

Primary care transformation in London

Public deliberation report
November 2024

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Foreword

We are immensely proud and excited to deliver this final report, which represents over a year of collaborative work, reflection, and partnership. Commissioned jointly by the five London Integrated Care Boards (ICBs) and NHS England London Region, this report is the culmination of a comprehensive and inclusive process that engaged a wide range of voices across London. It has been an honour to lead this important work, and we are truly grateful to everyone who contributed along the way.

The project unfolded across three key phases: beginning with initial research, interviews and fact finding, moving through regional workshops with healthcare leadership and frontline-staff, and culminating in the deliberative exercises with the public, patients, carers, advocates, and representatives from various groups. This multi-phased approach ensured we gathered a rich tapestry of insights from the people who know primary care best – those who work within it and those who rely on it.

We want to extend our deepest thanks to the many individuals and organisations who participated. From the oversight group, which brought together stakeholders from across the NHS, Social Care, Public Health, the voluntary sector, Greater London Authority, Londonwide Local Medical Committees, and patient groups, to the public and staff members who volunteered their time and experiences – your contributions were invaluable.

Clinical leadership was a cornerstone of this programme, and the involvement of clinical leaders, including two of the three Senior Responsible Officers (SROs), ensured that the needs and realities of frontline primary care remained at the heart of every conversation. Equally vital was the input from public and staff workshops. It has been a privilege to hear from those who came forward to share their views, and we are committed to continuing this dialogue.

This report marks the beginning of a new chapter in the ongoing transformation of primary care. The insights captured here will feed into local, ICB and regional strategies, driven by the needs and insights of people in London.

Thank you again to all who participated in and supported this process. We look forward to building on the momentum we have created and working together to shape the future of primary care in London.

With gratitude,



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Executive summary

Over the last year, NHS England London Region, in partnership with the five London Integrated Care Boards (ICBs), has undertaken an extensive programme of public and professional engagement to inform the future of primary care in London. Ipsos and Imperial College Health Partners (ICHP) were commissioned to design and deliver this work, with an independent Oversight Group established to offer strategic advice and input.

This has been an innovative and iterative engagement programme comprising of several phases. Phase 1 focused on gathering and synthesising key insights and issues in relation to primary care. Phase 2 then used staff insights to develop and refine the proposals for change in preparation for public deliberation (Phase 3).

This report focuses on Phase 3 – the deliberative public workshops and parallel engagement undertaken with individuals and advocates from marginalised communities and patient groups who might be differentially impacted. Discussions were framed around the patient pathway with four key areas of focus: initial access, triage and prioritisation, the future of streaming and onward care and team based working and proactive care.

Over the course of three workshops (one online introductory workshop and two full days in person) participants were able to learn more about primary care and the proposed areas of change. The deliberative format of the workshops facilitated genuine conversation with participants invited to share their experiences, exchange ideas and reflect on the potential implications for Londoners. A mix of plenary sessions with specialists and in-depth table discussions supported participants to weigh-up benefits and concerns, and to consider the trade-offs that were agreeable to ensure their expectations could be met in a real-world context. In a fourth and final full day in person workshop, these deliberations were then honed into a final set of expectations, which can be used to shape local implementation and engagement plans.

This engagement used purposive sampling, with minimum quotas across multiple demographic variables, including gender, sexuality, age and ethnicity, to ensure that the diversity of London was represented. Quotas for varying levels of usage of primary care, as well as caring responsibilities were also included, to ensure that these important lived experience perspectives were represented. More detail on the sample approach can be found in the main report.

All materials used in the workshops can be found in the appendices of the main report, including the discussions guides used by facilitators and presentations shared with the participants.

Cross cutting themes

There were some perceptions and priorities that participants consistently returned to, that underpinned and framed their views across all the areas explored.

The importance of reducing health inequalities and addressing inequities: Participants wanted any future changes to primary care to reduce health inequalities, and to be carefully assessed to ensure they don't worsen existing inequalities. They emphasised difficulties faced by vulnerable groups such as those without telephones, non-English speakers, and homeless individuals in accessing care. Diverse language support in primary care was seen as crucial for addressing the challenges faced by patients who don't speak English. Participants also strongly recommended prioritising patients with disabilities

and vulnerabilities to offset the additional barriers they encounter in accessing healthcare. They suggested proactive measures to reach marginalised communities, such as the homeless, and emphasised the need for tailored healthcare solutions.

Patient choice was seen as a crucial enabler that would improve convenience and deliver continuity in the way that is most appropriate for each situation: Participants frequently assessed proposed changes based on how they addressed the "Four Cs" in the context of primary care: convenience, choice, continuity, and consistency.

- **Convenience:** Participants desired a more convenient appointment booking system, shorter wait times, flexible options like remote consultations (e.g. video calls), and geographically convenient locations.
- **Choice:** Participants valued having more control over their care, including choosing between remote and in-person appointments. They felt that choice empowers patients to prioritise their needs but acknowledged the need to balance choice with system efficiency.
- **Continuity:** While some participants expressed a desire for the traditional "family doctor" model, others suggested this is infeasible with current and future levels of demand and GP capacity. They emphasised the importance of information sharing and adequate consultation time to improve continuity. Patient advocates stressed the link between continuity of care and psychological safety, particularly for marginalised groups.
- **Consistency:** Participants valued a consistent, reliable service and highlighted the need for standardised practices across healthcare providers and boroughs. They shared negative experiences with inconsistent processes between GP practices leading to difficulties when transferring their care from one area to another (for example as a result of moving home).

Participants understood the benefits and necessity of joining up data, though there were concerns about data security and privacy: Participants recognised the benefits of data sharing for improved healthcare but stressed the importance of robust security and privacy measures. They called for transparent data governance, including audit trails of data access and the ability to opt out of sharing.

If delivering changes to primary care services, there should be large scale public education and communications: Participants emphasised the need for clear, consistent, and widespread communication about changes to primary care. They recommended a multi-channel approach, including national and local campaigns, to inform the public and build trust.

Access

There is support overall for optimisation of digital access, with participants anticipating important benefits to be realised for the primary care system and for patients: Participants saw potential for using digital solutions to alleviate pressure on GPs and the system as a whole, while offering patients quicker, more flexible access to services.

They envisioned a future where the NHS App¹ facilitates 24/7 engagement, bypassing phone queues and reception bottlenecks. This would particularly benefit those with busy schedules, caring responsibilities, or health conditions requiring flexibility. Beyond convenience, participants felt digital

¹ We refer to 'the NHS App' throughout this report. Participants views were often framed by experience of the current NHS App; however their expectations were often future focussed and therefore were rooted in improvements to the NHS App or an equivalent digital application.

access could empower patients who prefer non-personal interactions, whether due to sensitive needs, neurodiversity, language barriers, anxiety, or safety concerns. They also appreciated the potential for digital systems to allow for more considered articulation of symptoms and needs.

Acceptance of increased digital access was conditional on ensuring that patients have a choice around whether or not to take this access route: Participants stressed that this shift must be optional, not mandatory, and that it should only be used where appropriate. Maintaining choice was paramount, with traditional access routes remaining vital to avoid excluding those unable or unwilling to engage digitally and to create capacity for these groups to access non-digital care. Participants emphasised the need for clear communication from the NHS, reassuring patients that all access routes are equally valid.

Consistency was seen as crucial for digital access, with the current fragmented systems and Apps causing 'digital exhaustion': Participants called for a consistent, user-friendly experience across the NHS App, practice websites, and other platforms. This consistency should extend to staff training and processes, ensuring patients are not disadvantaged by their chosen access route.

Pull not push: Uptake of digital access routes should be driven organically by the pull of a high-quality interface delivering convenience, rather than pushing patients onto digital routes: Crucially, participants stressed the need for the NHS App to be high-quality, reliable, and intuitive. This was deemed essential to build trust and encourage uptake. In the future, they wanted to be able to manage and order prescriptions, book appointments, receive test results, webchat with receptionists and medical professionals and view their medical records via an improved NHS App.

There was concern about the costs required to implement high-quality digital access routes, with a significant risk associated with underfunded digital infrastructure: Participants expressed strong concerns that inadequate funding or rushed implementation of digital access routes, particularly the NHS App, would result in a poor user experience and ultimately deter uptake. They emphasised that a subpar NHS App would severely damage patient trust, hindering the realisation of digital healthcare's potential benefits. While acknowledging funding limitations, they advocated for robust investment in the NHS App's development, rigorous testing, and ongoing maintenance to ensure reliability, usability, and alignment with evolving user needs.

Digital access could support parents and carers in managing their dependants' care, but there were questions about how this could be implemented appropriately: Participants generally felt that parents and carers should be able to access their dependents' health information through linked accounts on the NHS App, particularly for managing prescriptions, appointments, and medical records. This was seen as beneficial for convenience and continuity of care, especially for those with complex needs. However, concerns were raised regarding the linking and unlinking process, particularly for children. While automatic unlinking at age 16 was generally favoured, some suggested 18 or a parent/child-initiated unlinking. Safeguarding concerns were also highlighted, with participants and Patient Advocates emphasising the need for processes allowing children in potentially abusive or restrictive environments to separate their records earlier, potentially through a dedicated helpline. There was a recognition that this would be a complex matter that needed further thought to ensure the safety of the child / dependent.

Participants could see the benefits of a centralised phone number, however, the concept was confusing with many querying how it would differ from 111 and practice phone lines: While participants acknowledged the potential benefits of a centralised phone number for primary care access, particularly for those unable or struggling to use digital routes, concerns arose regarding potential

confusion with existing services like 111 and practice lines. A clear purpose and communication strategy for the centralised number were deemed crucial, as well as reasonable wait times and a transparent system for publishing them, with a potential callback system incorporating verification measures to ensure patient trust.

Digital Pods installed in community settings were seen as a potentially beneficial access route for specific patient groups, but participants had questions about how they would be managed:

While digital pods were viewed as a potentially valuable access point for patients, particularly those experiencing homelessness, lacking smart devices, or working non-traditional hours, participants emphasised the need for careful implementation. They recommended trialling pods in diverse local settings before any London-wide rollout to ensure effectiveness and address potential issues. Privacy concerns were paramount, with participants highlighting the need for concealed spaces and robust security measures to prevent data breaches and ensure reliable auto-logout functionality.

Continuity and improved quality of patient records was seen as a key benefit from increasing digital access, but was closely linked to security and privacy risks associated with data sharing:

Participants felt that expanded digital access could enhance the quality of patient records by facilitating greater information input from both patients and healthcare professionals, ultimately improving continuity of care. However, they also emphasised the need for robust data security and privacy measures, given the increased vulnerabilities associated with digital platforms and interconnected databases.

Summary of access expectations

Support for investing in improved digital access routes, with a more reliable and useful NHS App improving convenience and transparency as well as accessibility for some patients.

Digital access must be a choice, and offline access routes must be maintained and well-publicised to those who can't or don't want to use digital routes.

There **must always be an 'exit route' for patients to abandon digital access and speak to a human if required**. It is acceptable for this to be a call handler as long as there is robust training. This should be a free service, open for a minimum of 12 hours every day.

The NHS App user interface must be simple, easy to use and standardised. There could be a 'Local Services Button' where locally tailored information can be found. Accessible options (language, dyslexia friendly) should be available.

Changes should be introduced gradually to allow patients and staff time to adjust. There must be feedback mechanisms as it is implemented to catch any issues.

Whichever tech company is optimising and managing the NHS App should be a **trusted provider, with transparency about selection process** of the provider, and evidence of a track record.

The **NHS App should feature facial ID and/or 2-factor-authentication**, or equivalent, to make it secure.

Parents and carers should have the ability to link accounts, so that they can manage their own, and their dependants' care. This should **auto-unlink at age 16**, unless there are additional

needs or vulnerabilities. *(There was recognition that this is complex and needs to be carefully considered before implementing)*

All practices and primary care services should offer digital access routes. There should be one App for all Londoners (the NHS App) and practice websites should have consistent styles and structures. All digital access routes should have the same features available (such as booking appointments, repeat prescriptions).

Pods should be in a range of location types, to meet different patient needs: Some should be in 24/7 accessible locations, some should be in more private locations. The type of pod matters:

- If it has the testing equipment, it should be in a clean, private, well maintained, staffed, secure location.
- If it is just an access route, it should be in a more constantly available location.

(The expectations have been summarised here for accessibility. Please see the appendices of the main report for the full expectations as developed by participants)

Triage

There was support for improved triage through use of digital tools and joined up patient data:

Participants expressed widespread support for improving triage processes through better use of patient data, believing it would increase efficiency, speed, and quality of care compared to the way that triage currently works. They felt that a system with more integrated data and digital systems that communicate with each other would prevent delays, minimise missed information, and enhance continuity of care by eliminating the need for patients to repeat their medical histories. The potential for improved care outcomes stemmed from a belief that joined-up data, accessible across various primary care roles and organisations, could facilitate faster, more informed diagnoses and treatments. However, there were also concerns regarding the financial investment required for high-quality development, testing, and maintenance of data systems and digital tools.

Triage must account for non-medical factors, especially in relation to vulnerabilities or accessibility needs: Participants expressed a desire for a triage process that improves health equalities by considering both medical and non-medical factors (age, housing status, income, mental health, disabilities, addiction history, language needs, support networks, and access to transportation) when determining urgency and appropriate next steps. They believed this approach could help address existing health inequalities in primary care. Transparency around information use and fairness, along with regular reviews of individual circumstances, were deemed crucial. While recognising the need for more detailed information within integrated digital systems, participants cautioned against excessive screening questions. Some suggested tailoring additional questions to patients with known vulnerabilities, despite potential conflicts with the desire for consistent triage practices. Concerns about potential "gaming" of the system were acknowledged, though generally participants felt the benefits outweighed the risks. However, Patient Advocates expressed significant concern about potential disadvantages for vulnerable individuals less able to articulate their needs, particularly the elderly and those with mental health challenges.

There must be consistency of triage processes and priorities across London: Participants strongly emphasised the need for consistent triage protocols across London, ensuring the same factors are

considered and weighted equally regardless of the borough or access route used. They stressed that patients should receive equal prioritisation whether they phone, walk in, or use a digital platform. To achieve this consistency, participants highlighted the importance of adequate training for practices in a future triage system and a well-planned rollout that allows both staff and patients time to adapt.

There was optimism that AI tools could bring significant efficiency benefits to triage if applied to routine administration tasks and communication: Participants expressed cautious optimism about using AI tools to support primary care, particularly for automating low-stakes tasks within triage and routine administration and communications (such as test results), potentially increasing capacity and efficiency. They also saw promise in using AI for live translation across various platforms, improving accessibility for patients facing language barriers. However, they stressed the need for reliable translation software, accurate voice recognition that accommodates diverse accents and colloquialisms, and careful consideration of potential ethical implications.

AI tools were seen to have the potential to improve outcomes through early pattern recognition at triage stage: The ability for AI tools to identify patterns across data sets was seen as a particularly promising benefit, especially with respect to spotting symptoms of serious health conditions much sooner, sometimes even before the patient themselves has started to consider that there may be an underlying cause to multiple issues they were experiencing. They wanted AI tools to be used to look for patterns in patient records and flag patients who warrant a check-up based on these patterns.

Even among those who were supportive of AI tools in triage, there were concerns about data biases and efficacy: While generally supportive of using AI to improve the triage process, participants also raised concerns. A key worry was the potential for AI to disadvantage certain groups due to bias in the data used to train the algorithms. This concern was particularly strong among Patient Advocates, who stressed the need for diverse and representative datasets to ensure fairness. Participants emphasised the importance of understanding AI's capabilities and limitations, particularly its ability to grasp nuance in complex medical situations. However, some acknowledged that human bias exists within the current triage system and suggested that AI, if developed responsibly, could actually help mitigate this bias.

Clear rules on how AI tools can be used, robust testing, and patient choice were key to applying AI tools in an acceptable way: Participants supported the use of AI in triage for specific tasks like data organisation, pattern identification, communication automation, scheduling, and patient signposting. However, they emphasised that AI should never be used for diagnosis, treatment decisions, or replacing human interaction. Robust testing, professional accountability for AI errors, and an "exit route" allowing patients to opt for human assessment were deemed essential.

Participants worried about risks associated with a reduction in human interaction during triage, and clinical oversight was seen as an important safeguard: While participants recognised the potential of digital triage and AI to enhance efficiency and streamline processes, they also voiced concerns about the potential loss of personal interaction in primary care. Some feared a decline in patient-centred care, leaving patients feeling unheard and overwhelmed. The possibility of missed diagnoses due to the absence of visual cues and nuanced communication was also a concern. However, some participants countered that human error exists even with traditional methods, suggesting that a combined approach leveraging both human expertise and AI-driven tools could potentially mitigate these risks. Debate arose regarding the appropriate level of human oversight in digital triage, with varying opinions on whether only clinicians can be responsible for final triage decisions, or if receptionists can do so with clinical support.

