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Our plan for improving access for patients and supporting general practice

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Introduction

1. General practice is the bedrock of the NHS. The NHS has always relied on its resilience. Its importance and value have once again been demonstrated during the pandemic response. Our GP surgeries, through primary care networks (PCNs), have shouldered the lion's share of the COVID-19 vaccination programme alongside their existing workload. This financial year, they have also provided more appointments nationally for patients than in the equivalent period before the pandemic. It may not appear so in surgery waiting rooms, given social distancing requirements, but the vast majority of general practice teams have never been busier.
2. As with other parts of the NHS, most obviously ambulances and A&E departments, current workload pressures in general practice are intense. We are still coping with the additional demand and constraints of the pandemic. We see the release of pent-up demand, accumulated during the pandemic when people were less likely to consult their practice or seek specialist care. And general practice has the critical job of catching up on the backlog of care for patients on its registered list who have ongoing conditions, to avoid acute episodes or exacerbations that may otherwise result in avoidable hospital admissions or even premature mortality.
3. Most practices provide accessible, high quality care. Taking England as a whole, patient satisfaction with general practice at the beginning of the year has held up remarkably well. Based on data from 850,000 patients, the independent GP Patient Survey 2021 showed increases in: overall patient satisfaction with general practice; patient satisfaction in being able to make an appointment; and patient satisfaction with the appointment times offered. A reversal of recent trends, these results are objective testimony to the dedication and professionalism of the vast majority of GPs and their multidisciplinary practice teams, including practice managers and receptionists. They reflect how well the majority of practices have been able to adapt and innovate during the pandemic, maintaining and improving access, including using remote appointments. For many patients, remote consultations can often be more convenient.

The access challenges

4. At the same time, it is true that patients' ability to access primary care is often not as good as it should be. Some patients are experiencing unacceptably poor access to general practice, including an inability to contact practices – as witnessed by their stories and those reported in the media. Unwarranted

variation in practice performance has always existed but Healthwatch and the Care Quality Commission record rising number of concerns and complaints, typically about appointment availability, waiting times, and in particular, the ability to see a GP, and specifically face-to-face.

5. We understand the frustration of patients who were not able to access appropriate care when they needed it, but we are clear that is never an excuse for abuse or violence against staff. The NHS has a zero-tolerance approach to abuse and violence against its staff. There is no place for aggression, abuse, incivility, or any acts of violence in our society. If a person is violent, abusive or threatening to their GP or any general practice staff, they can be permanently removed from the surgery. The NHS will continue to support anyone affected by such incidents and work closely with the police and the Crown Prosecution Service to bring offenders to justice. A campaign will be developed, working with unions and professional bodies, to communicate this clearly to the public.
6. The wider context is that ensuring good access to general practice has been a complex and challenging issue for many years: for example, getting through to the practice on the phone, particularly first thing in the morning, and sometimes long waits for more routine care. In large part, the access challenge mirrors overall workforce capacity including the number of GPs, which has increased much more slowly than the number of hospital doctors. A series of measures are already being put in place to address this, including through the 2019 five-year GP contract deal, boosted by the Government's manifesto commitments to improve general practice capacity by increasing the size of the primary care workforce and delivering 50 million more appointments.
7. Widespread changes to the way that people accessed general practice services during the pandemic have been overlaid on these longstanding access challenges. The response to COVID-19 last spring saw an impressive almost overnight adoption of remote consultations and triage-first pathways to ensure care could continue during the first wave of the pandemic. Many of these changes offer long-term benefits for patients and practices. Even before the pandemic, thousands of patients were being assessed effectively and safely in general practice every day via remote consultations, whether over the telephone or online. For many this was the best option for them, so they did not have to take time out of their day to attend the surgery, while others preferred a face-to-face consultation in person. Online triage models will continue to improve and become easier for patients to navigate. Patients' input into this choice should be sought and practices should respect preferences for face-to-face care unless there are good clinical reasons to the contrary.

