is able to do it and that adequate supervision and support is provided.
> *NMC delegation advice sheet*

Yet often responsibility is divested rather than delegated . The result of poor delegation and supervision is to create stress for staff who feel unsupported and unclear about their role and in the worst case scenario to create danger to patients. So a promise from the employer to offer constant supervision and support requires follow through in order to ensure safe practice from a satisfied and confident workforce.

At Thistlemoor Practice there is a clear model for appraisal at regular intervals where individuals are offered the space to reflect on their role. There are bi-weekly meetings to reflect on practice and learn from it as a team/organisation. And there is an open door/open phone line approach which is valued and used by staff.

> 'You can go to their consulting room at anytime and I feel like I can ring the doctors at home if I need to. I do this about once or twice per month. I only do it if I feel 'something needs to be done now rather than wait till tomorrow.'

HCA interview

The process has effectively picked up members of staff who were not happy and adjustments made or not suitable and action taken. ëI know I only have to ask' is a common refrain not only from the HCAs but from the team leaders as well. This is modelled now amongst the HCA who act as mentors to new members of staff. Their roles change yet again. For example the HCAs have obviously developed knowledge of their practice and the role they play which is demonstrated by their willingness and ability to speak at national events and take part in training jointly with other health care professionals. Evidence of their confidence and competence is evident from the relationship with patients who know there is some difference from other nurses but seem nonetheless totally comfortable with this role within the practice and the care they receive.

Challenges and learning

Failures

The positive atmosphere at Thistlemoor is tangible. Yet there have been notable exceptions to successful staff development and selection. Occasionally staff have been accepted to work in the practice but have been found to be unsuitable. In these cases action was taken to address the issues and where necessary staff members have been asked to leave the practice, usually after extensive effort has been made to address the problem.

Discussing this is obviously somewhat uncomfortable for the senior doctors. There is discomfort about having made the wrong assessment and the actions that need to be put into motion to rectify the situation, often termination of employment. However there is no ducking the issue and the doctors are open in their admission and acceptance that sometimes it will not work. The challenge for this practice was to review the process of selection and build upon current system or change it in order to reduce incidence of a miss match.

> 'For a time we had a mission about taking on directionless 16 year olds and steering them towards a career but that did not really work.'

> 'We are quick to spot when people are not right. For example we had a young girl we suspected might be using drugs and we had to ask her to leave. This termination of employment was after efforts had been made to address various issues raised by unprofessional behaviour. Despite efforts it was impossible to accommodate the individual while maintaining patient and staff safety.'
> *GP interview*

As a result of unhappy and unsatisfactory experiences the practice has developed processes that ensure the safe and harmonious running of the practice. Safeguards have been built in as a result of such situations, including three month cooling off periods, options for mutual termination of contracts if there appears to be a mismatch of interests or acceptability.

The Challenge of being accepted by peers when introducing change

Both senior partners and nursing staff recognised that what they were doing at Thistlemoor is different from other practices and may not suit everyone working in general practice. The introduction of the model caused some irritation and tension in the early stages of implementing the model for those outside the practice. The partners observed that it caused

> 'There was some initial apprehensions and jealousy but that is no longer true. One method of overcoming this was good networking with colleagues outside the practice.'
> *GP interview*

Some of the nurses thought that bringing in a new model in a high profile way is likely to cause irritation with other colleagues.

> 'Within the practice there is a need to accept that the model will not suit everyone. The practice is very forward thinking ñ doing things now that others may do in the future. This disturbs some people.'
> *Nurse interview*

4 DISCUSSION

Balancing expectation and resources

Some patients expect and want to see a doctor when visiting a surgery. While the expectation is for immediate access the reality is often a wait of some time. Increasingly patients are being offered a choice of seeing a doctor sooner but with the proviso that it might not be someone you know, or waiting longer.

The Thistlemoor Practice and HCA model pushes the challenge and invites patients to face the reality of scarce resources. There is open access to health care practitioners (within designated surgery times), you don't even have to make an appointment, but the person you see might not be your own doctor, or even a doctor, or may not even be a qualified nurse.