Summary of triage expectations

There must be a consistent approach to triage across London, using the same systems and technology, and with the same prioritisation rules - this should be powered by data.

Triage should consider social factors (if they are known) alongside clinical factors, to ensure vulnerabilities, access barriers, and additional needs are considered when deciding onward care.

Vulnerable patients should still have some routine **direct interactions with a person** during triage, so that mental health and social issues may be picked up on.

AI tools should be adopted by the NHS in London to improve the efficiency and accuracy of triage, with a particular benefit being the ability to spot patterns and flag 'at risk' patients for a clinician to review.

Any **new AI functionality must be rigorously tested and evaluated** e.g. random spot checking on AI decisions. The data used to train the AI should be updated regularly and mirror London's diversity to avoid bias.

There should be accessible options e.g. language options, auto-translate (inc. understanding use of slang or misspelling). Where webchat is used patients must know whether it is AI or a human responding.

(The expectations have been summarised here for accessibility. Please see the appendices of the main report for the full expectations as developed by participants)

Streaming and onward care

Referrals directly to other healthcare professionals working within the primary care setting were broadly acceptable to participants so long as this results in being seen quicker, being seen by a clinician who can meet their needs, and does not involve excess travel times. Participants were generally receptive to the idea of being booked directly in with other healthcare professionals within the primary care setting, without an initial GP appointment, when appropriate. Depending on the patient need this could include pharmacists, physiotherapists, and dietitians. See Appendix A for the range of primary care roles referenced during these discussions.

Participants felt that this approach to streaming could lead to positive benefits such as reduce waiting times, optimised GP workload, and patients receiving care from the most appropriate professional. However, they stressed the need for a seamless and efficient referral process to avoid misdirection and unnecessary back-and-forth between healthcare professionals. Participants emphasised key expectations for referrals, including shorter wait times, convenient locations, and private consultation spaces within pharmacies. Concerns about potential travel difficulties, particularly for those with mobility issues or limited financial resources, were highlighted, with participants advocating for proactive measures to identify and accommodate such needs.

GP continuity was important to some, however, there was acknowledgement that this might mean waiting longer to be seen and therefore patients should be given a choice. There were participants who consistently expressed a strong desire for continuity of care, believing that a familiar GP

who understands their history and circumstances leads to better health outcomes, particularly for chronic or complex conditions. They valued the trust, open communication, and personal approach fostered by seeing the same healthcare professional. While acknowledging that continuity might entail longer wait times, there were participants who were willing to make that trade-off and appreciated having the choice between speed and seeing their preferred GP. However, they felt that receiving care from a different GP was acceptable in urgent situations or when convenience was paramount, especially for less personal or serious health concerns.

There were clear circumstances where GP appointments were seen to always be needed, e.g. to assess potentially serious or complex conditions, and/or where the patient has a current vulnerability. Participants generally agreed that GP appointments (which might need to be in-person but not necessarily, depending on the circumstances) should be prioritised for patients with potentially serious or complex conditions, particularly those where self-care has been ineffective. This prioritisation stemmed from a belief that GPs' expertise is crucial for evaluating and managing such cases, ensuring patient safety. Participants also felt that GP appointments should be reserved for young children, vulnerable individuals (e.g. those with dementia), those with complex or severe health conditions, and the elderly. Conversely, they found it acceptable for patients with less serious or urgent needs to be seen by other members of the primary care team, particularly when their expertise aligns with the patient's needs. This approach was seen as a way to optimise GP workload and ensure timely care for all.

On the whole, acceptability of utilising the wider primary care team was linked to a need for increased awareness of the skills and expertise of these professions. Participants expressed a need for public education to increase awareness and understanding of the roles and scope of practice of various healthcare professionals, particularly pharmacists and physician associates. This education was seen as crucial for building trust and encouraging patients to engage with these professionals, ultimately empowering them to make informed decisions about their care. Participants felt that public communication should highlight the benefits of accessing care from professionals beyond GPs, such as reduced wait times, increased convenience, and care from a specialist best suited to their needs. However, they also emphasised the importance of patient choice, ensuring alternative options are available if a patient is uncomfortable with the proposed care pathway.

Most participants were supportive of the idea of remote consultations, as long as other methods were still available for those who need them. Participants generally found remote consultations, such as video calls, to be convenient and efficient, particularly for initial assessments, follow-up appointments, or visual symptom checks. They appreciated the flexibility offered by remote consultations, such as video calls, especially for those with busy schedules or mobility issues. However, they also acknowledged that virtual consultations are not appropriate for all situations or patients, emphasising the need for in-person appointments when physical examinations or discussions of sensitive or complex issues are required. Concerns were raised about the potential exclusion of certain vulnerable groups, such as the elderly, those with mental health challenges, and individuals experiencing homelessness or addiction, if the healthcare system became overly reliant on digital solutions.

Data sharing benefits and concerns were amplified when considering streaming to members of the wider primary care team. As patients may be seen by professionals they aren't used to, and these professionals would need to access relevant data within their records, participants discussed the concept of compartmentalising patient records by levels of sensitivity. While participants saw value in having a centralised database that allows different healthcare professionals to access patient information securely, enabling more efficient and effective care, some expressed concerns about data privacy and

the need for clear guidelines on information sharing, particularly when it comes to sensitive health information.

Participants saw benefits around signposting to charities where relevant. Participants, particularly Patient Advocates, highlighted that charities and community groups can be a source of trusted information and support, sometimes offering more specialised services than the NHS is able to. However, some Patient Advocates felt that the NHS should be signposting to charities, rather than streaming, and that any support offered by charities should be supplementary to NHS services and not a replacement.

Summary of streaming and onward care expectations

The NHS in London should continue to expand and encourage use of the wide range of primary care roles available, however, patients should be offered a choice of where to go and / or who to see so that they can weigh up what matters most to them.

Public communications should **inform Londoners about the different roles in primary care** and what they are able to do, so patients are more trusting in the wider range of primary care roles.

If patients are streamed to other roles (including to a different GP), this **must result in shorter timelines to assessment/treatment and there must be appropriate facilities** (e.g. a private consultation space).

Distance to travel should be factored in and must be reasonable (c. 20-30 minutes via local public transport). Patients should have the option to indicate if travel is difficult for them and, where relevant, options like Dial A Ride should be considered.

The NHS should direct patients to self-care options where appropriate (e.g. low-level conditions such as Hay Fever). Where self-care is advised the rationale should be provided, and the patient should be directed to relevant health information. Patients should be encouraged to seek help again if symptoms continue.

(The expectations have been summarised here for accessibility. Please see the appendices of the main report for the full expectations as developed by participants)

Team based care and proactive care

A move towards a team-based person-centred approach to care was received with much support, yet participants were quick to identify potential flaws in this way of working. While participants wholeheartedly agreed that enhanced collaboration between primary care, social care, and community/voluntary teams is the ideal direction for the NHS, they also expressed significant scepticism about its feasibility. Funding was a primary concern, with participants questioning if sufficient resources existed to support such ambitious plans. Doubts were also raised about the practicality of achieving seamless coordination and collaboration between different organisations, citing the existing structure of GP practices as independent businesses and the perceived lack of coordination within the current system as significant barriers. Additional concerns centred around system capacity, facilities, and estate.

Integrated neighbourhood teams should be planned at a borough level to meet local population needs, but there was a lack of agreement initially around whether consistency across London

was necessary. While acknowledging potential financial and logistical hurdles, participants envisioned integrated neighbourhood teams operating at the borough level where it makes sense to do so and as opposed to any larger geography, as they felt this would ensure consistent access across all areas and avoid inequities. There was some debate about whether teams should be identical in each borough or tailored to local needs, considering factors like demographics, socioeconomic conditions, and prevalence of specific health challenges. However, there was strong agreement that children, vulnerable adults, those hesitant to seek care, individuals with low incomes, and those with unstable housing would benefit most from this team-based, person-centred approach.

There is a role for care coordinators to provide continuity and communication to patients, while at the same time alleviating the perceived otherwise administrative burden on GPs. While participants initially assumed GPs would coordinate integrated neighbourhood teams, they suggested this would be unfeasible and overly burdensome. The consensus favoured dedicated care coordinators with strong project management, communication, and safeguarding skills, as well as cultural sensitivity and trauma-informed approaches. However, debate arose regarding what level of medical training would be needed for the coordination role. Some felt communication and administration were the most important skills and that only basic medical training therefore would be required, while others believed advanced medical knowledge would enable more effective patient guidance and interpretation of care outcomes.

Integrated neighbourhood teams should be rolled out cautiously, with pilots to help the system learn and adapt along the way, with good regulation and a set of considerations in place to account for the kinds of groups they will serve. While participants embraced the concept of integrated neighbourhood teams, concerns about funding, feasibility, and effective implementation were paramount. They recommended a cautious, phased rollout, starting with borough-based pilots to allow for learning and adaptation. Participants stressed the need for strong leadership, clear transition plans, and adequate funding to ensure success. Accountability emerged as a key concern, prompting discussions about the need for robust regulation and oversight, potentially through a central authority. Participants emphasised patient empowerment, equitable access (including considerations for those without a fixed neighbourhood), and seamless digital connectivity between team members as crucial aspects of successful implementation.

There was unanimous support for proactive care, however community outreach initially received a negative response given assumptions around the likely cost vs benefits. While participants strongly supported the concept of proactive care, viewing it as both sensible and economically beneficial for a strained healthcare system, concerns about cost-effectiveness and potential intrusiveness were raised. The idea of door-to-door outreach, for example, was seen as potentially costly, and that people may not engage with it due to trust issues. Participants generally agreed that proactive outreach should be targeted towards areas and populations with the greatest need, and individuals should have the option to opt out of home visits.

Given the anticipated need for increased data sharing across organisations, and the vulnerable populations involved, data security and privacy must be prioritised. Participants voiced that the success of integrated neighbourhood teams relied on data sharing across various organisations, including community, voluntary, and social care entities. This, however, raised concerns amongst some about data security and transparency, particularly given the sensitive nature of medical records and the potentially vulnerable populations involved. Participants emphasised the need for robust security measures, clear guidelines on data access and usage, and patient control over data sharing. The ability for patients to opt out of data sharing, with a clear explanation of the consequences, was deemed crucial to ensure patient autonomy and trust.

Summary of team-based-working and proactive care expectations

Support for the NHS rolling out integrated neighbourhood teams at a borough level² to provide joined up, holistic and person-centred care for certain patient groups or populations. It is important to ensure that there is continuity for patients (using good records) and GPs should continue to have access to the wider records.

Access to INTs should be via GP or self-referral and should be for high-risk groups including; old and very young, homeless people, children in care and patients with special needs or certain diseases. Support should be available for people who can't travel (e.g. offers of transport and home visits).

The job of **care liaison officers (who do co-ordination) is not to make medical decisions** – they should coordinate patients' care across the various providers in the INT based on what they hear from the health professionals. They do not need to be medically trained, but should be trained in diversity and inclusion, customer service, mental health, and trauma.

INTs should be digitally and data enabled: so long as the data is all in one place, the professionals don't need to be. Given the potential extent of data sharing between individuals and organisations, patients should be given a choice around whether their care is managed by an INT.

There needs to be a consistent base level of care across London so that patients understand the system and don't see a change in quality of care if they move house. However, individual boroughs can then be flexible to meet specific extra needs locally.

This new way of working should be piloted in more deprived areas and with specific audiences to test appetite and should be independently reviewed. Beyond this initial period, there should also be ongoing monitoring and regulations as well as incentives for organisations to work together.

Proactive outreach should be focused on vulnerable populations and those who don't currently engage with services, and those in most need (e.g. homeless people, young people, the elderly, asylum seekers, those with English as a second language, with mental health conditions).

(The expectations have been summarised here for accessibility. Please see the appendices of the main report for the full expectations as developed by participants)

Key messages

There is recognition that the system cannot continue as it is, and in turn there was a real openness to change. Participants acknowledged the urgent need for change in primary care, expressing that the current system, strained by limited capacity and funding shortages is unsustainable, often leading to inadequate patient experiences. They reflected that increased funding alone wouldn't solve these systemic issues and that significant, potentially radical, changes are necessary. Despite their

² Please note that the final expectation wording refers to integrated neighbourhood teams 'operating' at a borough level. However, in discussions participants specified that this means planning and rolling out these initiatives at a borough level. The wording of the expectation has not been edited, as this is the wording that was voted on by participants.

support for transformation, participants expressed pessimism about overcoming existing barriers, particularly regarding integration, funding allocation, and workforce challenges. This pessimism was evident in their predictions of a future where GPs remain overburdened, staff shortages persist, and some went as far as to suggest privatisation of NHS services could be introduced due to unaddressed challenges.

There is enthusiasm for the opportunities that digital and technology can offer to the primary care system. Participants were enthusiastic about the potential for increased convenience and choice offered by digital access, particularly through the NHS App. They envisioned a future where digital platforms would streamline access, eradicate long wait times, and empower patients with greater control over their healthcare. Participants cited the ease of booking appointments, viewing test results, and accessing medical records directly through the NHS App as key advantages. Their positive outlook suggests that well-designed digital access routes, supported by adequate capacity in the system, could significantly improve patient experiences and satisfaction with primary care services.

While maximising digital access, traditional access routes must be retained and kept easily accessible for those who need them. While there was strong enthusiasm for expanding and enhancing digital healthcare access to improve convenience and efficiency, participants emphasised that this should not replace traditional access routes. Maintaining options like walk-ins, phone calls, and direct contact with staff through digital platforms was deemed crucial to ensure equitable access for all, particularly those who face barriers to digital engagement. Clear communication about the continued availability of these non-digital options was considered vital to prevent discouraging or excluding any patient from seeking care.

The limited awareness of wider primary care roles is likely to act as a barrier during a shift away from a GP-first model. Participants were surprised to learn about the diverse range of healthcare professionals within primary care, and articulated a need for public education to build trust and acceptance of receiving care from non-GP professionals. Highlighting the scope of practice, skills, and specialisms of these professionals was seen as crucial for empowering patients to make informed decisions about their care. Despite some nostalgia for the traditional GP model, participants envisioned a future where receiving care from the most appropriate healthcare professional, tailored to their specific needs, becomes the norm.

While participants were clear that a preventative approach to healthcare was long overdue, some remained sceptical about the feasibility of achieving this. While participants enthusiastically supported the concept of proactive, holistic care delivered through integrated neighbourhood teams, significant scepticism arose regarding the feasibility of seamless inter-organisational collaboration. Participants suggested that the success of this model hinges on effective communication and coordination between healthcare providers, which they felt was often lacking in the current system. This scepticism was reflected in their envisioned futures, where tensions between organisations and communication breakdowns persisted, highlighting the need to address these deeply rooted concerns to ensure the effectiveness of this new approach.

Data security and privacy are important, so systems must be properly invested in, and safeguards communicated to build trust with the public. Given the prevalence of high-profile data breaches and limited public awareness surrounding medical privacy regulations, participants expressed significant concern about data security and privacy in the context of proposed healthcare transformations. They emphasised the need for robust and transparent data protection measures, particularly as these changes involve increased reliance on digital systems, AI, and data sharing across

multiple organisations. Public reassurance regarding the security of these systems, coupled with clear communication about data governance rules and patient control over data access, was deemed essential for building trust and ensuring the success of these initiatives. Concerns about unauthorised access, data breaches, and the potential misuse of sensitive patient information were widespread, highlighting the need for robust security investments and transparent communication to address public anxieties.

The importance of patient choice. A consistent theme throughout the engagement was the importance of patient choice and agency in healthcare decisions. Participants strongly felt that patients should have more control over their care and treatment, particularly regarding digital interactions, balancing convenience versus continuity, and selecting the most appropriate healthcare professional for their needs. This emphasis on choice reflects a desire for a more patient-centred approach within primary care.

Introduction

Over the last year, NHS England London Region, in partnership with the five London Integrated Care Boards (ICBs), has undertaken a programme of public and professional engagement to inform the future of primary care in London. Ipsos and Imperial College Health Partners (ICHP) were commissioned to design and deliver this work.

London has a strong history of primary care transformation, and this work seeks to build on the [Strategic Commissioning Framework for London](#) and [Next Steps](#) strategy that were developed before the Covid-19 pandemic as well as the ambitions set out in the recent Stocktake of Primary Care undertaken by Professor Claire Fuller.