8. Having exited the emergency phase of the pandemic, all practices are currently grappling with the emergent challenge of working out the optimal blend of face-to-face appointments alongside remote appointments, wherever these are clinically warranted, taking account of patient preferences. There are limited evidence-based professional standards or guidance to help show what constitutes good practice or what is likely to be an unacceptable standard of care. Practices are working out the answers for themselves and their patients. Many are doing so brilliantly – often with much improved satisfaction – and not through a simplistic reversion back to pre-pandemic ways of working. Equally, other practices are still on a journey to that new optimal balance. However, a minority of practices are now offering wholly inappropriate access, with very low levels of face-to-face care. In August 2021 over 15% of practices recorded less than 20% of their GP appointments being held face to face. That is likely to be contrary to good clinical practice, even if it were to reflect the preferences of their patients.
9. For patients, a further change in their experience of access arises from the long overdue transformation of the general practice clinical workforce. In our hospitals, the consultant leads a multidisciplinary team of different professionals. That model is rightly becoming the new norm in general practice, with the GP expert generalist supported by a much wider array of clinical professionals. On top of all our critical work to increase the numbers of GPs, we have already recruited over 10,000 of an additional 26,000 staff who will be working in general practice by the end of 2023/24. Patients can increasingly expect to be able to see different types of healthcare professionals in general practice, who are more expert or appropriate in dealing their particular needs and conditions, including over 3,000 pharmacists already in place, paramedics and advanced nurse practitioners. We need to do more to ensure patients are aware of the range of skills and expertise available through primary care, alongside GPs specifically.

Further actions

10. The NHS is gearing up to a very challenging winter, with access to general practice an essential part of winter plans. This short guide, supported by Government, describes a number of further actions (below) that will now be taken by the NHS, Government and partner organisations, to support general practice and improve access including face-to-face appointments with GPs. They include steps to (a) increase and optimise capacity; (b) address variation and encourage good practice; and (c) improve communication with the public, including tackling abuse and violence against NHS staff.

A. Increase and optimise capacity

Forthcoming IPC guidance

11. NHS England understand that UKHSA is recommending a more flexible approach to patient consultations in primary care and general practice after reviewing the current infection prevention and control guidance on patient consultations in primary care. These will be published on the Agency's website.

Additional capacity funding for systems

12. During the first half of the financial year, an additional £120m was made available to general practice to expand capacity via local commissioners. The amount tapered to £10m for September. A further £10m of continued funding will be distributed in the same way in October 2021.
13. For the five months November to March, **a new £250m Winter Access Fund** will help patients with urgent care needs to get seen when they need to, on the same day, taking account of their preferences, instead of going to hospital.
14. The two main uses of the Fund will be:
 - (i) to drive improved access to urgent, same day primary care, ideally from patients' own general practice service, by increasing capacity and GP appointment numbers achieved at practice or PCN level, or in combination. This could be, for example, by funding more sessions from existing staff, or making full use of the digital locum pool framework, reimbursable at maximum rates set out in the [existing guidance](#). The fund could also be used for expanding extended hours capacity, including for example any contingency planning for bank holiday working. It could be used for extra administrative staff, eg at PCN, federation or practice level, where commissioners agree that is necessary, and agree that the solution planned is the optimal delivery model. The fund could also be used to employ other physicians such as retired geriatricians who are unable to work as GPs because they are not permitted to join the GP Performers List

- (ii) to increase the resilience of the NHS urgent care system during winter, by expanding same day urgent care capacity, through other services in any primary and community settings. In the [Urgent and Emergency Care Recovery 10 Point Action Plan](#), systems have already been asked to review capacity and demand across their portfolio of type 3 and 4 services, including those temporarily closed during COVID and to ensure available capacity and capability of urgent treatment centres (UTC) is matched to demand. UTC capacity could be expanded as an alternative to patients' own general practice service. Systems may wish to use primary care hubs including respiratory hubs (to manage increased cases of RSV, for example), or 111 Clinical Assessment Services (CAS) capacity where general practice is unable to expand, beyond the significant further expansion of 111 already planned. The CAS should continue to be able to transfer patients to their own practice as required for continuity of care. The NHS has invested an extra £23m into NHS 111 during August and September to help meet the increased demand in both call handling and clinical assessment services and a further £75m of funding has been allocated within the [H2 planning guidance](#).
15. It will be for local systems to determine the optimal use of the funding in line with local issues and solutions, national expectations and requirements. Local commissioners will be able to set their own local conditions, working with local partners. It is not designed as a 'pass-through' payment to individual practices.
16. The amount deployed will depend on local systems being able to demonstrate value including quantification of the scale of increased capacity and expected impact. A maximum indicative amount will be calculated on the CCG primary care weighted capitation formula, which takes account of inequalities. Funding up to this indicative ceiling will be released in early November to lead CCGs within ICSs, following plan submission and then NHS England approval. Local systems should continue to make decisions now, within existing resources to increase same day urgent capacity. A partway checkpoint will apply; funding could be reduced or discontinued if demonstrable progress has not been made by mid-December. All systems must develop and submit a plan, by **Thursday 28 October**, assured by the ICS board, in line with a simple standard template. PCN clinical directors must be involved in developing the plan. The focus on improving access should form part of the dialogue that CCGs normally have with their Local Medical Committees (LMC).