This challenges the public's expectation of and use of primary medical care services. The questions that the Thistlemoor Practice response to the challenge presents us with are

- Is this a safe way to use primary medial care services?
- Is it safe for the end user of the service?
- Are the health care outcomes beneficial to the individual?
- How does the practice as an organisation benefit?
- Can health care professionals work comfortably with the changing roles this brings?
- Are patients getting what they want from the primary medical care service or is this convenient for a target driven model?

The experience of the practice at Thistlemoor shows that in a carefully managed environment these questions can all be answered positively.

This method of using resources in primary care has meant changes from traditional

patterns of delivering care and some adjustment may be needed from staff and patients to accommodate the change.

Patients who were already on the practice list when it was taken over were presented with this model rather than choosing it themselves. Approximately 200 patients from a list of 5,000 left the practice. Patients joining the practice now are made aware of the different model of care provided by the practice and in fact made to read the practice leaflet before they join the practice so they could chose not to come to the practice if they did not like the model. The fact that the practice has registered another 2,500 patients indicates that patients are attracted to this model of care which seems to provide a high quality care with ease of access.

This model is a way of maximising the resources available with the current system and of meeting the demands placed on the practice to meet the quality outcomes framework targets and other aspects of the PMS and GMS contracts. As such it is a health service led model but does not move away from patient centred care as once the patient presents, everything is done to make sure all their needs are met at each visit, albeit by a team of healthcare providers instead of a doctor in the traditional model. It also appears to deliver a highly satisfied patient population.

The model certainly allows the practice to meet Quality Outcome Framework targets and access targets, the agenda of the PCT and Department of Health. Through the use of protocols and templates by HCAs and a system of call and recall and opportunistic screening and recording of information with interventions where necessary, the practice has a high level of attainment in all areas of the QOF. Each target examined during this evaluation was above the national average and well on target for the year when the evaluation visit occurred.

Therefore this method of using semi-skilled members of the team to perform routine recording and monitoring goes a long way to meeting the needs of the practice in terms of securing their budget and in meeting the objectives of the local PCT in terms of keeping up to date with the health of the local population.

If this monitoring of patients was simply a means to a financial end, attained by using the least expensive delivery method it may be expected that patients would not find this satisfactory. However, the increase year on year of patient numbers at the practice would indicate that the model has a lot to offer patients. Instant access to health care as well as a competent professional and friendly atmosphere is what attracts patients here. HCAs have quickly become accepted as part of the way a consultation works and the knowledge that a doctor can be seen if necessary is reassuring to patients. This practice has demonstrated that it used resources efficiently and effectively in order to deliver high quality care to patients.

Role development

A necessary and possibly unintended consequence is that roles of individuals and professionals have changed. The doctors are no longer ‘simply clinicians’ they are developers, organisational managers, and educators. Similarly the nursing role of senior nurses has adapted by becoming more supportive and specialised. Indeed no role appears static as individuals grow they change from the mentored to the mentor. This happens not only within a profession but across professional boundaries and hierarchies. The use of HCAs allows other professionals to develop in other areas such as management and leadership. This development is not without its critics .

There is a point of view which suggests that clinicians should concentrate on their strengths, namely the clinical role. Further there is a concern that assuming other roles for which they are not fully prepared could distract the physician so that neither role is successfully fulfilled leading to poorer patient care. Explicit exploration of role and reflection on progress and activity would be essential to avoid problems. Introducing changes into practices is a complex issue. When roles change, identities also change. These changes invoke emotional responses in professionals which are often both surprising and powerful. For this reason attention must be paid to the process of change. Often the change agent or developer will be aware of this process and will have a role of facilitating it. A change agent may be a clinician of any designation and they must be aware that introducing change can be demanding of time and energy. A practice introducing change should assess how a change agent can successfully fulfil the role of change agent and practitioner.

Access to health care professionals

The 'most appropriately trained health professional' (submission to WiPP) is the one who can most quickly carry out a set of health care interventions at the least cost.

The practical translation of this is the person who can see you soonest and carry out the necessary assessment and interventions most quickly. In Thistlemoor Practice this is a HCA. This works well for patients:

> 'I'm very happy with the situation of HCA to nurse to doctor. I like the fact that regular checks are done by HCA, but if you need an immediate problem sorting the right person sees you.'
> *Patient interview*

This is designed to make the system of primary medical care work as effectively as possible making best use of the scarce resources of health care professionals and appointment times.
This approach asks both professionals and patients to alter their approach to the traditional model of primary medical care where patients make an appointment to see their doctor.