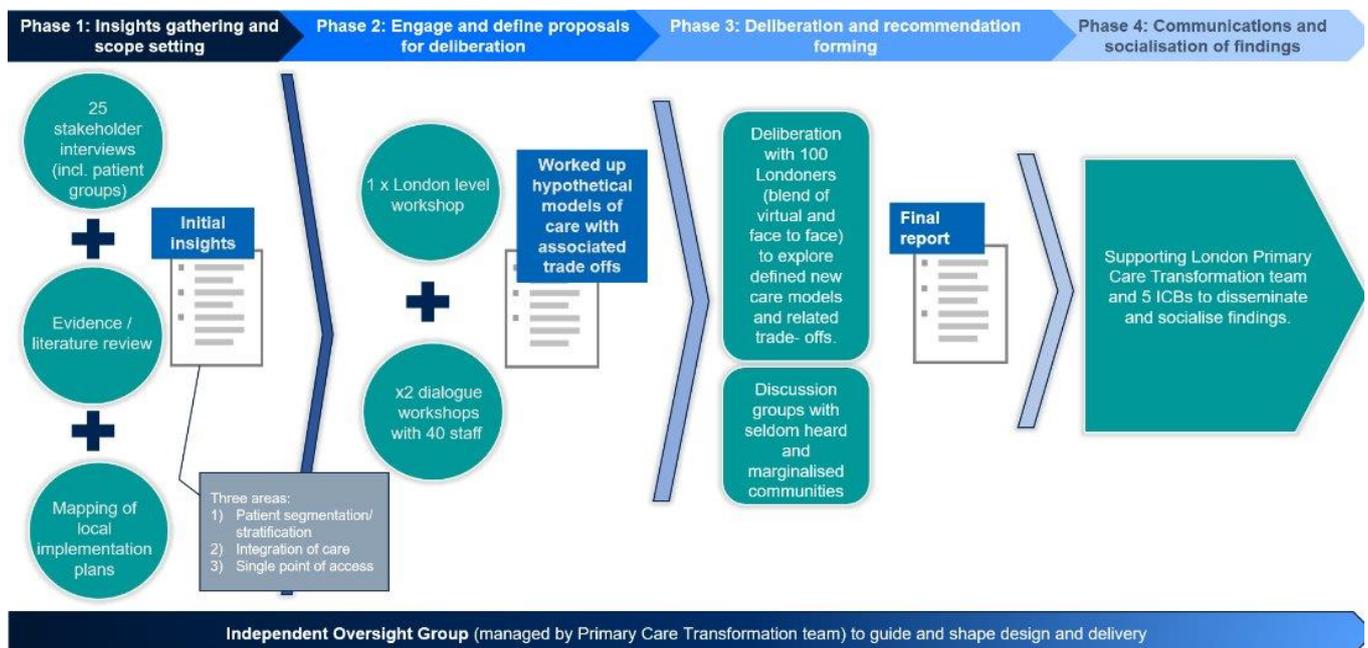
This is a complex agenda, with multiple interests and issues that need to be considered as part of any pathway redesign. There was therefore a strong desire to involve both Londoners and staff in a deliberative process to understand expectations around primary care in the context of future care models, and views on the trade-offs at play, to shape how care should be delivered in the future.

The engagement programme aimed to enable Londoners to become partners in shaping the future NHS and provide health system leaders the opportunity to understand carefully considered staff and public views at a London level, which can then be used to shape local implementation and engagement plans.

Overview of the engagement programme

This has been an innovative and iterative engagement programme comprising of several phases.

Figure 1.1. Overview of programme of work



Phase 1 (August – October 2023) – aimed to gather and synthesise key insights and issues in relation to primary care through a desk review of national documents and local implementation plans as well as

interviews with key stakeholders. This phase explored future ambitions and care models and how these may be operationalised surfacing associated enablers and trade-offs.

This phase helped demonstrate clear support for change and **why** it is needed and a clear consensus on the essence of **what** new care models should be, but there was less clarity around **how** to implement these changes and the level of which there should be consistency across London. Read Phase 1 report [here](#).

Phase 2 (November 2023 – April 2024) - looked to develop and refine the proposals for change and to elicit additional detail around **how** these changes might be implemented and feel for patients. This phase started with a system level workshop with representatives from across London's ICBs, NHSE London Region and other regional and national bodies, followed by two virtual dialogue workshops involving 40 staff representing a variety of roles that work within, or alongside, primary care.

The aim was to build on the findings from Phase 1, prioritising key questions for exploration during the deliberative phase, building an understanding of potential constraints and clarifying what was off the table for public influence. The discussions helped hone the topics and issues for the public deliberation and added essential detail around how to articulate these changes to the public. Read Phase 2 report [here](#).

Phase 3 (May – September 2024) - built on the insights and learnings from Phase 1 and 2. The deliberative process involved facilitating conversations with members of the public with the aim of creating a set of granular public expectations regarding the future of primary care in London.

Over the course of four workshops participants were asked to listen and learn about the topic and exchange ideas and reflect on them. Topics included: initial access, triage and prioritisation, the future of streaming and onward care and ways of working and multi-agency teams and proactive care. In parallel we also engaged individuals and advocates from marginalised communities, and patient groups who might be differentially impacted, to ensure our findings were informed by a diverse breadth of perspectives.

The public deliberation was planned for and designed before the 2024 General Election however the workshops took place several weeks after the election. Public concern about the pressure on GP practices had risen since May 2022, according to polling undertaken by Ipsos UK and The Health Foundation Polling in May 2024³. Over three-quarters of the public expressed concern: up from 73% in May 2022 to 78% in May 2024. The main causes of this pressure were staff shortages (48%), lack of funding (43%), and improper use of services (39%). While the Covid-19 pandemic was previously considered a significant pressure, it is no longer seen by the public as a top cause of pressures on GP practices (11% down from 38%).

This findings from Phase 3 form the focus of this report.

All of the discussion guides and materials presented to participants in Phase 3 can be found in the appendices.

³ [Public perceptions of health and social care May 2024.pdf](#)

Methodology

Deliberation is a progressive form of engagement used to address complex problems. It convenes ‘mini publics,’ reflective of a larger population, over an extended period to grapple with trade-offs and dilemmas in the context of real-life constraints. This method creates an opportunity for decision-makers to understand public views that are carefully considered and rooted in real-life context and as such can help to build trust and relationships between official bodies and citizens and inform more trusted and supported policy in the longer term.

This deliberative method was deemed to be appropriate due to the complexities of the topics covered and provided a space to debate and discuss relevant issues and for key expectations to emerge.

Public deliberation workshops

A two-hour virtual workshop on 10 July, and three all day in-person workshops were held with participants (see below for sample detail) on 13, 14 and 27 July. The workshops explored potential changes to primary care in London and their related trade-offs and sought to understand what mattered most to the public, their red-lines and expectations. The workshops consisted of presentations from experts and smaller group discussions. Participants were mixed between sessions so that they were with different people. This was done to allow the participants to hear a wider range of perspectives, and to avoid ‘group think’.

Figure 2.1. Public Deliberation Workshops



Workshop 1: The case for change

Workshop 1 focused on introducing participants to the deliberative process, with a more detailed deep dive into the case for change to contextualise the deliberative process. Participants were introduced to primary care - how services are commissioned and how it fits into the broader NHS. They were also introduced to the options for change and the dilemmas system leaders are grappling with.

Participants were also introduced to the ‘Four Cs’ – each representing different factors that patients weigh-up when it comes to their care and what matters to them most. These areas were informed by insights gathered during previous phases with system leaders and staff:

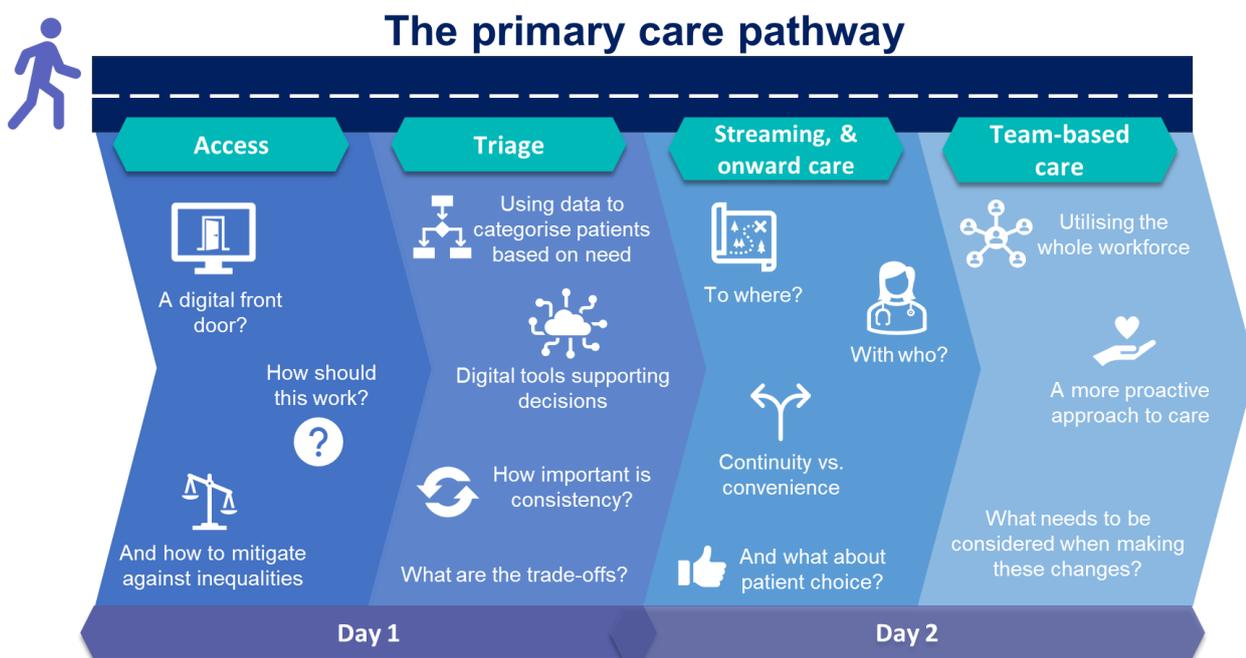
- **Convenience:** How flexible and easy each stage of the patient journey is for patients.
- **Choice:** How much choice and ownership patients have in how they receive care.

- **Continuity:** How patients care is managed in a continuous way, so that they do not need to repeat their story multiple times. This may mean continuity through seeing the same professional, or continuity of their patient records, which are accessible and well used by any professional they see.
- **Consistency:** How primary care and the patient experience varies from borough to borough within London.

Workshops 2 and 3: exploring potential areas of change

Workshops 2 and 3 were framed around the patient pathway and introduced participants to the key concepts and the proposed changes:

Figure 2.2. The primary care pathway



To help root these discussions workshop 2 included a presentation highlighting the diverse needs of London's population and the concept of health inequalities.

Across both workshops participants were invited to share their own experiences and think about the experiences of others, reflect on the concepts and proposals being introduced and discuss the different trade-offs and implications for Londoners. The weekend concluded with a creative activity where participants envisioned and shared their desired futures of primary care via a letter from their future self.

Workshop 4: Refining and finalising expectations

Workshop 4 concluded the deliberations. Participants examined draft expectations based on a high-level analysis of discussions from previous workshops. These draft expectations covered each of the four pathway stages: access, triage, streaming and onward care, and team based and proactive care.

Participants edited these expectations live, first in small groups and then as a whole, to ensure they accurately reflected their views. After group discussions to address any differences, participants finalised

the expectations. The workshop concluded with Ipsos and ICHP members presenting a final set of expectations, based on the groups' input, to participants and system representatives. Participants then voted to indicate their levels of support for the final set of expectations for each area.

Throughout this report the expectations have been summarised to increase accessibility in the main body of the report. You can find the full un-edited expectations in appendices F – I.

Sample approach

106 participants were recruited in total, from across all five ICS regions and all 32 London Boroughs, and representing a spread across multiple demographic and attitudinal variables.

Table 2.1. Public participant quota

Category	Quotas set
Gender	Male/Female x45 each Room in quota for non-binary.
Sexuality	x8 identifying as LGBTQI+
Age	A spread across age groups, 18-70+
Ethnicity	Minimum 40 from minority ethnic groups
Working Status	Quotas for Full-time, Part-time, Unemployed, and Retired
Socio-economic group	x30 each from AB, C1C2, and DE
Parents/carers	x25 parent of child under 15, and x18 Carers.
Use of primary care	x30 of each: Light (people with episodic illness), Medium (people with 1-2 long term conditions including mental health), and Heavy (people with multiple long-term conditions)
Geography	x20 from each ICB, with a spread across boroughs within each ICB.
Attitudinal	x20 each of those who are optimistic or pessimistic about the future of the NHS, if changes made. X30 who are unsure/neither.

Parallel strand of engagement

To ensure the deliberative process engaged with and heard from a range of different voices we conducted a parallel strand of engagement with individuals or advocates from marginalised communities

and patient groups who might be differentially impacted by the proposed changes, to ensure their perspectives were considered as part of the engagement.

The Oversight Group (see below) helped inform the selection of these cohorts and the delivery was supported by Working with Everyone, an organisation specialising in providing a voice to communities who are often under-represented in public engagement.

We heard from individuals or advocates from the following groups:

- People who are, or have been, homeless
- People who have been involved with the Criminal Justice System
- People who have experienced problems caused by their drug or alcohol use
- Refugees and other vulnerable migrants
- People who identify as transgender
- People experiencing severe mental health
- The traveller community
- Care leavers
- People with sensory impairments
- People with neurodiverse conditions
- Older people / people living with frailty.

The parallel engagement included a mix of small focus groups and individual interviews, with activity taking place both before the main public deliberation workshops, to inform the development of workshop stimulus, and after in order to test and validate the expectations formed by the wider public group. Whilst this approach has limitations, it helped us to ensure a wider range of voices were included in the process – allowing us to involve groups who were otherwise unlikely to be represented in the main sample and to create a more psychologically safe setting for those disproportionately impacted by stigma who might not have engaged, and shared as openly, in a large-scale engagement exercise.

Oversight Group

An independent Oversight Group (OG) was established to advise on the design and delivery of the engagement programme. Members represented views from across the system, including senior clinicians, public and patient advocacy groups, representatives of elected officials and communications and engagement specialists - see table below. The OG was invited to critique and challenge the design and delivery of the programme and the content of the staff dialogue and public deliberation workshops, ensuring information provided to participants was balanced, fair and transparent.

Table 2.2. Oversight Group membership

Name	Role
Agatha Nortley-Meshe	Regional Medical Director for Primary Care, NHS England London Region (Senior Responsible Owner for this research)
Charlotte Benjamin	Chief Medical Officer, NHS North West London. (Senior Responsible Owner for this research)
Will Huxter	Regional Director of Commissioning, NHS England London Region (Senior Responsible Owner for this research)
Mike Bell	Chair - South West London ICB (Chair)
Lisa Harrod-Rothwell	Deputy Director – London wide LMCs
Rosemary Watts	Assistant Director of Engagement – South East London ICB
Emma Smyth	Communications Director - NHSE London region
Helene Brown	Medical Director Service Improvement & Professional Standards - NHSE London (until Feb 2024, now Medical Director, Community Physical Health, North East London NHS Foundation Trust)
Becky Kingsnorth	Assistant Director for Primary Care Programmes and Transformation – North Central London ICB
Ethan Williams	Greater London Authority
Jacob Lant	Chief Executive - National Voices
Anne Whateley	Former Director of Partnerships and Integration – Central London Community Healthcare NHS Trust
Shanika Sharma	PCN Clinical Director – North East London
Raj Matharu	Chief Officer, Local Pharmaceutical Committees – South East London
James Ray	Regional Clinical Director UEC - NHSE London region
Suzanne Hall	Director of Engagement - Policy Institute, King's College London
April Wareham	Independent Consultant - Working with Everyone

Stella Vig	National Medical Director for Secondary Care - NHS England
Phillipa Wright	Chief Allied Health Professions Officer for London – NHSE London region
Tonia Michaelides	Director of Health and Care in the Community – South West London ICB
Kevin Fenton	Regional Director, Office for Health Improvement and Disparities (London) – Department of Health and Social Care
Rebecca Rosen	Senior Fellow - Nuffield Trust

Alongside the OG, the deliberative workshops were also supported by a small number of specialists who helped support the development and delivery of workshop stimulus or acted as subject-matter experts across the events.