Expanding numbers of GPs and other primary care professionals

17. **NHS England and NHS Improvement is working with systems to strengthen their existing plans to increase numbers of GPs towards the 6,000 Government manifesto commitment.** A record 3,793 GP specialty training places were filled in the first recruitment round this year, and the ambition is to get to 4,000 in the second round. The latest comparable data (June 2021 compared to June 2019) showed that there were now over 1,200 more full-time equivalent (FTE) GPs than two years before, with a headcount increase of almost 2,500. But much more still needs to be done. We are expecting all parts of the country to have established a digital locum bank model or equivalent by December and the Winter Access Fund can support optimal use. GP expansion plans, already being finalised by every system, will need to include significantly increased uptake in the use of GP recruitment and retention initiatives including the GP fellowship scheme, the mentorship scheme and the new to partnership payment. With assistance from BMA GPC, RCGP and HEE, NHS England will work to communicate these schemes widely and effectively, and examine further steps that may be required, including by setting up a new national advisory group.

18. The Government's manifesto commits to expanding the number of other primary care professionals by 26,000. This is essential to expanding general practice capacity and bringing a wider range of skills to the primary care team, enabling GPs to focus on what only GPs can do. PCNs have flexibility to employ any of 15 different roles and are successfully employing over 10,000 extra staff already. **The NHS planning guidance issued on 30 September confirmed that systems are required to achieve their share of the 15,500 target by March 2022**, putting in place additional support wherever necessary for their PCNs to help with recruitment, developing rotational roles with other services, eg ambulance trusts, or joint roles eg with mental health trusts. We will also be supporting PCNs to make the best use of as many new nursing associate and trainee nursing associate roles as possible through the scheme as part of further strengthening and securing the future of practice nursing. Maximum reimbursable rates for 2021/22 have been uplifted to include the Agenda for Change 3% pay uplift. Pharmacists joining PCNs will automatically be trained to prescribe, lifting workload from GPs; and we continue to increase the role of community pharmacists in delivering appropriate clinical services.

Moving to cloud-based practice telephony

19. During the emergency response to the pandemic and subsequent recovery, practices continue to face an unprecedented increase in demand across all digital and communication channels, including telephony. With increasing

volumes of telephone contacts there has been a significant strain on older analogue technology. For patients and reception staff alike, this can be a source of huge frustration.

20. An estimated one-quarter of practices have already moved to cloud-based telephony. As well as providing more phone lines for inbound and outbound calls, and automated queuing, cloud-based systems can provide data about patient demand to help give feedback about current performance and inform practices about the level of administrative support they need for call-handling.
21. **NHS England will enable and drive full adoption of cloud-based telephony across all practices, as rapidly as possible. This could include – subject to value for money – a short-term national solution available for all practices to deploy by the end of the year.** This would precede a longer-term supplier framework, to support local deployment of cloud-based products as existing local contracts expire.

Making best use of community pharmacy

22. **Use of the Community Pharmacist Consultation Service (CPCS) can help alleviate pressure on GP appointments by harnessing the skills and knowledge of community pharmacists to treat a range of minor illnesses.** Using the service gives a patient a same-day appointment in a community pharmacy and helps improve patient experience, as well as directing demand to the most appropriate setting. 800 practices are already signed up to provide the service. NHS England is providing support through a nationally procured resource that will help practices use the new service. All practices are encouraged to sign up by 1 December 2021. The PCN [Investment and Impact Fund](#) provides an incentive for PCNs to develop plans to implement CPCS or increase their current referral rate. Participation is also a condition of a practice being able to benefit from the Winter Access Fund.
23. We are already piloting the supply of contraception by community pharmacies. NHS England will work with DHSC to consider how far and fast we can expand the role of our pharmacists in the supply of medication, as part of relieving workload on GPs.