Conclusions

The HCA's journey has been possible at Thistlemoor Practice because there is a positive commitment to developing individuals in a learning environment. This is rooted in a number of beliefs:

- Getting the best out of individuals, seeing potential and developing it. There is a positive philosophical choice being made here that individuals have the potential to develop given the right support.
- The organisation will work better if individuals and teams within it are well trained supported and motivated.
- It makes business sense: if you have skills you can use them to your advantage
- It helps patients to get the health care that they need within the present system.

Conclusions for general practice

- This is a robust model for primary care. It is not a quick fix and demands skill

and commitment.
- The model appears to satisfy staff and patients
- It helps meet targets such as QOF (all QOF targets are on track and are consistently significantly above maximum requirement and access (patients are seen when they present at the surgery)
- Allows staff to grow and develop thus increasing capacity in the primary health care team
- Encourages access to primary care services that respond to patient need rather than to the assumption that a doctor must be involved
- It allows doctors to concentrate on utilising their expertise and clinical skills where it is needed, taking away the mundane more mechanistic tasks out of general practice. Younger GPs may find it an attractive alternative way of practicing whereas traditional GPs may feel it compromises their role as holistic practitioners.

Five key success factors

One of the questions that is asked of such a project as Thistlemoor is whether this can be done elsewhere is it replicable.
It is tempting to seek to lift a piece of good practice or a model and apply it to our own situation expecting and hoping for the same success. While the evaluation of this model identifies a success story we would caution against a simple copying of the model. Our rationale for this is that the individuality of each general practice in our current health care system means that it would be impossible to find identical 'starting conditions' for such a project.
One major difference between a practice which is well established and the Thistlemoor experience will be that at Thistlemoor the development of the practice followed a vision and was the practice environment was built to deliver that vision both physically and culturally. For an established practice the emphasis may well lie in managing change in order to deliver the vision of a new pattern of care.

It is possible to identify key success factors and it may be possible for others to adapt their own situation and make use of the learning generated by the experience of the Thistlemoor practice. One of the enabling factors in this learning process is the openness of all staff at the practice in making their learning processes available to others.

What are the factors that have made this a success?

What would somewhere else need to do/have in place/understand in order for this to be a success? The evaluation has identified the following areas.

Success factors

Perspective/vision clear where they wanted to go

Perhaps the most important aspect of Thistlemoor's success is the consistency of the vision for the practice and its development and refinement over time. The vision is deceptively simple: 'working as a team and delivering health care by the most appropriately trained professional'. The realisation and refinement of the vision has taken 10 years. The HCA model has contributed to the vision and has become central to the current success of the practice. However it is not the vision but a means to fulfil it.
The refinement of the vision has continued and is shared with all who work at the

surgery from the interview stage onwards.
The Vision is shared and modelled at the interview stage through team interviews of applicants. As one of the doctors commented, 'This may be a bit daunting for applicants but they know what they are getting into.'

Material

Having the appropriate physical environment has played an important part in the development and success of Thistlemoor.
A premises that was capable of expansion was developed to fit around the vision and emerging model. In practical terms this means allocation of appropriate space to HCAs. There is a large number of consulting rooms, each equipped with the necessary basic equipment.
This gives two clear signals:

- The HCA has a valuable role
- The HCA consultation is a key part of the consultation for the patient.

Infrastructure

Investment in other aspects of the infrastructure is also evident and a key success factor. Emphasis on Information technology systems has allowed records to be easily transferable between parts of the practice (and beyond). Information gathering from the patient is thorough and kept to the minimum number of occasions. The IT resource is an investment not only in hardware but is backed up with an on site technician.
Equipment for each stage of the patient's journey through the practice is readily available as well as the teaching and learning resource to back this up. Creative use of new technology is also evident mobile phones with flexible contracts to keep costs down, photographic equipment as teaching and diagnostic aids.

Opportunity and risk taking

- Astute use of resources and the possibilities offered by skill mix and change in professional roles
- Contracting arrangements through the new GP contracts
- Skill mix and role boundaries that are becoming more flexible
- Making use of QOF targets to enable income generation.

All these, combined with the risk of capital expenditure and investment in staff, have allowed the development of Thistlemoor's overall vision and the expansion of the HCA role.