How to read this report and stylistic conventions

A deliberative methodology is a qualitative approach, used to gain in-depth insights into the topic area. As it has a relatively small sample it is not intended to be generalisable to the views of the wider public, nor to wider clinicians. Findings are not intended to be statistically representative of the wider public. These findings are used to illustrate why people hold particular views rather than how many people hold those views.

Due to the small sample size, and the nature of deliberative engagement, findings are presented at a whole-sample level, rather than segmenting according to demographics. Where relevant, the language indicates whether views were shared by a majority or minority of participants, for example using words such as 'some', 'many' or 'few'.

The opening chapter covers crosscutting themes - views, concerns and priorities that participants consistently shared throughout the engagement, that are not specific to just one of the four themes but underpinned and framed their views across all of the themes. Subsequent chapters cover each of the four topic areas in turn - Access, triage, streaming and onward care, and team based working and proactive care – providing a narrative to the public's deliberations before concluding with a summary of their final expectations for that topic. The final chapter touches upon a number of key messages, which came through further from participants as they concluded their deliberations with a projective task looking into the future and describing what primary care looks and feels like in 10 years to come.

Verbatim quotes are used to illustrate particular points, these are coloured **purple** if from a deliberative workshop participant and **teal** if from a parallel engagement focus group member or interviewee.

Crosscutting themes

This chapter outlines views, concerns and priorities that participants consistently shared throughout the engagement, that are not specific to just one of the four themes, but rather underpinned and framed their views across all of the themes.

The importance of reducing health inequalities and addressing inequities

Participants reflected on their own lived experiences and felt that the current primary care system may amplify health inequalities. They noted that access may be harder for some vulnerable patients, if they do not have a telephone, do not speak English easily, or are homeless.

Participants thought that the range of languages must be a challenge for the NHS to navigate in boroughs where there is a higher number of patients who do not speak English, and some understood from their own experience that this also places a burden on family members (including children) who may be required to act as a translator to facilitate access to primary care.

"I have grandparents who don't speak English and I have had to go in as a translator, which then makes it more challenging to get it right."

In considering the proposed changes, participants felt that patients with disabilities and particular vulnerabilities should be given some level of priority to counterbalance the additional challenges they face with their health. They thought that many people book GP appointments unnecessarily and take up resource and capacity that could be used by those who need it most.

"A few years ago I was for equality, but now I feel like I'm going towards equity a bit. Equity could prioritise the people who need it more. I've learnt to realise that that is okay, I don't need the same treatment."

Participants suggested community initiatives and proactive care could reduce burden on the system and reach marginalised groups such as homeless people. They highlighted the need for tailored healthcare rather than a one size fits all model to ensure needs are met.

"Go to the places that they are, to offer some level of access there – go to the people. It has to be their choice but how can we make it accessible"

Patient choice was seen as a crucial enabler that would improve convenience and deliver continuity in the way that is most appropriate for each situation.

Early on in the engagement, participants often flagged that the current primary care system is failing to achieve all of the Four Cs.

Convenience: Participants found the current appointment booking system inconvenient, citing long wait times and difficulties booking appointments due to work schedules. They desired more flexible options like remote consultations (e.g. video calls) and direct booking for specific primary care services. Some wanted to be able to see a GP closer to work than home due to long commutes and more convenient locations generally, to fit around busy schedules. There was agreement that the booking system is inconvenient as it requires patients to call at specific times to get an appointment.

"I work Monday to Friday, 09:00 until 17:00. I do actually struggle to get a doctor's appointment, because I'm only really free at the weekends... I would have to book time off work a month in advance, which isn't always convenient if you've got something at short notice."

Patient advocates also raised convenience as important, sharing how convenience, or lack of, can make the difference between someone being able to access a service or not, particularly for patients less able to travel or those who may need additional flexibility due to their existing health conditions.

"I want it to be convenient. I have issues with walking and if I've got to get a bus all the way to the doctors, and then have to go again two days later to pick up the prescription then that is no good to me"

Choice: Participants believed the system should offer patients more control over their care, for example, they wanted the choice between remote and in-person appointments based on their needs. This was closely linked to convenience, given that convenience changes on a case-by-case basis, so choice allows the patient themselves to determine what will work best. Choice was often considered as an enabler for the other Cs, given that it may allow patients to decide whether they themselves prioritise convenience or continuity depending on their personal circumstances. This view was shared by Patient Advocates who noted that one size won't fit all, and even an individual's preferences may vary depending on the circumstances.

"If it's possible to have the choice of the different treatment options available but within the timescale that you need. So, if there was an option that was available sooner than later and it might be, for example, over the phone rather than going face to face, it might be more convenient."

"I feel that convenience and choice are important for care leavers as they tend to have more chaotic lives compared to other people their age, some people really need to be seen in person, others can't cope with that"

There was recognition that choice needs to be offered to a reasonable extent only, with participants noting that too much choice may put additional burden on the primary care system. The right balance was hard to define, but typical examples given by participants was the idea of offering patients a few options for appointments so they can choose the best one. This was also apparent in discussions about opting in or out of data sharing (see next section).

Continuity: There were participants who expressed frustration over constantly seeing different GPs, with some nostalgia for the 'family doctor' model of care. Participants who felt this way said that changing GPs means they have to repeat their medical history and makes it difficult to build a rapport, which was especially problematic for those with chronic conditions.

However, other participants felt that such a level of continuity is outdated and infeasible in today's world given the level of demand. These participants felt that they already rarely see the same GP, and that information sharing and adequate time with clinicians is more important to providing quality care.

"I think it should be divided into two things, continuity when it's important, like serious health issues and you feel like you need the same person, but if it's just a sore throat or nothing so important, I think anyone, as long as the records are up-to-date so anyone can read the notes. "

As with convenience, choice was seen as an important enabler for delivering continuity in the best way possible, by allowing patients to decide for themselves when continuity is more important for them, and when they'd rather be seen sooner or more flexibly.

Patient Advocates emphasised that for more marginalised groups continuity of care is strongly linked to psychological safety and a key enabler to overcoming fear of judgement and feeling able to communicate openly. Trust and rapport can take longer to build and, once established, felt important to maintain.

"I want to talk to somebody knows my background. The fear of stigma for me was massive"

Consistency: Participants felt that consistency in healthcare is important because it builds trust and confidence. They highlight the need for more standardised practices across primary care providers, and emphasised the importance of a consistent, polite, and reliable service. Several reflected on their negative experience of transferring GP practices, which in some cases led to a delay in receiving essential medication. They highlighted the need for better organisation and communication between practices to ensure a seamless transition for patients.

The desire for consistency often contradicted other important expectations for participants, such as gradual rollout of changes, and ability to flex approaches to local areas. In the final workshop the compromise was settled with expectations for controlled but gradual rollouts, and controlled variance between local services, to limit inconsistent approaches to only where it is valuable.

Consistency of approach across London was seen as particularly important for more transient groups – travellers, care leavers, asylum seekers and homeless people – who were unlikely to receive care in one fixed borough. Patient Advocates for these groups noted that lack of consistency can result in confusion and frustration as well as acting as a significant barrier to accessing care.

"Consistency is a very big problem for asylum seekers as they're often moved between accommodations. We've had loads of cases of people who've been moved from one side of London to the other stay with their old GP because they want to stick to what they know rather than start all over again"

Participants understood the benefits and necessity of joining up data, though they were concerned about data security and privacy.

While increased data sharing heightened participants' concerns about security and privacy, they concluded that the benefits of better joined-up data and wider data sharing within the NHS would outweigh these risks, as long as security is managed appropriately. Participants wanted to see 'platinum level' security built into the systems which hold patient records, and any software that facilitates service delivery.

"I guess the biggest thing for a disadvantage is data protection. The more you're using online the more you're close being hacked."

There was a strong desire for health records to be compartmentalised by different levels of sensitivity, so that access could be given freely for the least sensitive information, while more restricted for the most sensitive unless there is a genuine reason for a specific professional to see it. Patient Advocates also felt that certain social factors (if known) should be considered more sensitive and regularly reviewed, for example, anything linked to substance misuse or domestic violence.

"I don't want my optician to know about my sexual health. But I want my optician and GP to talk about things, eye health can relate to the brain."

"The person treating me for a kidney infection, do I want them to know about my mental health issues? Will that lead to them writing it off or assuming it's about that?"

Participants also wanted there to be transparency around who has accessed their data, which parts of their health record they have accessed, when and why, so that there is a clear audit trail to hold individuals accountable if data is misused or accessed without justification.

Patient Advocates also appreciated the potential benefits, particularly around minimising the need for patients with complex histories to have to repeat their story but noted that fear of stigma and mistrust of authority were also significant themes.

"There's a whole group of people in the travelling community particularly, but also in the settled community, for whom confidence just can't be improved. There's a mistrust of authority, a mistrust of big data"

There was a lot of discussion about the role of patient consent for data sharing. The most nervous participants wanted to be actively asked for consent when their data is going to be accessed. However, when considering the impact of requiring consent each time, participants generally concluded that an opt-out system would be more appropriate, with data-sharing being the standard unless a patient takes the action to retract their consent. It was important to participants that any patient wishing to opt out is clearly informed about the potential consequences of doing so.

"What I would like is a locked system because I do not trust the NHS. I want to allow whoever is handling it to unlock my data only when I consent to it. I want data to be shared but it must be shared securely each time and temporarily."

If delivering changes to primary care services, there should be large scale public education and communications.

Throughout all four themes, participants emphasised the need for the public to be informed of changes, to ensure they know what they should do, to build trust in the system and new processes, and to ensure transparency and accountability to the public.

Participants felt that communication messages should be designed and also delivered at a London or national level to make sure they are clear, consistent and accurate. They wanted to see investment in a

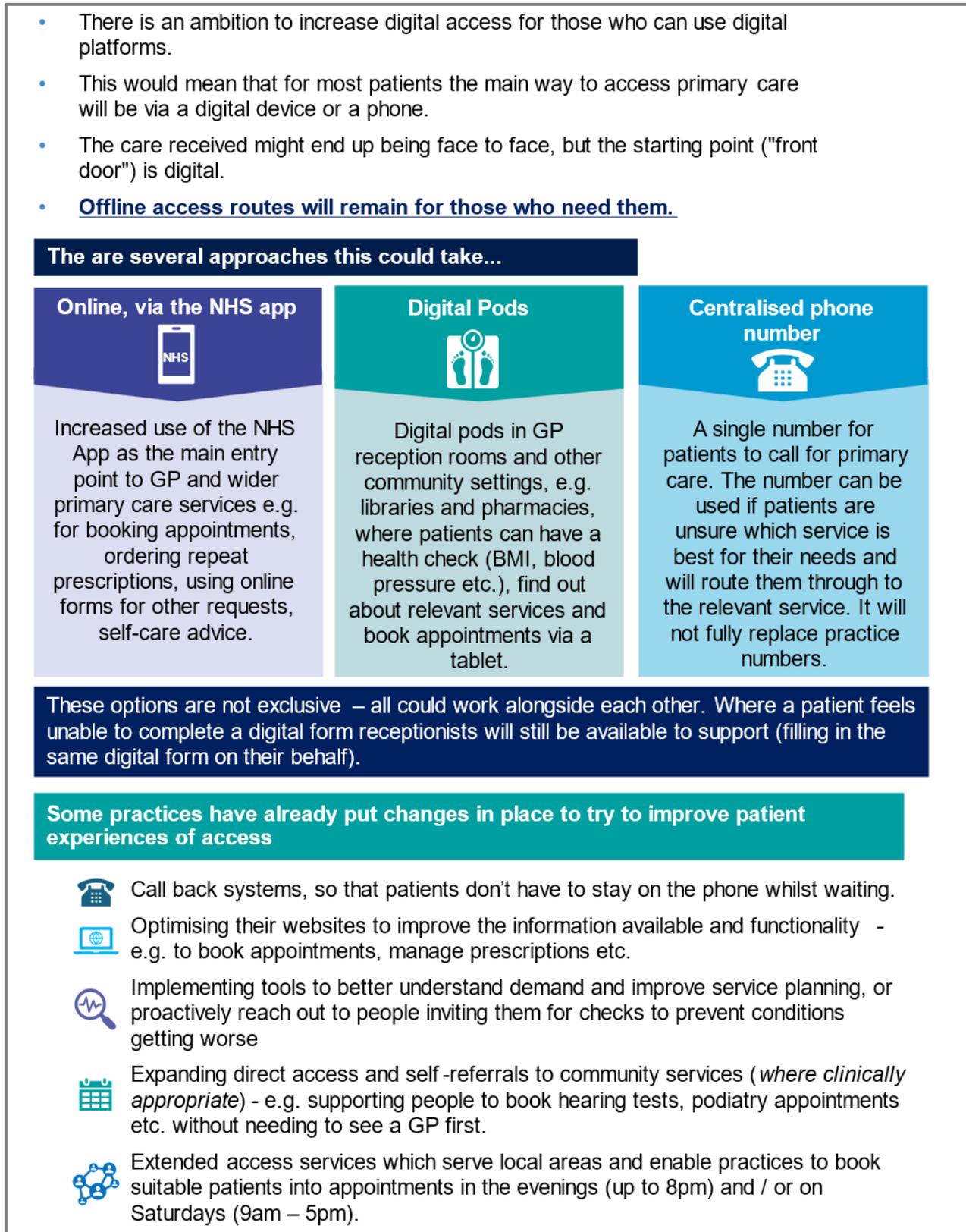
strong communication campaign, with a range of channels used, such as TV, Radio, leafleting, social media, billboards, and education in schools.

However, they also felt that local dissemination of these messages would be needed, adapted to suit the populations in local communities. They suggested GP practices, faith groups, community leaders, and local councils all be included in sharing the education needed to bring the public along with any future changes to primary care services. Patient Advocates also suggested information at bus stops and on buses which tend to be widely seen in London. Another suggestion was sharing information whilst people are waiting on the phone for appointments.

“When you’re on hold [for your GP Practice] instead of having music could there be something more, a bit more informative?”

Access

Figure 4.1. Summary of the information presented to participants to inform access deliberations (full materials in Appendix A)



Throughout this chapter, and those which follow it, we refer to the ‘the NHS App’. Participants views were often framed by experience of the current NHS App, however their expectations were often future focussed and therefore were rooted in improvements to the NHS App or an equivalent digital application.

There is support overall for optimisation of digital access, with participants anticipating important benefits to be realised for the primary care system and for patients.

Participants saw potential to alleviate a significant amount of pressure on GP time and the primary care system overall, by encouraging most patients to use digital access routes, creating more in-person capacity for those who most need it.

"I feel like these computer systems will take a lot of pressure off the GP."

They expected digital access through the NHS App to be quicker and more flexible for patients, avoiding the 8am phone call rush, and the ‘bottleneck’ at practice receptions. Being able to use the NHS App as a point of access 24 hours a day would provide significant convenience, given that many patients are limited by working hours and/or family and caring responsibilities. Patient Advocates also saw benefits for patients who need more flexibility due to existing health conditions.

“Among the care leaver community there is higher prevalence of things like depression, so being up in the morning to be on the phone by 8am is a struggle.”

Aside from convenience for patients, participants thought that increased digital access may also benefit patients who prefer not to interact in person, either because their needs are routine, because the topic is sensitive and they feel embarrassed, if they are neurodiverse, if they require translation, or if they are just anxious when speaking to people. Digital access (i.e. through the NHS App) was also seen as a safer option for people who may not want their conversation to be overheard, for example patients experiencing domestic abuse.

"There are so many situations where you do not want to be heard such as dealing with abuse. This gives a great option."

“Traditionally you would be faced with a receptionist on the phone, wanting to know what your appointment's about, and you're not wanting to tell them because it's a big enough deal that you're going to go and tell the GP”

Some also thought that patients may feel less pressure inputting information into a digital system, as opposed to over the phone or in person to a receptionist, as they might have more time to think through their symptoms and articulate their needs more thoroughly. Linked to this, one Patient Advocate raised the importance of forms not ‘timing-out’ so that those who are less digitally confident and require longer to input their information have appropriate time to do so.

"It gives you thinking time compared to when you are with someone face to face."

“It can be hard to remember everything that has been covered in previous appointments, so it's helpful to have the information in one place”

Participants thought that accessing primary care through the NHS App could provide patients with more ownership over their care, especially if they can see their records, track appointments and test results, and order prescriptions.

Generally, improved digital access was seen to be important to better prepare for the future and to move with the times.

Acceptance of increased digital access was conditional on ensuring that patients have a choice around whether or not to take this access route.