Optimising involvement in the COVID vaccination campaign

24. **Participation by a practice in the COVID-19 vaccination programme can never be at the expense of providing reasonable patient access to core GP services.** This was a condition of sign up to take part in phase 3 of the COVID-19 vaccination programme. Where access to primary medical services is challenged, for example where levels of face-to-face appointments with GPs in the practice are inappropriately low, commissioners must put in place

immediate solutions to resolve the position, including considering alternative provision for vaccination of the affected population, most likely through community pharmacy.

Reducing administrative burdens

25. In February 2020 **DHSC and NHS England jointly committed to reducing bureaucracy on general practice with a particular focus on the burdens placed by medical evidence and certificates, such as fit notes and DVLA checks**. The isolation note was introduced in March 2020 and acted as a form of evidence to support self-isolation, protecting GP services from a surge in demand for fit notes for COVID-19 absences. In July 2021, the government set out plans to deliver digital transformation of the fit note including removing the requirement to sign in ink (from April 2022, sooner if possible) and committing to amending regulations to allow a wider range of eligible professionals to sign fit notes at the earliest opportunity. Plans to embed electronic fit notes in hospital systems planned from spring 2022 and encouraging hospital doctors to issue fit notes to patients in their care will also further reduce the burden on GPs.
26. **Changes have also been made to DVLA certification**. In February this year, a simplified process to renew licences for those with epilepsy and multiple sclerosis was introduced allowing patients to self-declare when there has been stability in their condition with no follow-up with their GP required. DHSC is working in partnership the DVLA to expand these changes to other conditions and are looking at opportunities to increase the range of medical professionals that are able to provide DVLA with information.
27. Based on feedback, **annual GP appraisals** were refocused in October 2020 to support professional development and wellbeing better, with simplified information requirements to free up time for the GP and GP appraiser alike. This less burdensome system continues in 2021.
28. As part of the 2021/22 NHS standard contract, **secondary care providers must assess and address certain processes¹ that generate avoidable administrative burdens for GPs**. Information Standards Notices will be published later this year to improve the way transfer of care information and data is shared by secondary care to primary care, removing the need to send email attachments or paper letters requiring manual processing. In addition, NHS England has emphasised that local system plans should hold providers to account for eliminating any unnecessary redirection of activity to general practice from other providers where this could reasonably be arranged directly

by that provider, for example phlebotomy, organising investigations and, in particular, prescribing of medications.

Re-phasing PCN service specifications and the extended access transfer

29. **In August 2021 NHS England confirmed that it would re-phase the introduction of new PCN service specifications from October 2021 to no later than April 2022**, aside from hypertension detection in the community, working in tandem with community pharmacies; and tackling health inequalities. QOF income protection ended in April, given the importance of the work that QOF incentivises, evidence of its effectiveness set out in the recent QOF review², and the reduction in QOF performance during 2020/21. We are not intending to reopen previously agreed QOF arrangements and repurpose QOF funding to improve access, for example by substituting new practice-level access metrics such as proportion of face-to-face appointments.
30. **To support core general practice capacity and avoid disruption to existing service provision over the winter period, the planned transfer of current CCG-commissioned extended access services to PCNs will now be postponed until October 2022.** This will defer the preparatory work PCNs will need to do before the transfer and therefore prevent diversion of resource away from clinical capacity over the upcoming winter period. The transfer of funding and associated nationally consistent service requirements will now take place in October 2022. Commissioners should ensure that they make the necessary arrangements to extend existing services. This also allows more time for PCNs to explore how best to unlock synergies with in-hours services at practice level, as well as consider the option of collaborative working at larger scale than individual PCN footprints. Where a PCN can demonstrate its readiness, commissioners are encouraged to make local arrangements for a transition of services and funding to PCNs before October 2022.

Redirecting capacity from locally commissioned services

31. Local systems should review again whether any capacity funded through locally commissioned enhanced services can be redeployed with immediate effect to support urgent same-day access. Services that help tackle avoidable emergency admissions should be maintained.

² [NHS England » Report of the Review of the Quality and Outcomes Framework in England](#)

B. Address variation and encourage good practice

Practice-level review of levels of face-to-face care

32. Practices have already been reviewing if they have got the balance for patients right between remote and face-to-face consultations, as well working to improve the quality of their data reporting. **We expect all practices to have completed such an exercise by the end of October, as part of ongoing reflection on professional practice and surgery management arrangements** rather than as a reporting exercise.