Learning organisation approach

Developing a general practice is increasingly becoming more like growing a small organisation. Continual review of individual and team performance through the use of appraisal and feedback is essential for organisational growth. In order to succeed in this area requires thought to be given to the nature of learning in an organisation and the roles required to achieve it. It requires practitioners to shift their perspective. This might mean seeing yourself as developing from a clinician to clinician with a management role, or from senior partner in a medical practice to senior medical practitioner in a health care delivery system.

Medical practitioners have been doing this for years; perhaps the difference is that it now requires an explicit place in the practice set up. Making this explicit offers

practitioners the opportunity to make choices about roles and the structure of their organisation. Further active development of this role will make the organisation more effective. Not only is this true for medical practitioners but nurses can also explore the roles they have as team leaders and identify their developmental route accordingly. Organisational development is required if a changed role is introduced as acknowledgement of the change and its implications will alert practitioners to possibilities and pitfalls. The temptation to introduce a changed role expecting it to cure a problem, while continuing everything else as it was should be resisted as change will be unlikely to be successful.
Enablers here include

- Individual mentorship
- Individual learning plans and appraisal
- Reflective team meetings as well as business meetings.
- Learning for individuals both within the practice and externally.
- An atmosphere of teaching and learning.
- Financial reward on offer for staff to take on additional responsibility / extended roles.

Working in a health economy

Exploiting the dual position of GPs as entrepreneurs and clinicians. GPs are independent contractors working within a health economy, both local and national. As independent practitioners they can take risks and with new contracting arrangements develop new systems.
They are also being encouraged to work more collaboratively within their surgeries and with others in the local heath community.
The development of a vision and model that departs from the local pattern presents opportunities and threats. The opportunity to grow, attract attention from outside, to take others custom can invite criticism and even hostility. So the development of such work needs careful management of relationships with colleagues to prevent damage but to move beyond the status quo.
It is a balancing act with other providers and other agencies as well as entrepreneurial behaviour as against co- operative behaviour. Practice based commissioning is an area where this balancing act is likely to be developed.

Education and staff training resources

Whether this is provided in-house or by an external provider, education and staff training needs to be ongoing and continuous. Staff development in the Thistlemoor practice is provided mainly by the doctors who are committed and have planned for this to happen. This was unavailable externally. However there may be opportunities for the commissioning and provision of such training and development programmes with new practice based commissioning arrangements.

Appendices

Appendix 1

Outline the role of the HCA assistant

As per Doctor Nalini Modha's submission

The role of HCAs in practice

The practice's HCAs have become integral and valued members of the nursing team

and it would be hard to deliver the practice's present standard of care without them. Their roles have expanded and they now undertake a range of tasks, i.e. phlebotomy, electrocardiograms (ECGs), new patient interviews, assisting with minor surgery, smoking cessation, and stocktaking.

There is no definitive list of tasks that an HCA can do. The key is competence to do the delegated task. This requires:

> Appropriate training
> Observation of the HCA's work in practice
> Assessment of the HCA's competence
> Documented evidence of competence

HCAs should also work to strict guidelines and protocols to ensure safe practice. It is also important to ensure that the practice nurse understands the implications of being accountable for delegation of care to HCAs. The practice decided that its HCAs needed to be observed and assessed for competence while undertaking tasks in the practice; in addition to attending courses and study days, and that they also needed strict guidelines to ensure safe practice. We have developed and formulated competencies and guidelines.

HCA's were first introduced into the Practice 5 years ago. We did not have a structured HCA training programme in our PCT for HCA's at the time, we therefore arranged training for our reception staff by utilising the skills of specialist nurses employed by the PCT and of the NHS Hospitals Trust e.g. acute respiratory specialist nurse, cardiac rehabilitation nurse. Our nurses also provided supervision and mentorship.

Training was carried out on site for blood pressure monitoring, ECGs, Spirometery, Doppler, inhaler technique and peak flow measurement and venepuncture. Our nursing staff have supervised venepuncture and given training in infection control, sharps disposal, health & safety, urinalysis, blood sugar monitoring, chaperoning, and assisting in minor surgery and joint injections.

We have two staff meetings a week where the whole practice team meets to discuss critical incidents, complaints, etc.