Participants were clear that choice is critically important in the context of increasing digital access. They shared concerns about groups who may struggle to use digital routes, or would not want to, particularly elderly or vulnerable patients, patients without digital devices, blind people and homeless people. These concerns were shared by Patient Advocates who highlighted that there is often an assumption that people will have someone to support them, or access to appropriate devices and Wi-Fi, when for many this is not the case.

“They [refugees and asylum seekers] might not have digital access, they might not have a device, they might not have data.”

“It is not always easy to do certain things online. Everyone thinks you have someone all the time who can do it for you, but that is not the reality”

For this choice to be achieved, participants expected that traditional and non-digital access routes should be maintained as an option, so that patients can continue to phone or walk into their practice to access primary care. They also emphasised that patients that come through non-digital access routes should be treated equally to those that come through digital routes, and that patients should not be pushed to use digital routes if they are not comfortable doing so.

“I want to see really advanced digital access where someone that is able to will be able to get their needs sorted but I also want to see a really good parallel system that is equitable and is totally non digital for those that need it.”

Participants were worried that patients may get the false impression that they have to use digital routes, especially if they hear public communications explaining how to use the NHS App and encouraging people to try it out. For this reason, they wanted the NHS in London to clearly communicate that phoning and walking into practices is still a valid and welcomed way to contact primary care.

“People should not be made to feel they HAVE to use it, so doing it the traditional way should not be made to be the stupid or OLD way of doing it.”

Consistency was seen as crucial for digital access, with the current fragmented systems and Apps causing ‘digital exhaustion’.

Participants reflected on their experiences of the current available digital access routes and felt that a key issue is the lack of consistency, with many different Apps, systems that are not used in the same way between different practices, and inconsistent practice websites. They described a ‘digital

exhaustion' from trying to use such a fragmented digital healthcare landscape and urged for a simple consistent digital access design across all London boroughs.

“I’m in my 20s, I’m tech savvy, but I still can’t get my appointments... They keep signposting you to things online when you’re saying something. If I’m getting exhausted and I have no disabilities, how are those people being expected to navigate all this? I worry.”

“I have to use four Apps to do different things, order prescriptions, make appointments, receive results.”

“I think I’ve got 5 Apps now for my healthcare. I remember asking people if they had the NHS App and people were telling me they did, but it turned out they were all talking about different Apps”

Participants felt that with a shift to more digital access, consistency needs to also be applied to non-digital routes, noting that receptionists have different training, standards and processes currently. They suggested that receptionists should ask the same questions as digital triage tools, so that there is consistency between the access routes, ensuring that patients are not disadvantaged by using digital or traditional access routes. Patient Advocates highlighted that consistency of process is particularly important for groups who might be more transient.

“I move from borough to borough and different Local Authorities, different receptionists at the same practice, I’ve been told different things. So consistency would be nice”

Despite general agreement that consistency is key, there was debate about the role of practice websites. Some participants felt that this is the right place for tailored local information and options, as not all boroughs have the same needs, may not offer the same services, and may not have the same messaging priorities for what they need to communicate to their local community. Others were concerned about this suggestion, feeling that practices already have too much variation between their websites and processes, and that local tailoring of practice websites should be limited.

“Regarding the practice website, it should be able to be customised by each practice. I think there should be components that are the same for consistency and usability and to make it user friendly.”

Participants also stressed the importance of well-planned rollout of changes, with adequate training for all primary care staff. They felt that there would be a risk to consistency if all staff are not aware of, or trained in, the new digital access routes when they are implemented, as they may treat them differently between practices. Training to support patients who are less digitally confident was also recommended.

Pull not push: Uptake of digital access routes should be driven organically by the pull of a high-quality interface delivering convenience, rather than pushing patients onto digital routes.

Participants felt that take up of digital access routes should be organically driven, by delivering convenience and a high quality, user-friendly NHS App with multiple attractive features, that builds

patient trust over time through experience. The current digital access routes were seen as unreliable, inconsistent and not easy to use. With this experience in mind, participants emphasised that the NHS App and practice websites themselves must be overhauled and significantly improved to deliver the experience that patients need, before striving for widespread take up of digital access.

“If they want more people to use more digital routes, it has to work better.”

Improved usefulness: Participants had specific ideas about how the NHS App could be made more useful to encourage patients to choose this access route including the ability to:

- Manage and order prescriptions
- Manage and book appointments
- Receive test results
- Webchat with receptionist and medical professionals (some specified live chat)
- View individual medical records
- Track the progress of their case (e.g. referrals, pending results, review status, next steps).

Ease of use and quality design: Participants shared concerns that digital access routes could be off putting, confusing or overwhelming if they are not designed with a simple style and intuitive process.

- The design should be sleek and simple, with occasional references to Apple’s style.
- Forms should not ask too many questions at once or time-out if someone is taking too long to respond
- Pages should not display too much information in one go.
- Options should be clear and intuitive.
- Patients should have the option to skip questions if they are unsure how to answer or the question doesn’t feel relevant.
- Patients should receive reassurance that the information they have provided has been registered and received and be shown information on what the next step is.
- Digital triage tools should have built in speech recognition, language options, and reliable real-time translation, possibly taking advantage of AI tools to deliver this.
- The NHS App and all online forms should be adapted to work on all types of devices and operating systems and should be compatible with screen-readers.

A clear exit route if required: Participants wanted there to be a prominent button that a patient can use to choose to exit the digital form to speak to a person. They felt this may be needed for patients who are struggling to use the digital platform or if the options presented do not meet the patient’s needs.

"There should be a little red button on the NHS App that says, "I'm finding it difficult to fill this form out, can you help me"

"You get asked the routine questions and that's great. But you're waiting for the question to be asked that you want asking and it never gets asked. And it's like, OK, how do I then leverage that in?"

There was concern about the costs required to implement high-quality digital access routes, with a significant risk associated with underfunded digital infrastructure.

Given the poor experience of digital access routes reported by many of the participants, there was a strong concern that limited funding or rushed decision making could undermine the quality of digital access routes, particularly the NHS App. Participants felt strongly that if the NHS App does not perform well, patient trust would be damaged long-term, and the potential benefits from this change to accessing services would be delayed or missed completely.

They appreciated that there is limited funding available but emphasised the importance of securing adequate budget to properly invest in the development of the NHS App, ready to meet the needs of patients in a reliable way.

Participants wanted to see rigorous testing of the platform, to address technical issues and for ease of use. They drew comparison from other industries, where high-tech companies tend to invest heavily in user-testing and reliability.

Aside from the upfront investment in development of the NHS App, participants stressed the importance of ongoing budget to maintain and improve the NHS App, so that it remains useful, reliable and up to date with user expectations. If patients regularly experience or hear about 'glitches', participants felt public trust would deteriorate, and patients would opt to use non-digital routes to access primary care.

Digital access could support parents and carers in managing their dependants' care, but there were questions about how this could be implemented appropriately.

Participants felt that parents and carers would need access to the profiles of their dependants, possibly even by having their accounts linked on the NHS App. This was seen as important so that they can easily manage prescriptions, appointments, and view medical records, particularly if they have complex needs. Patient Advocates could also see the benefits of similar processes being in place for carers of vulnerable adults, such as patients living with dementia, so long as access was restricted to current care.

"There's a difference between somebody having the ability to order your prescription for you and someone being able to read something that happened 20 years ago...I'm an ex-addict, I've been really open with my kids, but there's certain stuff in there I wouldn't want them to see"

While this was seen as a convenience and continuity benefit, there were some concerns about when and how dependants accounts should be linked and un-linked. Generally, the view was that children's account should automatically unlink at the age of 16, but there were participants who felt it should be 18, or that these should remain linked until the parent or child requests that it be unlinked.

There were also safeguarding concerns raised about children who may be in an abusive home environment, or a strict cultural environment, where they may be safer if their records are private from their guardians at an earlier stage; these concerns were shared by Patient Advocates. Participants felt that there should be processes for children to request an early separation of their records from their guardians, possibly by ringing a helpline, however there was a recognition this needed further thought to ensure the safety of the child / dependent.

“If I've got a 14-year-old or 15-year-old and I've got access to their information on the App and then suddenly I don't because they've decided they want to go on the pill and I don't approve, that might put them at risk if I'm the wrong sort of person.”

Participants could see the benefits of a centralised phone number, however, the concept was confusing with many querying how it would differ from 111 and practice phone lines.

Participants had concerns that a new number could be confusing to patients, who may not know when they should call their practice directly, 111, 999 or the new centralised phone number. They felt that the purpose of the centralised phone number would need to be clearly defined and communicated.

However, participants perceived some important benefits in a centralised phone number and could serve a range of purposes: An initial access pathway for those unable to use the NHS App or support for those trying but struggling to use the NHS App. Further, participants thought that a centralised phone service could take advantage of its scale, employing a more varied skill set, such as translators, which may not be economically viable at a practice level.

There was much debate about who should staff the phone lines, and what level of training they need. Many felt that the call handlers would need some basic healthcare training so that they are able to understand patients concerns and appropriately signpost. They also felt that these staff should have enough technical training to be able to troubleshoot issues with the NHS App when patients call for this type of support. Importantly, they wanted to see call handlers be reassuring and empathetic, as they would serve as an alternative to the digital routes which are unable to offer this.

"[When discussing an example patient persona] He's called the centralised line. He needs a more personalised experience, people checking if he's understood, or booking the appointment for him. Recognising that he's not quite understanding or contacting his GP for him."

Some participants felt that the phone line should operate 24/7 to maximise accessibility for patients. However, following further deliberation, many agreed that 12 hour opening hours would be acceptable, as long as it was every day, including weekends and public holidays. This was seen as important to ensure that a patient can find a day and time that works for them regardless of their work schedule or responsibilities.

Participants felt that it would be important for wait times to be reasonable when calling the centralised phone line and wanted target and actual wait times to be published for transparency. To help manage waiting times, participants suggested a call back system, but expected this to include some verification system so that patients could trust that the call they receive is from the NHS, and not a scam call.

Digital Pods installed in community settings were seen as a potentially beneficial access route for specific patient groups, but participants had questions about how they would be managed.

As shown in Figure 4.1, participants were introduced to the idea of digital pods being set up in a range of locations to act as an access route for patients.

Participants appreciated how pods could improve access for homeless people, people without smart devices, and people who work late or long hours. However, they wanted to see trialling digital pods in a range of locations in local areas before a London-wide rollout to identify any issues and ensure they work effectively.

Privacy was a concern, with participants suggesting that some patients would want to use pods in a concealed space. They also perceived a risk that pods may risk exposing patient's private information if the device does not reliably and quickly auto-log out after use, or if they are vulnerable to hacking or interference.

“Data security will be an issue for me. A pod won't be secure information wise, and who will have access to that. That's one of the reasons I don't have the NHS App”

Participants debated many types of locations where pods could be accessible and useful, while still providing cleanliness, assistance, and privacy when needed. They concluded there should be a range of pods for different purposes, and not all pod locations need to meet all the same criteria. Some pods could be in less private locations such as train stations or supermarkets, where the priority is ease of access at any hour. Other pods would be aimed at patients who need support and privacy and could be in places such as libraries and community centres, where opening hours are shorter, but cleanliness and maintenance are easier to manage.

Continuity and improved quality of patient records was seen as a key benefit from increasing digital access, but was closely linked to security and privacy risks associated with data sharing.

Participants felt that digital access could improve the quality of information in patient records by allowing more information to be entered by patients and healthcare professionals, which could be accessed more easily to improve continuity. They emphasised that the quality of information gathered at the point of access would rely heavily on the quality of the questions patients are asked.

"It relates but it is heavily reliant on quality input. The continuity of it all is based on that. If it is not able to ask the right questions at the top level, then there can be issues."

However, having more access to services via phone, the NHS App and pods meant further considerations about data security and privacy. Devices and software that are linked to joined-up databases were seen as potential vulnerabilities that may be compromised or hacked.

To address these concerns, participants wanted the NHS App and pods to have strong security features such as 2-Factor-authentication, facial recognition and auto-log out. Participants were also keen to see

careful selection of organisations who would develop and manage the software and devices used to access patient records, as well as transparency with the public about the organisations involved.

Summary of access expectations

Support for investing in improved digital access routes, with a more reliable and useful NHS App improving convenience and transparency as well as accessibility for some patients.

Digital access must be a choice, and offline access routes must be maintained and well-publicised to those who can't or don't want to use digital routes.

There **must always be an 'exit route' for patients to abandon digital access and speak to a human if required**. It is acceptable for this to be a call handler as long as there is robust training. This should be a free service, open for a minimum of 12 hours every day.

The NHS App user interface must be simple, easy to use and standardised. There could be a 'Local Services Button' where locally tailored information can be found. Accessible options (language, dyslexia friendly) should be available.

Changes should be introduced gradually to allow patients and staff time to adjust. There must be feedback mechanisms as it is implemented to catch any issues.

Whichever tech company is optimising and managing the NHS App should be a **trusted provider, with transparency about selection process** of the provider, and evidence of a track record.

The **NHS App should feature facial ID and/or 2-factor-authentication**, or equivalent, to make it secure.

Parents and carers should have the ability to link accounts, so that they can manage their own, and their dependants' care. This should **auto-unlink at age 16**, unless there are additional needs or vulnerabilities. *(There was recognition that this is complex and needs to be carefully considered before implementing)*

All practices and primary care services should offer digital access routes. There should be one App for all Londoners (the NHS App) and practice websites should have consistent styles and structures. All digital access routes should have the same features available (such as booking appointments, repeat prescriptions).

Pods should be in a range of location types, to meet different patient needs: Some should be in 24/7 accessible locations, some should be in more private locations. The type of pod matters:

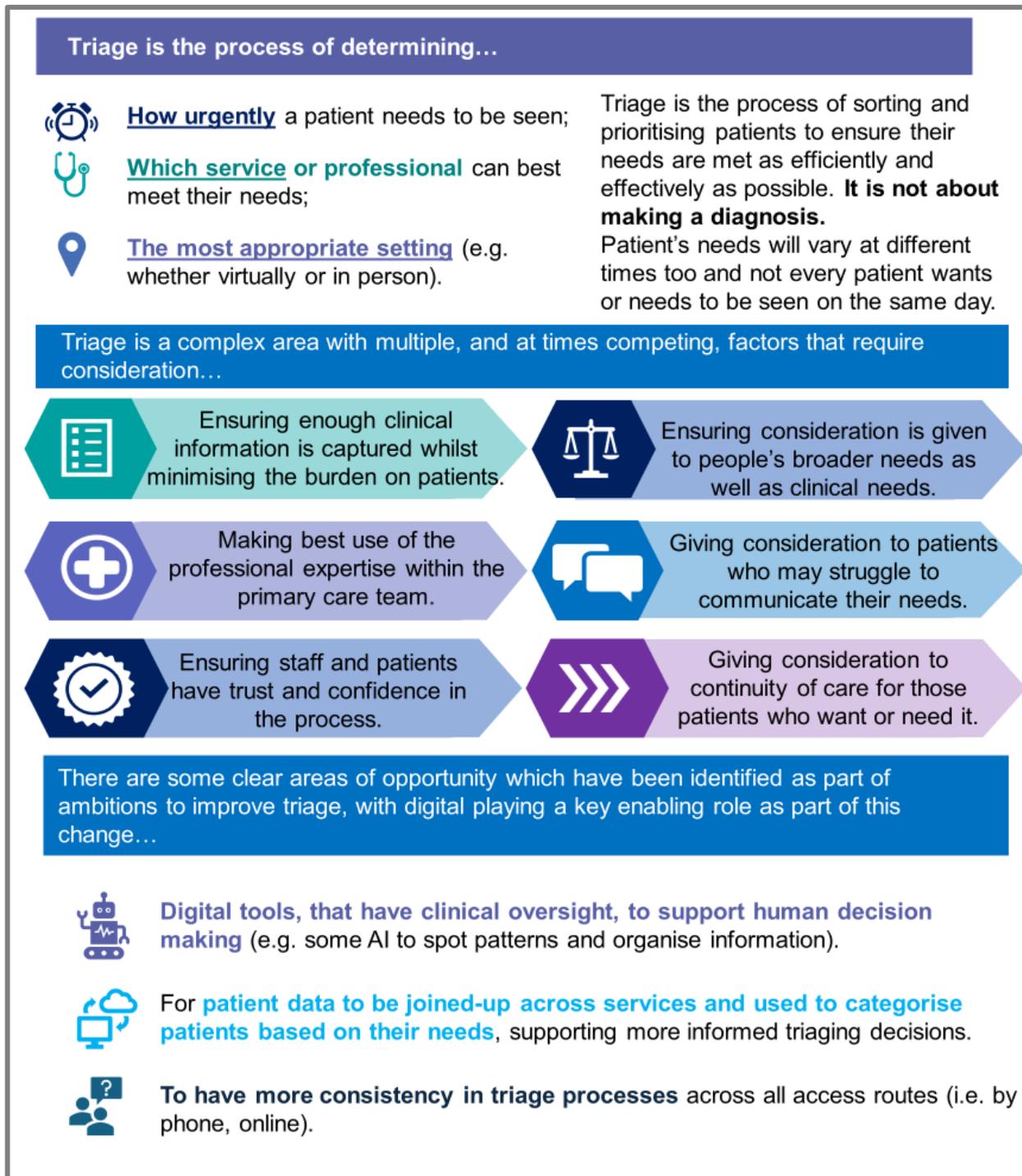
- If it has the testing equipment, it should be in a clean, private, well maintained, staffed, secure location.
- If it is just an access route, it should be in a more constantly available location.