Developing the evidence base on hybrid access models and providing professional guidance

33. The Royal College of GPs has a vital role in promoting excellence in primary healthcare and advocating professional standards. **To assist practices in working through what is the new optimal blend of remote and face to face triage and care, NHS England and DHSC have asked RCGP to consider providing a further update to its guidance to practices by the end of November**, including their advice on how practices can ensure they are providing the appropriate proportion of in-person GP appointments for their registered population, that is both clinically warranted and takes account of patient preferences.
34. **NHSE will now also commission an additional QOF improvement module, focused on optimal models of access including triage and appointment type.** Additionally, NHSE England will work with research partners such as NIHR with the aim of securing a 'big data' analysis of the impacts of remote versus face-to-face consultations and understanding the role of continuity of care at the core of the GP-patient relationship.

Incentivising improvements in patient experience

35. **A new real-time measure of patient reported satisfaction with general practice access is to be rolled out nationally and incentivised as early as April 2022.** Patients will automatically receive a message following their appointment and asked a series of questions about how they rate their access to care.
36. **As part of plans for PCNs, individual practices will be incentivised under the Investment and Impact Fund (IIF) to improve their rates of**

satisfaction for 2022/23. The scale of the incentives will be increased significantly in 2023/24 within the planned GP contract envelope.

Data transparency

37. In August 2020, NHS England, together with the BMA issued guidance to ensure all GP appointments are being recorded appropriately and to fully capture the scale of work and workload in general practice. A new standardised set of GP appointment categories was also introduced in March 2021. Practices are expected to ensure that data is captured accurately and in a timely manner to enable much more timely reporting on activity, capacity and waiting times. This more accurate GP appointment data will better show the scale of what general practice does for us all, as well as highlighting potential areas for improvement. To facilitate self-assessment and local conversations about the access offer, we understand that **NHS Digital is working to publish activity and waiting time data at individual practice level as soon as possible.** This will include the proportions of appointment by different professions and by different appointment modality. As the new data comes on stream, patient reported satisfaction levels will also be published.
38. As part of wider work on NHS data transparency overall, NHS England and NHS Digital will then consider how best to create a simple visual tool – learning from the UK Coronavirus Dashboard – to allow anyone to understand different aspects of general practice performance.

Expanding the Access Improvement Programme

39. NHS England and NHS Improvement have established a new Access Improvement Programme (AIP) delivered by the existing Time for Care team which is working with over 900 practices to reduce waiting times, optimise workflow and improve patient experience, and in so doing, improve the working lives of practice teams.
40. **Starting this month, a new intensive form of the programme will support more than a further 200 practices experiencing the greatest access challenges** to help them reduce waits, increase the number of appointments offered each day, including through face-to-face care. The AIP will use interventions that have shown most impact and do so in a more intensive and accelerated format. On-site support will be provided by primary care improvement experts. They will help practices assess demand and capacity, identify gaps with the service level and responsiveness sought by patients. This will lead to a tailored practice improvement plan which will include

making appropriate use of digital tools, ensuring sufficient face to face care, and best use of the multidisciplinary team.

41. The pace and scale of further roll-out will be determined in 2022, learning from the initial impact of what works.

Tackling unacceptable variation

42. **All ICSs should start an immediate exercise to look at the following data and intelligence on their individual practices:**

- (i) any practice with overall appointment numbers lower (excluding COVID-19 vaccinations) than in the equivalent pre-pandemic months
- (ii) the 20% of practices locally with the lowest level of face-to-face GP appointments – as opposed to whole practice, including appointments with other staff
- (iii) the 20% of practices with the most significant level of 111 calls from their patients during GP hours
- (iv) the 20% of practices with the most significant rate of A&E attendances compared to what would be expected
- (v) The Care Quality Commission (CQC) will provide NHS England and NHS Improvement with data relating to the volume of feedback they have received at a regional and practice level; this includes concerns, complaints, whistleblowing allegations and feedback received through their 'Give Feedback on Care' process.
 - local Healthwatch intelligence; and
 - local CCG and LMC intelligence.