Time is dedicated to teaching/learning activities. We have had interactive teaching sessions on:

- Medicine management
- Confidentiality
- Recognizing ill patients
- Working within competence
- Consultation skills
- Minor illness triage
- Minor illness telephone triage
- Record keeping
- Communication skills
- Summaries
- New patient medicals
- Dealing with angry/aggressive patients
- Stress management

Reflective practice informs future practice policies which are tailored to meet the needs of the practice population.

All staff, including receptionists, have Basic Life Support and child protection training every year.

Tasks Undertaken by HCAs at the Surgery

Opportunistic health checks during surgery

2 HCAs are on duty to identify patients from the open surgeries in the morning and evening; those patients who have not had a blood pressure check height, weight and urinalysis in the past 2 years.

- They are offered a health update and given leaflets for diet, alcohol and smoking cessation if necessary
- They also see all patients with medication queries and deal with any problems with the help of a clinician if necessary
- All asylum seekers or patients who do not speak English and might need help with interpreters are seen first by the HCA. They try to find out the reason for attendance, using language line if necessary and arranging for translators/interpreters if required.

BP Checks

- HCAs check BP opportunistically and provide interim checks for hypertensives, follow up checks after medication changes and pre-treatment BP checks
- Check medication compliance and flag up inconsistencies i.e. over/under use
- Give out hypertension packs following 2 raised BP recordings and arrange appointment with a clinician
- Arrange ECG and blood tests prior to diagnosis of hypertension
- Check follow up diary dates and arrange next BP check

ECG/Spirometry/Dopplers

- Provision of special clinics twice a week but also carry out procedures in an emergency
- Patients are given instruction leaflet at time of booking an appointment and a compliance form is filled out before test
- Results and forms are scanned into patient records ñ the Spirometery result is passed to the COPD specialist nurse
- ECG forms are filled in before starting the ECG recording with information about CXR results, blood results, reason for test, BP, symptomatology and eligibility for direct access stress clinic referral. Results are scanned and templated and passed to requesting doctor for follow-up.

New Patient Checks

- Aim to do new patient checks at time of registration, if possible
- HCA checks that the patient understands the surgery procedures and knows how best to access help
- Repeat medications are added to the computerized patient record after checking with a clinician. Patients are encouraged to bring all their repeat medications with them at the time of the check
- Any notes on current problems are added to the record via consultation mode
- Nurses are requested to see patients if necessary
- The HCA who undertook the new patient check summarises the records within 8 weeks of receiving them at the practice
- Patients with a complicated medical history are encouraged to see a clinician soon after joining the practice

Electronic Pathology Results

- One HCA is responsible for looking at all microbiology results, and printing out scripts for antibiotics according to protocols and are given to the doctor for checks
- All urine results and blood group for pregnant females are entered into the records in read coded form, via templates

Chronic Disease Management

The HCAs make an important contribution to the cardiovascular, diabetes and asthma clinics. The HCA sees the patient first and records blood pressure, weight and other required information. She also undertakes routine blood tests, blood glucose monitoring, and peak flow technique. This enables the specialist nurse to focus her time and skills on education and medication review with the patient. This has been much appreciated by both patient and specialist nurses. They also help with filling out forms, giving out appointments, smoking status, Spirometery, Dopplers, urinalysis etc.

Prescription - Medication Management

HCAs check:

- Medication review dates, and if medication is due for issue
- Compliance ñ they query items that have not been ordered
- Check diary entries for chronic disease monitoring and attach letters with appointments or ring patients to book appointment if a check is due
- Check there is a diagnosis attached to each item on the active problem list
- Synchronise quantities so all items can be ordered together each time
- Make sure all scripts are processed generically at the same time as ensuring that certain items are not converted to generic when guidelines recommend no generic substitution
- Remove any items from repeat screen onto ‘x’ files when they have not been ordered for over one year
- Flag up requests for inhalers to asthma nurse when they are ordered by patients classified as ‘dormant’ asthmatics

Other tasks include:

Display of patient information leaflets, making notices for notice boards, ordering and maintaining leaflet stocks, restocking consulting rooms with swabs, sample bottles, forms etc, digital photography ñ taking photographs and transferring them onto

patient's records, assisting in minor surgery and chaperoning.

All the above factors mean the roles are changing within general practice. From clinician to clinician manager, educator, developer
From nurse to team leader, manager, leader
From HCA with limited responsibility to multi- tasking and highly contributive member of the organisation.