90% of participants voted that they support 'all' or 'most' of these expectations.

This is a summarisation of the key expectations formed during workshops, to improve accessibility in this report. See the full list of expectations and voting responses in Appendix F.

Triage

Figure 5.1. Summary of the information presented to participants to inform triage deliberations (full materials in Appendix A)



There was support for improved triage through use of digital tools and joined up patient data.

Participants were supportive about improving the triage process so that it is more efficient and makes better use of patient data to improve speed and quality of triage. They reflected on their experiences of primary care and felt that currently, triage can be prone to delays and missed information.

They were optimistic about the benefits of more joined up patient data, which would improve care outcomes, as well as save time for both patients and primary care professionals. With all information in one place, they felt that patients would not have to repeat themselves, and the professionals they interact with will be better informed about their history, improving continuity.

Participants were also optimistic about more joined up data being visible to a variety of different roles and departments within primary care, who may connect the dots between seemingly unrelated symptoms leading to faster and more informed diagnosis or treatment.

Aside from patient data, participants were also hopeful that better joined up systems would mean medical research and guidance is better shared and applied more consistently to improve patient outcomes as well as consistency of care.

As with access, there was concern about the level of financial investment needed to ensure high-quality reliable systems, adequate testing, and ongoing maintenance.

Triage must account for non-medical factors, especially in relation to vulnerabilities or accessibility needs.

Participants felt that triage processes should weigh up a combination of medical and non-medical factors when assessing the need and urgency of a patient's case, as well as the appropriate next step. They felt that this would be an equitable approach and help address current health inequalities in primary care.

Factors that participants suggested should be considered during triage were: A patient's age (if they are very old or very young), their housing status, if they have a very low income, whether they have mental health challenges, disabilities, history of addiction, language needs, whether they have a support network or are fairly isolated, and their access to a car or public transport. They suggested that this information could ensure that the patient is offered the right accessibility support (e.g. language support, minimal travel needed) and the right type of appointment (e.g. in person appointment, their regular GP).

Patient Advocates highlighted the need for transparency around what information is being used and how to ensure fairness, as well as the need for regular reviews in case someone's circumstances change.

“Our GP surgery knows we are registered blind and need assistance, they realise it's not so easy for us to do certain things. Any new system will need to know that there are certain requirements some patients need”

“The social factors I'm a bit worried about. So it gets written down that you're in an abusive relationship and they need to be careful, that's great. But then ten years on, that's still following you... So there's something about short-term and long-term vulnerabilities.”

For this to be achieved participants understood that more detailed information would need to be available in the joined-up systems that sit behind the digital triage.

Despite wanting wider information used to inform triage, participants did not want to see too many standard screening questions for patients. Some felt that additional questions could be asked only to patients that were already known to experience any of these vulnerabilities, despite this deviating from the general support for consistent triage.

Some participants worried that patients may exaggerate or lie when providing information to take advantage and 'game the system' so they are seen quicker. For most participants, this risk did not outweigh the benefits but it was a significant concern amongst Patient Advocates who felt that vulnerable individuals could be disadvantaged if they are less able or confident in articulating their needs than others – the elderly and people with mental health needs were two groups specifically highlighted.

"If you are very literate, you can answer the prompts in a way that allows you to get an appointment even faster."

"What worries me about this is that somebody could be in actually quite a bad way, but they write it down as 'it sort of hurts a bit'. And somebody who is less ill but better at answering the questions could get an appointment first."

There must be consistency of triage processes and priorities across London.

It was important to participants that triage protocols are consistent across London and the same factors considered and weighted in the same way no matter what borough a patient is accessing care in.

Further, participants emphasised the importance of consistent triage processes between different access routes, wanting reassurance that a patient phoning their practice would receive the same prioritisation and be triaged on the same factors as they would if they walked in or had used a digital access route.

Participants were concerned that inconsistencies could arise if local practices did not buy into the new triage system or were not adequately trained in how to engage with digital triage systems and therefore wanted rollout to give time for practices and patients to adapt to digital triage.

There was optimism that AI tools could bring significant efficiency benefits to triage if applied to routine administration tasks and communication.

Participants were cautiously optimistic about the use of AI tools for supporting the triage process. They felt that these could automate many low-stake tasks and significantly speed up triage, increasing capacity within primary care.

Participants were also hopeful about the potential for AI tools to be used to automate routine communications, such as follow up messages after an appointment, medication review scheduling, or scheduling routine tests.

"I'm not a fan of AI, but it would be more accessible to have AI as the first point of call to deal with the bulk of calls and decide if you need to go to the GP, pharmacy, urgent care, or book an appointment."

As language was recognised as a key access barrier for many patients, participants thought that AI tools could improve accessibility if used for live translation on the NHS App, practice websites or during phone calls, in a far more cost-effective way than having translation staff. Patient Advocates agreed, but emphasised the need for any AI tools to use reliable translation software. They also highlighted that any voice recognition software will need to be able to understand different accents and colloquialisms in order to be inclusive.

AI tools were seen to have the potential to improve outcomes through early pattern recognition at triage stage.

The ability for AI tools to spot patterns across data sets was seen as a particularly promising benefit, which participants felt could spot symptoms of serious health conditions much sooner, sometimes even before the patient themselves has started to consider that there may be an underlying cause to multiple issues they were experiencing. They wanted AI tools to be used to look for patterns in patient records and flag patients who warrant a check-up based on these patterns.

Even among those who were supportive of AI tools in triage, there were concerns about data biases and efficacy.

Participants raised many concerns about how AI tools may be used, even if they did support the idea overall. A key concern was that as AI tools are still relatively new, the capabilities and limitations may not be fully understood yet, especially when being applied to such important processes that could change the outcomes of patients' health. Participants were sceptical about AI's ability to understand nuance, which may be important when assessing relevant information for triage. There were also concerns about the risk of bias, which would depend on the data used to develop and train AI tools. This view was felt particularly strongly by Patient Advocates who shared concerns that AI could exacerbate existing prejudices. Participants wanted to be sure that AI tools would be developed with extensive and diverse data sets from across London, so that all communities are represented in the data, and no-one is disadvantaged by biased AI decision making.

"I've got years and years of doctors telling me it's all in my mind. So the AI is going to be more likely to spot that I'm a hypochondriac than the actual diagnosis because it's mentioned more times."

However, some participants noted that bias exists within the human staff who currently triage patient cases whether they are receptionists or doctors. They suggested that using AI tools, if developed with diverse data sets, may actually remove some bias from the current triage system.

"There is a bias in humans and so there needs to be a way of avoiding that in any AI that is developed so that we are not replicating that bias...If you could find a way of demonstrating to care leavers that these systems could overcome some of the biases they experience that would be very helpful."

Clear rules on how AI tools can be used, robust testing, and patient choice were key to applying AI tools in an acceptable way.

For AI tools to be acceptable in the triage process, participants were clear about what tasks and roles they could be used for, and which should never be replaced or supported by AI. Using AI tools for organising data, spotting patterns to be flagged to professionals, automating communications and scheduling, and signposting patients felt acceptable. However, participants stated that AI tools should never diagnose patients or make final decisions about their treatment or replace necessary human interaction.

"Is AI going to take over and we'll never see a real person? It's a bit scary in this shift, are we being pushed to that?"

Participants also emphasised the importance of robust testing of AI tools before they are applied to real life triage processes, and the need for accountability to specific professionals or departments if such tools make mistakes.

As with digital access, participants wanted to see an 'exit route' option, so that a patient can request for a human to assess their triage if they feel that something is being misunderstood or overlooked by an AI driven digital tool.

"If the AI assists, we still want triage from a doctor – something you can press to say, 'I still want to speak to a person'."

Participants worried about risks associated with a reduction in human interaction during triage, and clinical oversight was seen as an important safeguard.

Despite general support for digital triage supported by AI and automated tools, participants shared concerns about the potential risks associated with reducing human interactions during the early stages of the patient journey. Some felt that digital access and triage may lose too much of the personal aspect of primary care, leaving patients feeling less cared for, less heard, and overwhelmed by information.

"Reassurance, trust and empathy is lacking in digital – the system can't build up a relationship."

"When it's not a person it's also harder to know what's genuine and what's a scam"

Others had concerns that reducing human interaction could lead to symptoms and signs being missed. They were concerned about patients inputting their own symptoms which they felt verged on self-diagnosis expressing that a human may spot visible signs or read nuance that digital tools are unable to.

"This could also be seen as self-diagnosing, if I'm explaining what my issue is I'm creating bias and I'd rather the doctor be able to tell what the issue is."

“Why do we need to see a person if we can put everything on an app? I think we do need the human touch, as people don’t always give the information, or they don’t know what they don’t know.”

However, some participants noted that human professionals miss things too, and misdiagnosis is already an issue that some had experienced themselves. These participants felt that combining the strengths of both human and AI driven digital triage may mean less is missed.

“I have concerns around diagnosis from AI, where is the information coming from and going, so there needs to be a doctor. I would trust AI more than a GP, but I would like to have a person to review it and ask the questions at the end – Triage to be checked by a person.”

There was debate about the qualification or expertise needed for human oversight of digital triage. Some participants wanted clinicians to be responsible for making final triage decisions, supported by digital tools that streamline information or possibly even make suggestions. However other participants felt that this would undermine the benefits of the change by taking up clinicians’ capacity. Others felt that receptionists would be appropriate, given a perception by some that they are already involved in the triage process.

Summary of triage expectations

There must be a consistent approach to triage across London, using the same systems and technology, and with the same prioritisation rules - this should be powered by data.

Triage should consider social factors (if they are known) alongside clinical factors, to ensure vulnerabilities, access barriers, and additional needs are considered when deciding onward care.

Vulnerable patients should still have some routine **direct interactions with a person** during triage, so that mental health and social issues may be picked up on.

AI tools should be adopted by the NHS in London to improve the efficiency and accuracy of triage, with a particular benefit being the ability to spot patterns and flag ‘at risk’ patients for a clinician to review.

Any **new AI functionality must be rigorously tested and evaluated** e.g. random spot checking on AI decisions. The data used to train the AI should be updated regularly and mirror London’s diversity to avoid bias.

There should be accessible options e.g. language options, auto-translate (inc. understanding use of slang or misspelling). Where webchat is used patients must know whether it is AI or a human responding.

95% of participants voted that they support ‘all’ or ‘most’ of these expectations.

This is a summarisation of the key expectations formed during workshops, to improve accessibility in this report. See the full list of expectations and voting responses in Appendix G.

Streaming and onward care

Figure 6.1. Summary of the information presented to participants to inform streaming deliberations (full materials in Appendix A)



Referrals directly to other healthcare professionals working within the primary care setting were broadly acceptable to participants so long as this results in being seen quicker, being seen by a clinician who can meet their needs, and does not involve excess travel times.

Participants were generally open to the idea of being triaged to be seen by other primary care healthcare professionals, such as physiotherapists or pharmacists, as opposed to GPs in certain circumstances. They understood the challenges around GP capacity and felt that this model of care could reduce waiting times and unnecessary appointments for patients, as well as relieving pressure on GPs, and saw the sense in care being delivered by the most appropriate healthcare professionals who have the specialist

skills to better support their clinical need. See Appendix A for the range of primary care roles referenced during these discussions.

“If I have an issue send us directly there, instead of sending it here and there. It would save me time... It can also save a lot of time for GPs too”

“I wouldn’t want to go to the doctor and bother them if I’m in physical pain when I could instead see a physiotherapist.”

At the same time there were some concerns raised around patients being referred to the wrong professional, and then being sent back to their GP. Participants were clear that the success of the system will rely on a seamless and efficient referral process.

“People are not aware of other sectors; people need to feel they are talking to someone with expertise that understands their issues and that can delve into people’s needs. People don’t want to jump through multiple hoops to get to professionals.”

“Pharmacists are very good, but if you need something that needs a prescription, they can’t do that. We have had instances where we have gone round in circles. It felt like we were being pushed from pillar to post”

Participants consistently expressed an expectation that when directed to members of the wider primary care team, the following would need to be true:

- Patients must be seen in a shorter timeframe for assessment and treatment.
- Patients should not have to travel too far to be seen.
- If patients are directed to pharmacists, there must be suitable private consultation spaces.

Concerns around having to travel further were raised by Patient Advocates, both in relation to mobility issues and the potential costs involved. Participants emphasised the importance of proactively giving people the option to indicate if travel could be difficult for them to ensure they are not directed to options they then cannot access.

“They need to know if someone has a disability and that they may need assistance. There is often an assumption you can bring someone with you, or that you have a carer. That’s not always the case and that can be difficult”

“Care leavers don’t have that familial support where someone can drive them or the money to pay for the bus. Their budgets tend to be depressingly small. They can’t get there”

“Asylum seekers have no money at all, they haven’t even got enough money for bus fares. So what’s convenient for me with the car and that sort of thing is very different to what’s convenient for an asylum seeker because they have to walk to wherever it is that they’re going to”

GP continuity was important to some, however, there was acknowledgement that this might mean waiting longer to be seen and therefore patients should be given a choice.

Continuity of care emerged as a central theme throughout discussions. It was felt that a familiar GP who knows an individual and their background can lead to better health outcomes, especially when dealing with chronic or complex conditions. Some participants expressed that seeing the same GP or healthcare professional builds trust, facilitates open communication and allows for a more personal approach.

"When I book an appointment, I want to see the same GP every time, they know your history and the relationship is very important to me for trust."

"I've got multiple conditions and I prefer to see the same GP. Sometimes the notes are not accurate."

Continuity of care and having the option to be seen by a familiar and trusted professional with knowledge of a person's medical history was also a strong and consistent theme across our parallel engagement activities.

"You're bounced around different foster homes, social workers and health professionals. They're in one meeting and then they're gone. Familiarity and having a good relationship would really help support care leavers to show-up and engage in their health"

"There are groups that really would be vulnerable if we told them to go somewhere else. The dual diagnosis stuff, the anxiety that people can have, the trauma that people can have, it goes back to the whole isolation thing, and [feelings of] rejection"

There was acknowledgement that continuity with a person's own GP might mean a patient may wait longer for an appointment. This was a compromise that participants indicated some would be willing to accept. The option to choose between whether to be seen more quickly or waiting longer to see their own GP was therefore seen as important.

"I think there needs to be that option [...] choosing either the fastest route to be seen or going back to the same doctor."

However, participants also felt that seeing a different GP is acceptable in more urgent situations or when it offers greater convenience, particularly if the issue is less personal or serious. This view was shared by most Patient Advocates.

"There might be some things, like an ingrowing toenail or an ear infection, things a bit more minor where I'm going to go for convenience. I just want this sorted out and I don't really care if I know the person, I just want it done. But for other things that are longer-term and a bit more dependent on relationship, I would value continuity."

There were clear circumstances where GP appointments were seen to always be needed, e.g. to assess potentially serious or complex conditions, and/or where the patient has a current vulnerability.

During an exercise in which participants matched fictional patients with the perceived appropriate professional for their needs, participants tended to prioritise GP appointments for patients presenting with potentially serious conditions or complex needs, or where a patient had already tried another route (e.g. self-care) and their situation was deteriorating. You can find the stimulus materials and discussion guide for this exercise in Appendix A and D.

Participants focussed on risk to patient safety and felt that cases like these would require a GP's expertise to evaluate and manage the situation.

“[A GP is needed] when you feel very poorly and don't know why. It is different when you know you have a cold or flu.”