43. **Following rapid local consideration, each ICS should finalise an initial list of practices, unlikely to be more than 20% of all local practices, where it will be taking immediate further steps to support improved access.** The initial list should take account of the need to address healthcare inequalities and **be submitted as part of the plan for action described in paragraph 16 for regional assurance by close on Thursday 28 October.**

44. **CQC will work with NHS England to support systems in this process and to make the required improvements across those practices which are not meeting people's reasonable needs.** CQC is rapidly developing an inspection

methodology with a particular focus on access to GP services. Wherever appropriate, it will make unannounced inspections.

45. **A wide variety of actions are likely to be required to resolve the issues:** for example, to increase resilience, smaller practices offering unacceptable access may be expected to partner with other practices, federations or PCNs, as an alternative to the application of contract sanctions and enforcement. Where practices do not engage with support and are in breach of their contractual obligation to meet the reasonable needs of their registered patients, appropriate contractual action will need to be undertaken by CCGs/ICS.
46. **This work on tackling variation is a national requirement of any system securing funding from the Winter Access Fund described in paragraphs 12-16.** Each draft plan submitted must include two parts: (a) how the funding will be used and expected benefits; and (b) the actions planned to increase access for patients in the agreed list of practices who are struggling the most – including actions with struggling practices that do not involve additional funding. National funding will not be released to any ICS unless its plan adequately tackles part (b) as well as part (a).
47. Taken as a whole, the draft submission from systems for the Winter Access Fund must aim to:
 - (i) **ensure all practices achieve at least pre-pandemic activity levels for the equivalent period (excluding COVID-19 vaccinations).** Systems will be required to report total appointments delivered in non-practice settings (eg UTCs) over each month of Nov-March clarifying baseline, additional capacity and proportion of face-to-face care
 - (ii) **increase overall appointment volumes in general practice and ensure appointment levels reflect the full deployment of ARRS staff.** Plans for spend should include quantification of likely capacity in FTE, and approximate appointment capacity. Practices who are not achieving pre-pandemic appointment levels by November will not be able to access the Winter Access Fund but should access further support as set out above
 - (iii) **increase the proportion of face-to-face appointments with GPs in the system,** with a particular focus on those practices with levels that are a cause for clinical concern. System plans must provide for an appropriate overall proportion of face-to-face capacity as part of the additional capacity bought (ie if boosting remote capacity, this must be paired with other solutions). Any practice exhibiting levels of face-to-

face care judged to be of clinical concern will not be able to access the fund but should access further support as set out above

- (iv) **minimise 111 calls in-hours and avoidable A&E attendance that could otherwise be seen in general practice.** 60% of 111 dispositions are for primary care. We also expect to see fuller use of 111 routing calls to general practice
 - (v) **support all practices, by December, to sign up to and make full use of general practice referrals to the community pharmacy consultation service for minor illnesses** to divert demand and improve patient experience. Access to the fund by a particular practice is contingent on sign-up to the GP Community Pharmacist Consultation Service (GP CPCS).
48. **Systems will be required to produce a fortnightly update report for their region.** This should be linked to existing UEC/winter pressures reporting, as an additional adjunct, and take account of the reporting burden on practices and PCNs.
49. **Systems will need to take immediate action to prioritise and support this work on improving access.**

C. Zero tolerance of abuse and public communications

50. **NHS England will work with the BMA GPC, the RCGP and patient groups such as Healthwatch and National Voices to develop communications tools that can help people to understand how they can access the care they need, in general practice.** This will need to incorporate the anticipated changes and developments outlined above.
51. While the majority of patients receive high quality convenient care from their GP teams, we understand the frustration of patients who were not able to access appropriate care when they needed it. That is never an excuse for abuse or violence, which is too common in many NHS settings including in A&E departments and against ambulance staff. General practice staff are dedicated to delivering care for patients, and have the right to work free from fear of assault or abuse in a safe and secure environment.

52. NHS England will immediately establish a £5m fund to facilitate essential upgrades to practice security measures, distributed via NHS regional teams.
53. **The Government and NHS England will work with the trade unions and the Academy of Medical Royal Colleges to launch a zero-tolerance campaign on abuse of NHS staff.**
54. NHS England and Government will not tolerate abuse or violence directed at NHS staff. We are taking action to protect and support staff through the NHS Violence Reduction Programme and the NHS continues to work closely with the police and the Crown Prosecution Service to bring offenders to justice. The government is now legislating for the maximum prison sentence for common assault to be doubled to two years if the victim is an NHS worker, through the Police, Crime, Sentencing and Courts Bill 2021.

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