The Thistlemoor Practice model supports this by allowing all these to develop and so provide responsive patient care and capitalise on possibilities for organisational development.

Appendix 2

CHECKLIST FOR PRACTICE

INTRODUCTION

General practices, like all other areas in the NHS, are experiencing a period of change, change which seems to be relentless and accelerating. This can be exciting, innovative and inspiring. It can also be daunting, frightening and challenging.

One way of enjoying or surviving periods of change is to be aware that they are happening and to use structured approaches to managing changing times. By using a structured approach it is easier to feel more in control during times of change and less like a ship being buffeted by storms.

Introducing a new skill mix, such as the use of HCAs or even considering it as an option is likely to represent a change in your practice. Considering and then implementing change and managing the transition from one way of working to another requires thought and planning. The purpose of the check list below is to give you areas to consider and suggest processes that may be useful in order for you to think through systematically any change. Whether you end up with a system like Thistlemoor or use elements of it, structured planning will help.

A catalyst for change

If any of the questions below apply to your practice it will certainly involve change in the practice.

1. Is your list size growing or changing?
2. Is your clinical workload changing?
3. Is your practice about to undergo change (is someone leaving? Partners retiring?)
4. Are you likely to have an opportunity to change your staffing make up?
5. Are you developing areas of special interest?
6. Is there an opportunity through practice based commissioning to do something new or different?
7. Have you moved premises recently?
8. Are you taking on a specialist area on behalf of a number of practices?
9. Are there opportunities to take on extra work e.g. a branch surgery?

Change can be daunting for anyone, not least for those introducing change. Such 'change agents' can face an exciting and unsettling time for themselves and usually find a range of responses among colleagues. Others who may be involved in the process of change but are not initiating the change usually experience a similar range of emotional responses. These may show themselves as different behaviours in response to change, sometimes including anger and bereavement reactions.
It may be useful to consider the following questions to think through the impact of change and whether any of the elements of the model described in the evaluation could be adapted for your practice. This process will be useful in itself to develop your thinking and help plan your approach. It is especially helpful if you can do it with a colleague who will be involved in the process or who might be a source of support.

PREPARATION

How will you take people with you and persuade them that this change is a good idea?

Could you

1 Have a discussion with all the practice team outlining the situation and consider options for change?
2 Assess the feelings and views of the staff on possible changes? They will almost certainly be thinking about them already.
3 Set out the outcome that could be achieved by the change using examples from those who have already achieved the change
4 Prepare a clear process for such a discussion for example
    -Outline the current situation
    -Identify implications of this situation
    -Explore options for the future
    -Consider the positives and negatives of options

Where is your support for this?

Can you identify a colleague in the practice who also recognises the opportunities/necessity for change? It is often useful to share ideas and develop them critically and supportively. Instituting change can provoke a lot of uncertainty and having an ally is a big help.

OVERCOMING BARRIERS

Where might resistance be evident?

The prospect of change is often experienced as threatening. This is very common and you might find it useful to think through the objections that may be voiced to any proposals. There are many responses
'That will never work here'

'We haven't got time for this'
'It will be too disruptive for patients'
'At last someone is talking sense, let's do it tomorrow!'
It is useful to remember that these expressions are often because of anxiety about change

What can you do to allay those fears?

How would you address issues that are seen as negative?

You could
* Gather evidence from other areas.
* Think through your proposal with a small group, acknowledging that there may be obstacles to overcome but recognise that you are very used to overcoming obstacles anyway. You probably have a lot of experience in doing this as a team already, experience on which you can build.

MAKING A BUSINESS CASE

How will you persuade internal and external people that this makes financial sense?

Preparing a business case based on skill mix taking into account all the elements and being open about the implications will give a clear understanding to anyone from whom you are seeking funding or approval to institute such change.

Answering the questions below will help you to build a business case that will be helpful to anyone who may have an interest in this change, for example the PCT, or practice based commissioning consortium.

- What will the costs be of changing your method of working?
- What will the benefits be to patients, staff?
- What are the risks?
- Have you undertaken a risk assessment?
- Have you plans to minimise the risks involved in the change?
- Do you have an agreed and shared strategy for managing clinical risk? (For example protocols are they updated agreed and evidence based, monitoring, mentoring)
- Are you clear about who is accountable for the practice of HCA?
- You need to discuss this with nursing staff as well as partners and be very clear about delegation and accountability.
- How will the HCA s be clear about their responsibility? (Thorough induction, training and ongoing evaluation procedures will help with this.)