“[A GP is needed when] you have symptoms for a few days – such as when you need antibiotics etc. Something that lingers, then you need to be able to see a GP”

Some participants indicated that they placed greater trust in GPs compared to other healthcare professionals. This trust stemmed from GPs' medical degrees, years of practice, and the view that their experience would be vital in addressing and diagnosing certain health issues quickly and effectively.

“We've got GPs who've spent 5 years in medical school and lots of training to be that project manager, centre of team [...] They have that general knowledge. Then they can put you onto the right person.”

It was clear too that participants felt GP appointments should be prioritised for young children, the very vulnerable (for example patients who have dementia), those flagged as having complex or severe health conditions (including mental health) or those who are elderly.

On the contrary, participants found it acceptable for patients to be assessed by members of the wider primary care team where their needs were less serious or urgent (for example for UTIs, rashes, eye infections), or where it was clear that the speciality of the professional better suits the person's needs.

On the whole, acceptability of utilising the wider primary care team was linked to a need for increased awareness of skills and expertise and trust in these professions.

Participants were often surprised to learn about the training and skillsets of certain professions, in particular Pharmacists and Physician Associates (see Appendix A for the range of roles discussed by participants). On learning this new information, they highlighted the importance of educating the public about the qualifications, skills and experience that exist within these professions to build trust, alleviate concerns and/or resistance to engaging with them. Having this knowledge and understanding was considered important in supporting patients to make informed decisions around their care.

“This could be part of the online system. Have it [the professional's qualifications, skillset and experience] flash up with their experience and it means we don't have to guess.”

“It’s important to make it clear to people who they’re going to see, what their profession is, what their abilities are, their capacity, and what they can do for you”

Participants felt that public education and communications should outline the benefits to being assessed and treated by other healthcare professionals (beyond GPs), such as being seen quicker at a time or place that is more convenient, and by a more appropriate professional. At the same time, choice was still seen to be important. Participants were clear that alternatives should be offered if the patient is unhappy with what is being proposed.

“What happens if you don’t like the person you get sent to? At the moment, I just change. It’s important for us to have freedom of choice,”

Most participants were supportive of the idea of remote consultations, as long as other methods were still available for those who need them.

Participants appreciated the potential convenience and efficiency of remote consultations, such as video calls, especially for initial conversations, follow-up appointments, or when dealing with visually presenting symptoms such as rashes. They appreciated the flexibility remote consultations offer, particularly for those with busy schedules or mobility issues.

“It is convenient, works for me, if I have commitments this is easier as it is remote and flexible especially if it is an initial conversation.”

However, during the conversations they also acknowledged that remote consultations may not be suitable for all patients or situations. They emphasised the importance of having face-to-face appointments as an option, particularly when a physical examination is required or when discussing sensitive or complex issues.

They also expressed concerns about the potential for certain groups (the elderly, individuals facing mental health challenges, homelessness, or addiction) to be excluded or discouraged from seeking care if the system became too complex or relied heavily on digital solutions.

Data sharing benefits and concerns were amplified when considering streaming to members of the wider primary care team.

As patients may be seen by professionals they aren’t used to, and these professionals would need to access relevant data within their records, the concept of compartmentalising patient records by levels of sensitivity was reiterated in this discussion.

While participants recognised the value of having a centralised database that allows different healthcare professionals to access patient information securely, enabling more efficient and effective care, some expressed concerns about data privacy and the need for clear guidelines on information sharing, particularly when it comes to sensitive health information.

"If they're sharing your medical history, securely, I'm quite happy for professional to know about me, and opt out if I want to opt out, so there's one record with all your stuff. That gives me the confidence to go to these different people who can all access my information. If it all works, they can all work together."

Participants saw benefits around signposting to charities where relevant.

Participants, particularly Patient Advocates, highlighted that charities and community groups can be a source of trusted information and support, sometimes offering more specialised services than the NHS is able to.

"They [patients] know that Age UK a charity, they know the background, they know the history, they know the legacy, and so they've got that trust."

"I'm a victim of FGM. When I went to the doctor to talk about how the FGM is affecting me, I think maybe they didn't know what to do. They referred me to a charity for victims and the charity have now offered specialist help"

However, some Patient Advocates felt that the NHS should be signposting to charities, rather than streaming, and that any support offered by charities should be supplementary to NHS services and not a replacement.

Summary of streaming and onward care expectations

The NHS in London should continue to expand and encourage use of the wide range of primary care roles available, however, patients should be offered a choice of where to go and / or who to see so that they can weigh up what matters most to them.

Public communications should **inform Londoners about the different roles in primary care** and what they are able to do, so patients are more trusting in the wider range of primary care roles.

If patients are streamed to other roles (including a different GP), this **must result in shorter timelines to assessment/treatment and there must be appropriate facilities** (e.g. a private consultation space).

Distance to travel should be factored in and must be reasonable (c. 20-30 minutes via local public transport). Patients should have the option to indicate if travel is difficult for them and, where relevant, options like Dial A Ride should be considered.

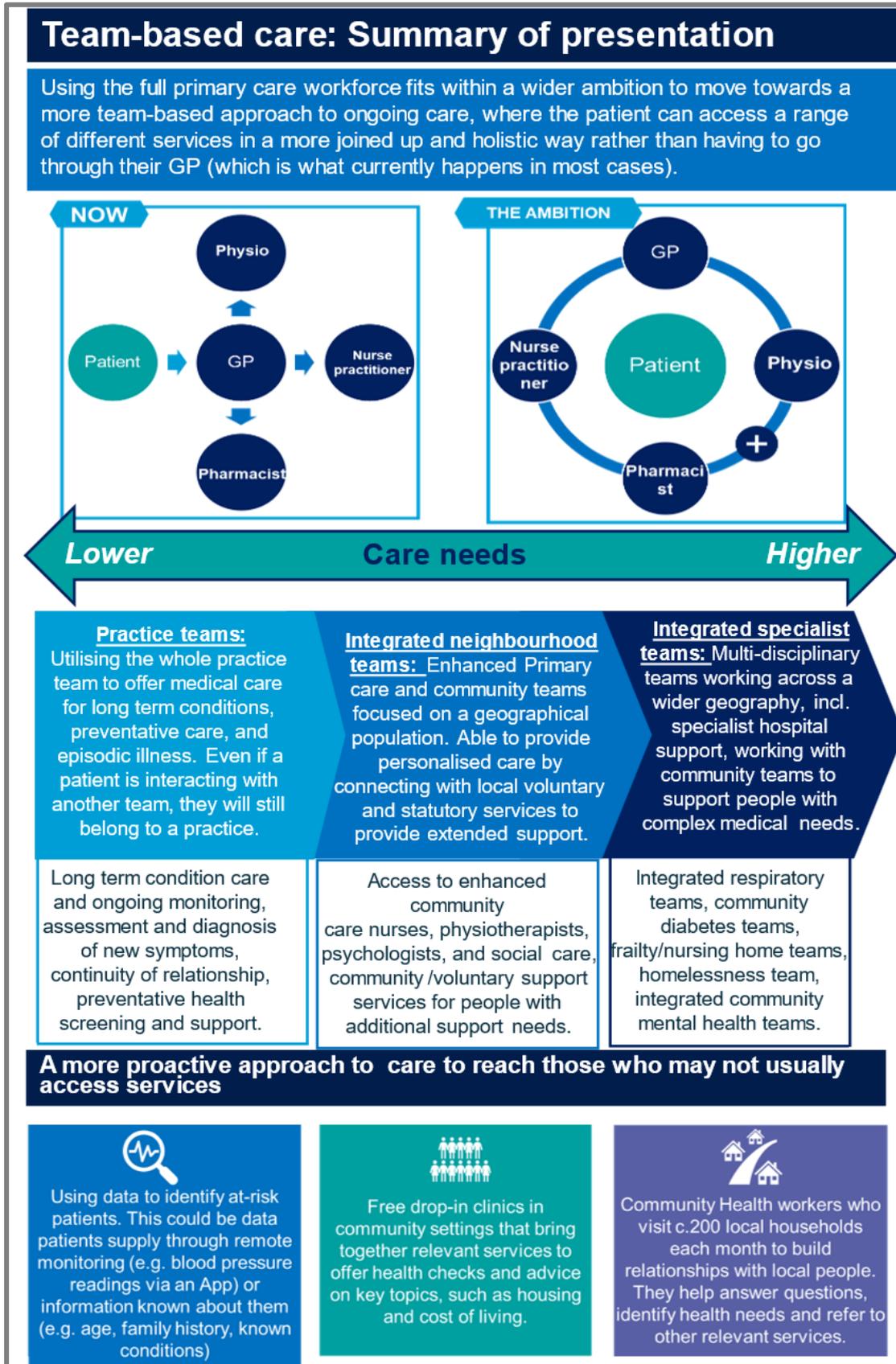
The NHS should direct patients to self-care options where appropriate (e.g. low-level conditions such as Hay Fever). Where self-care is advised the rationale should be provided, and the patient should be directed to relevant health information. Patients should be encouraged to seek help again if symptoms continue.

88% of participants voted that they support 'all' or 'most' of these expectations.

This is a summarisation of the key expectations formed during workshops, to improve accessibility in this report. See the full list of expectations and voting responses in Appendix H.

Team based care and proactive care

Figure 7.1. Summary of the information presented to participants to inform deliberations (full materials in Appendix A)



A move towards a team-based person-centred approach to care was received with much support, yet participants were quick to identify potential flaws in this way of working.

There was no disagreement from participants that enhanced primary care, social care and community/voluntary teams working together to provide personalised and holistic care to patients is the right direction of travel for the NHS. Participants quickly identified potential benefits to patients of this perceived ambitious way of working, including more efficient, convenient and coordinated care. As well, some saw the potential to free up GP capacity for those who most need it.

At the same time, participants were unanimously sceptical about how this would work in practice. Funding was the primary concern, with participants questioning specialists who were present in the workshop around whether there was enough money to support these plans. Linked to this, questions around the feasibility of the approach were raised too, with participants speculating on the likely difficulty of different organisations working together in a coordinated and collaborative way. GPs being set up as individual business, and inferences to the way funding works currently as a barrier to true integration, were also flagged as barriers to realising the ambition. The perceived lack of coordination and communication within the current system drove much of this scepticism.

"For me, this already exists and doesn't work because no one talks to each other, there's no consistency, and you can't guarantee people are going to do what they say they will do".

Several other concerns were noted such as capacity within the system, and facilities and estate.

Integrated neighbourhood teams should be planned at a borough level to meet local population needs, but there was a lack of agreement initially around whether consistency across London was necessary.

Once participants were able to look beyond the financial and feasibility barriers noted above, they started to consider how the teams could be set up and operate. Participants assumed that they would operate at a borough level, and consistent access to these teams across areas and population groups was important to avoid unfairness and potential postcode lotteries.

"I think those areas that have allowed uptake of service, that can improve consistency. There could be high student locations, young people who don't go to the GP or dentists, opticians. So, having an accessible team approach offered consistency to all Londoners. We don't want levelling down."

At the same time, there was some debate around whether each borough would need to establish the same set of teams for its population, with some participants reflecting that integrated neighbourhood teams being set up differently across London and tailored to suit the needs of each borough would be more sensible. They recognised that some boroughs have an older population, some have more drug problems, there are particular economically deprived areas, and areas with a high rate of people with English as a second language.

"Consistency between areas and equity between boroughs is a big thing."

There was more agreement on the demographic groups, across the board, that would most benefit from team-based and person-centred care. These included children, vulnerable adults, those who tend to avoid seeking care, those on very low incomes, homeless people and asylum seekers.

There is a role for care coordinators to provide continuity and communication to patients.

While it felt intuitive to participants for GPs to fulfil the necessary coordination role for patients within the context of integrated neighbourhood teams, this was deemed unfeasible and burdensome. Instead, and prompted by a suggestion of an alternative to this, participants were keen to see care coordinators take on this role. Excellent project management and communication skills were seen as paramount for care coordinators to have. Patient Advocates also raised the importance of care coordinators understanding safeguarding issues, cultural sensitivities and trauma informed approaches.

“If people aren’t aware that somebody is traumatised and may be acting and behaving in ways affected by that trauma, for example, they might be misinterpreting somebody’s behaviour as aggressive or if somebody doesn’t turn up for appointment, they get taken off the books because they didn’t realise that this is a typical manifestation of post-traumatic stress”

However, there was lots of debate around whether they would also need to have medical training. One view was that this role is all about coordination and administration, so as long as they were well linked in, care coordinators wouldn’t need to understand the medical side of patient care. The other view was that *some* medical training would be useful so that they can point patients in the right direction and interpret outcomes for the patient.

Integrated neighbourhood teams should be rolled out cautiously, with pilots to help the system learn and adapt along the way, with good regulation and a set of considerations in place to account for the kinds of groups they will serve.

Linked to earlier concerns raised around funding and the feasibility of this way of working, participants were curious to learn from other areas who had already started to rollout neighbourhood team working. They called for adequate funding, strong leadership, clear transition plans, and a cautious rollout with borough-based pilots to help the NHS learn and adapt along the way.

Participants also perceived there to be additional risks associated with accountability, and they spoke about regulation a lot to this effect. While they understood that individual professions and organisations were regulated, participants wondered if there needed to be an integrated regulatory function in place over and above this.

“It needs a central authority that is highly regulated, and the quality needs to increase. All the privatisation has blocked the communication.”

Beyond regulation, there were a set of considerations voiced around how these teams would operate given the kinds of populations in mind which they would serve:

- **Patient empowerment and agency:** An emphasis on patient empowerment, agency and choice was important to participants and some suggested efforts to improve patient education and confidence in self-management of their conditions too.

- **Equitable access to neighbourhood teams:** Access would need to be equitable across different demographic groups with participants suggesting home visits for those who need these, transportation assistance, and proactive inquiries from the NHS to assess patients' needs. Particular consideration should be given to patients who don't have one 'fixed' neighbourhood including the traveller community, care leavers, asylum seekers and homeless people.

“I would just want to see that there was at least some consideration being given to people whose lives are not borough specific and a way of, you know, accessing this kind of service without being able to prove that you live in a particular borough...in the last year I've 'lived' in eight different London boroughs.”

- **Digitally enabled and connected neighbourhood teams:** Co-located teams were seen as preferable and convenient for patients, but participants recognised this might not always be feasible and thus instead voiced that teams would need to be digitally connected. If the data is all in one place, the professionals don't need to be. As well, there was recognition that it is acceptable to travel a bit further to receive specialist care, but that no one should need to travel that far within a borough.

“Practically, getting them in the same place isn't going to happen”.

There was unanimous support for proactive care however community outreach initially received a negative response given assumptions around the likely cost vs benefits.

The concept of proactive care had universal support from participants. It felt completely sensible, made economic sense for the NHS to strive towards this going forward given the strain on resources, and some participants deemed this agenda long overdue.

“I think the idea of a proactive approach is very good because it will prevent a lot of spending in the future”.

However, there were concerns around how proactive community outreach could be costly to the NHS. In particular, the example of door knocking felt like high cost for little return, and also might not be effective because of trust issues within communities.

“There are community groups better placed to deliver that service. Some people won't answer the door to strangers, access would be better if from a recognised person.”

There was a feeling (expressed by some, and because of trust issues) that people should be able to opt out of this proactive outreach which involves going to people's homes. After deliberation, participants concluded that outreach should be very targeted to areas/populations where the need is greatest.

Given the anticipated need for increased data sharing across organisations, and the vulnerable populations involved, data security and privacy must be prioritised.

Participants quickly inferred that to make this way of working successful, data would need to be shared across multiple organisations, including community/voluntary and social care organisations which heightened anxiety for some. As well, given the assumed vulnerable populations involved, and the sensitivity of medical records, participants stressed the importance of increased data security and

transparency over who has access to what information and why. This was a particularly consistent expectation amongst Patient Advocates.

“There is an increased risk of data insecurity due to the number of organisations that would be involved.”

Given this, and the expectation that neighbourhood teams would need to be digitally enabled and connected, participants felt that patients should be able to opt out of data being shared to support team-based care with the consequences of doing so clearly explained to anyone who desires this.

“Some Trans people fear been outed in the community, or more people than necessary knowing that they're trans. For trans people having a bit of control about who can know that is a concern for people. It's about that choice and people knowing what information would be shared, who will have access to it, and having the option to opt out of that”

Summary of team-based-working and proactive care expectations

Support for the NHS rolling out integrated neighbourhood teams at a borough level⁴ to provide joined up, holistic and person-centred care for certain patient groups or populations. It is important to ensure that there is continuity for patients (using good records) and GPs should continue to have access to the wider records.