CAPACITY

Are there any sources of funding available to fund a change in premises design?

For example are there any initiatives from the PCT, Private finance or Practice based commissioning.

What will the change involve practically?

- Can you work through with the whole team what the change will mean? What would a patient 'pathway' be in a changed service?
- Could you work through a scenario for a typical patient? It might be useful to think of a mix of straightforward cases as well as difficult cases. (it is often tempting to think how a change will not work because of complicated cases, while the reality may be that those cases are less common than first thought)

VISION

How clear is the vision of what the practice is trying to achieve?

Having a clearly articulated vision of what the practice is setting out to achieve and how that will be realised is very helpful for keeping staff focussed on the service being developed. Increasingly general practice is being required to behave as a small organisation with a vision and staff to deliver the vision to a defined clientele. It is helpful if certain processes are borrowed from organisational thinking to assist development. This includes having a vision, developing and supporting individuals and the team, reflection on developments and monitoring of progress.

Is the vision shared by everyone?

A hallmark of successful organisations is the ability shown by all staff to articulate what their organisation does and how it works.

Are there champions of the vision?

If this is one persons idea it will be useful to have change agents on your side to move developments forward. Change takes time and having people who are enthusiastic can bring others along.

BUILDING A PRACTICE THAT DEVELOPS ITS STAFF AND CULTURE

Successful organisations pay attention to learning from experiences as individuals and as a larger team. Structured reflection on practice is a part of continual professional development for individuals and reflection as a team is equally valuable. Your practice probably does this already and it is useful to make this a formal part of 'organisational' life so that it becomes the norm. Change can then be seen as an opportunity for learning from both successes and setbacks.

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Does everyone have a learning plan?

Reflective practice is an effective method of developing staff and indeed it is necessary for continued registration for professionals. A learning plan tailored to the individual helps develop skills, knowledge and attitudes of team members and will

increase chances of success.

Do you meet as a team?

Team meetings that are run constructively with genuine participation have a beneficial effect on the success of organisational development. Whether this is with clinical meetings alternating with reflection on team issues or a combination of both, time invested in these distinct areas will benefit the development of the change process.
How often do you meet?

Do you meet and learn with clinical supervisors?

Health care assistants need supervision to minimise risk and increase competence. These meetings will be part of minimising risk and developing the confidence of the whole team?

Are all staff actively engaged in learning?

For example:

- do you undertake case review/critical incidents?
- Are the HCAs observed in practice?
- Are they monitored and is the monitoring used for development
- Is there regular feedback.
- Are things written, discussed, understood, checked and clarified for different parts of the practice

What resources can you use from within the practice?

Often members of your staff will want to develop roles as teachers or trainers. You may well have staff who have qualifications in these areas or who want to develop them. These are resources that can be used to help guide staff through the implementation of innovations in the practice.
Have you identified a senior trainer role and someone who looks after learning in the practice strategically?

TELLING OTHERS ABOUT THE CHANGE

Can you make a good case for this locally with your practice based commissioning colleagues?

How will you present this to your practice population?

If you are intending to change how patients are seen, perhaps a nurse led service; patients will be pleased to be informed of this before it starts. Sometimes practices consult with patients asking whether they would be in favour of certain changes and acting on the results. Others introduce changes and inform patients that this will be happening with a review after a certain period of time. Whatever you choose to do it is important to be clear about the process, i.e. whether you are seeking views before a change or informing of a change that is about to happen. As long as the process is clear and the service does not deteriorate recipients of service are satisfied.
Problems can arise when change is sudden and unexplained. Patients are like professionals in that they may find change unsettling

How will you let others in the area know of developments in your practice?

Do you have a network of colleagues to work with on this who may be facing similar capacity issues? These colleagues may well prove a source of support and will certainly be interested in what you are doing.

While all this may seem like a lot to think about it is important to realise that change can be both exciting and daunting. General practices are usually peopled by enthusiastic well motivated staff who can draw on a wealth of experience. Formalising a change process may seem strange but by preparing yourself you increase your likelihood of success.

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