Access to INTs should be via GP or self-referral and should be for high-risk groups including; old and very young, homeless people, children in care and patients with special needs or certain diseases. Support should be available for people who can't travel (e.g. offers of transport and home visits).

The job of **care liaison officers (who do co-ordination) is not to make medical decisions** – they will direct patients' care based on what they hear from the health professionals. They do not need to be medically trained, but should be trained in diversity and inclusion, customer service, mental health, and trauma.

INTs should be digitally and data enabled: so long as the data is all in one place, the professionals don't need to be. Given the potential extent of data sharing between individuals and organisations, patients should be given a choice around whether their care is managed by an INT.

There needs to be a consistent base level of care across London so that patients understand the system and don't see a change in quality of care if they move house. However, individual boroughs can then be flexible to meet specific extra needs locally.

⁴ Please note that the final expectation wording refers to integrated neighbourhood teams 'operating' at a borough level. However, in discussions participants specified that this means planning and rolling out these initiatives at a borough level. The wording of the expectation has not been edited, as this is the wording that was voted on by participants.

This new way of working should be piloted in more deprived areas and with specific audiences to test appetite and should be independently reviewed. Beyond this initial period, there should also be ongoing monitoring and regulations as well as incentives for organisations to work together.

Proactive outreach should be focused on vulnerable populations and those who don't currently engage with services, and those in most need (e.g. homeless people, young people, the elderly, asylum seekers, those with English as a second language, with mental health conditions).

84% of participants voted that they support 'all' or 'most' of these expectations.

This is a summarisation of the key expectations formed during workshops, to improve accessibility in this report. See the full list of expectations and voting responses in Appendix I.

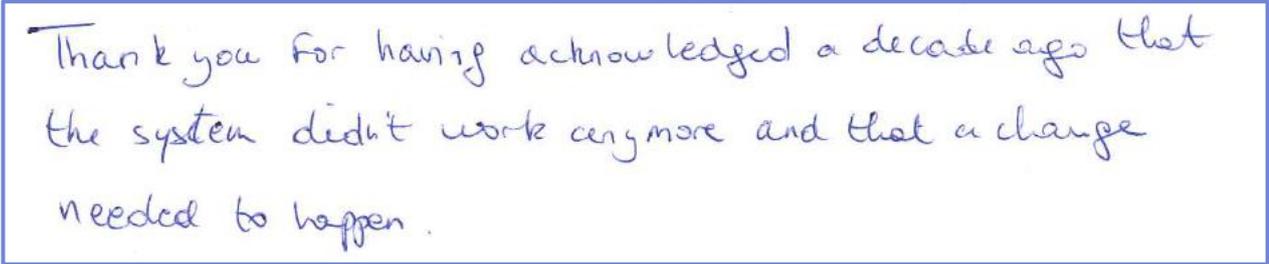
Key messages

This final chapter summarises some of the key messages that came through in the deliberative engagement concerning potential future changes to primary care service delivery. Throughout we weave in participants' own hopes and fears gathered during a projective exercise they did at the end of workshop 3 where participants were asked to write a letter from their future self, from the year 2034, describing what primary care services looked and felt like. We include excerpts from these letters below.

There is recognition that the system cannot continue as it is, and in turn there was a real openness to change.

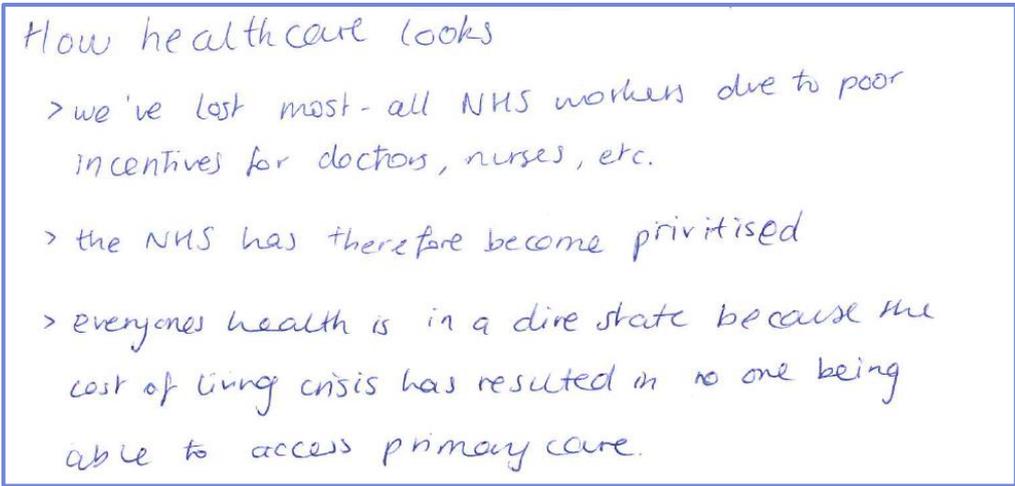
Participants immediately recognised and understood the case for change. Their own and others' experience of primary care demonstrated to them that things cannot continue as they are given stretched capacity, a lack of funding within the system and poor patient experience. They engaged with the information presented that built on their own experiences, connecting to the concepts of health inequalities, but also comprehended that increased funding alone cannot solve the issues.

There was acceptance that to meet the needs of patients going forward, large and potentially radical changes are needed. Even where participants held concerns and scepticism, they tended to support the overall changes suggested, albeit with the conditions described within this report.



Thank you for having acknowledged a decade ago that the system didn't work anymore and that a change needed to happen.

Despite support for the changes, there was a high level of pessimism around the complexity within the system to be able to deliver real change (for example around integration), the available funding going into primary care, and the likeliness of improvements in workforce recruitment and retention. In their letters from the future, there were references to GPs continuing to be stretched and overworked in 2034, staff continuing to leave the NHS as well as hints from some that privatisation of NHS services could be introduced due to unaddressed challenges.



How healthcare looks

- > we've lost most - all NHS workers due to poor incentives for doctors, nurses, etc.
- > the NHS has therefore become privatised
- > everyone's health is in a dire state because the cost of living crisis has resulted in no one being able to access primary care.

There is enthusiasm for the opportunities that digital and technology can offer to the primary care system.

This engagement saw strong support for the development of improved digital access routes to primary care. For patients who are willing and able, digital access routes should be maximised and consistently adopted across practices and boroughs. Aside from the opportunities related to efficiencies for the primary care system, participants were enthusiastic about the convenience and choice improved digital access routes could create.

In participants' letters from the future, positive depictions of the year 2034 often detailed the ease and convenience of accessing primary care using digital routes (notably via the NHS App), an eradication of current long waiting times to get through to GP practices and references to increased functionality within the NHS App (and online more generally), such as the ability to book GP appointments, view blood test results and access medical records directly no matter which borough you live in and receive care.

- I can book GP Appointment easily through NHS App.
- In NHS App, I can see my medical history, they will also send me a reminder of check ups.
- I can go to the community hub anytime (not just a pop up in 2034) if I have multiple issues. I can get all the help I want at the same day.
- I feel positive about the direction we are going, me and my kids are used to the new digitalized NHS system.
- My parents are able to access the comprehensive care NHS provide.

While maximising digital access, traditional access routes must be retained and kept easily accessible for those who need them.

While there was high support for increasing and improving digital routes to encourage take up for most patients, this support was strictly conditional on the preservation of traditional, non-digital access routes. These routes include walk-ins, phoning the surgery, or pressing a button on a digital access platform to be diverted to a speak to someone.

Aside from being maintained, these non-digital routes must be well communicated so those who cannot easily use digital routes know that they have alternative options, and they are not deterred from accessing care.

The limited awareness of wider primary care roles is likely to act as a barrier during a shift away from a GP-first model.

Participants were surprised and interested to learn about the wide range of professionals within primary care who are available to care for patients. It was clear that public education about the range of roles available, and their capabilities and specialisms, is important to build the trust necessary for acceptance of streaming patients to non-GP professionals in the future.

In their letters from the future, even where there was some nostalgia around the traditional GP family doctor model, participants' accounts of the future signalled a realisation that being treated by an appropriate healthcare professional for a person's needs was incredibly important.

I STILL
HAVE CONCERNS AS I HARDLY
SEE MY GP. BUT I FEEL I
HAVE THE NECESSARY TEAM
ROUND ME. I AM ABLE TO
GET THE RIGHT PERSON TO
SEE FROM THE START OF MY
APPOINTMENT.

It was very good to see my blood results
and know that I have been directed
from my healthcare team to see a
& dietitian as my diabetes needs
monitoring.

While participants were clear that a preventative approach to healthcare was long overdue, they remained sceptical about the feasibility of achieving this.

The theme of prevention, and the NHS taking a more proactive approach to delivering primary care services was well received and evident in participants' support for integrated neighbourhood team working to provide holistic care to those most in need. However, throughout discussions participants

recognised that these new ways of working will rely heavily on organisations working seamlessly together in the future to deliver care, which didn't always feel feasible. This scepticism came through in some of the letters from the future, where participants described different tensions between organisations and a persistent lack of communication and coordination between different healthcare professionals.

PATIENT
ALTHOUGH THE ~~PHYSICIAN~~ PSYCHIATRIST HAS CONTACTED THE GP PRACTICE NUMEROUS TIMES, ASKING FOR RESULTS, NO ONE IS RESPONDING TO THEIR CALLS. AND WHEN THE DIETICIAN HAS CALLED THE SOCIAL WORKER, NO ONE REPLIES. MY BROTHER'S HEALTH CONTINUES TO SUFFER AND THIS IS IMPACTING HIS MENTAL HEALTH TOO. WHY ARE THE TEAMS SO BAD AT COMMUNICATING WITH EACH OTHER? TO WHOM SHOULD I COMPLAIN?

Data security and privacy are important, so systems must be properly invested in, and safeguards communicated to build trust with the public.

Throughout this engagement, and unsurprisingly given the prominence of high-profile societal data breaches and a lack of awareness around the current rules in place concerning access to medical records, data security and privacy were very top of mind for participants.

In rolling out changes which involve an increased reliance on digital systems and AI, wider use of the whole primary care team, and care delivery across multiple organisations including social care and the third sector (i.e. integrated neighbourhood teams), the public will need reassurance that there has been adequate investment in robust and secure data systems. All measures, including existing data governance rules, must be transparently communicated in an accessible way so that the public can build trust in who can see their data, and how their data is kept safe.

Concern about unnecessary access to sensitive information and the risk of data breaches was prevalent throughout the workshops and came through in some of the letters from the future.

It was very hard to use my mobile/computer to log on to book an appointment and check my Medication. The internet keeps going down. My data was breached on my NHS App and I feel very nervous about all my private information being shared

The importance of patient choice

A final theme that came through the workshops as participants discussed potential changes to primary care services going forward was the importance of choice. There were clear expectations voiced around offering more agency to patients around their care and treatment. This was true across all areas discussed: for example, the option to choose to speak to a human during interactions with digital entry systems; and choice over whether to prioritise convenience or continuity depending on their personal circumstances. This might mean waiting longer for an appointment with their own GP if continuity was more important to a patient than the convenience of being offered an appointment sooner with another healthcare professional from the wider primary care team.

The health service is person-centred, which makes me happy as all the integrated health care have worked together with AI to make appointments convenient to me. The waiting hours is reduce as I have choice of what and time and who I can see. My treatment is great

Appendices

Appendix A: Stimulus all workshops

The full workshop stimulus can be downloaded [here](#).

Appendix B: Workshop 1 Discussion guide

Wednesday 10th July, 18:00-19:30

Workshop 1 (1.5 hours, online): Participants are introduced to primary care (how services are commissioned) and how it fits into the broader NHS. Participants are introduced to the options for change and the dilemmas system leaders are grappling with.

Timings	Setting	Activity	Objectives
17:30-18:00	Waiting room	Facilitators / observers / notetakers meet at 5.30pm.	n/a
18:00-18:05 (5 mins)	Plenary	Participants enter the virtual workshop and test audio/video settings, change screen names.	n/a
18:05-18:15 (10 mins)	Plenary	<p>Introduction (Ipsos Chair)</p> <ul style="list-style-type: none"> Welcome What to expect, overview of fieldwork What is deliberation? Why is this important? Housekeeping <p>A few words from Caroline Clarke, Regional Director for the NHS in London</p>	Introduce members of the public to the project and process, their role and how the findings will be used. Set the scene and stress the importance of participation. Explain delib and foster enthusiasm for their role in this process.
18:15-18:25 (10 mins)	Plenary	<p>Primary care presentation – Rebecca Rosen, Senior Fellow – Nuffield Trust</p> <ul style="list-style-type: none"> What is Primary Care and where does this fit in the NHS? Outline of roles and services, how they work together currently. Deep dive into general practice and its role in PC How services are commissioned / relation to the NHS. 	Inform participants about the scope of primary care services (first point of access to healthcare for most), but also explain how it operates and is funded.
18:25-18:55 (30 mins)	Breakouts	<p>Discussion: reflection on presentation (Facilitators)</p> <p>Welcome to our breakout room everyone. I'd like us to start by quickly introducing ourselves. Please can you each share:</p> <ul style="list-style-type: none"> Your name What part of London you live in Who is in your household? 	Gather initial awareness of primary care and experiences of receiving care. Explore continuity, convenience, consistency and choice (the 4 Cs) which we will return to throughout the workshops.

	<p>We are going to speak about ‘four C’s’ now, which will come back up throughout the workshops, so I’ll take a moment to introduce them now. FACILITATOR SHOW ‘FOUR C’S’ SLIDE.</p> <ul style="list-style-type: none"> • Convenience: this means being seen in a timescale, time or place which is convenient for you and your routine and travel options. This could mean more options of locations in London (e.g. nearer your work, rather than your home), or the option to have a virtual appointment so you don’t need to travel. • Continuity: this means familiarity with the person or team treating you, and all the professionals involved in your care having the right information about you. • Choice: having opportunities to make choice around your care. This might mean a choice between things: e.g. between digital and being seen in person, or; e.g. you might have the choice to be seen sooner by a different GP, or wait a bit longer to see your own GP. • Consistency (between one area and another): of approach across your neighbourhood, borough or London as a whole. If you receive care in a different borough (e.g. if you move house), how different will the process feel. <p>In the context of primary care...</p> <ul style="list-style-type: none"> • What does convenience mean to you and how important is this currently to you? • What does continuity mean to you and how important is this currently to you? • What does choice mean to you and how important is this currently to you? • What does consistency mean to you and how important is this currently to you? <p>What is most important to you when seeking or receiving primary care?</p>	
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18:55-19:05 (10 mins)	Plenary	<p>Case for change presentation – Charlotte Benjamin, Chief Medical Officer – North West London ICS</p> <ul style="list-style-type: none"> • Outlining the current challenges supported by data including widening health inequalities / outcomes gap • Why change is needed • Key dilemmas as we consider future ways of working • Reassurance that staff and leaders within primary care are committed to finding the best ways to overcome these challenges (ensure that the case for change and risk of doing nothing does not leave participants feeling too pessimistic to engage) 	Introduce participants to the case for change, while reassuring them that there is an opportunity to get this right by involving patients and the public in policy development and implementation.
19:05-7.28 (23 mins)	Breakouts	<p>Discussion on the case for change (Facilitators)</p> <p>How does everyone feel having listened to that presentation?</p> <ul style="list-style-type: none"> • What stood out to you? • Was the information surprising, or familiar? • Did the information make sense, or is there anything that you would like clarifying? <p>We heard about the key challenges facing primary care – how did this information compare to your own experiences of primary care?</p> <ul style="list-style-type: none"> • Do you notice these challenges in your own primary care experiences? • What do these challenges mean for people like you, but also other people? <p><u>Collect questions that people have as these can be answered during Saturday’s workshop</u></p> <ul style="list-style-type: none"> • 	Gather reactions to the case for change and experiences of some of the challenges shared. Explore, spontaneously, some of the ideas around how these challenges could be solved going forward, while pushing back where necessary (i.e. around funding, GP capacity).
19:28-19:30 2 mins for close	Plenary	<p>Wrap up (Chair)</p> <ul style="list-style-type: none"> • Thank and close • Reminder of next stage of fieldwork. 	Close the first workshop and remind participants of the next steps.

Appendix C: Workshop 2 Discussion guide

Saturday 13th July, 10:00-16:00

Workshops 2 and 3 (full weekend, in person): Participants deliberate the options for change, with [accessible stimulus](#) designed to draw out the trade-offs and elicit public expectations. There will be opportunity for Q&A with field specialists as well as hearing directly from people with lived experience. Participants will be mixed up again on tables so that they are exposed to a range of views.

Timings	Setting	Activity	Objectives
9:00-10:00	Plenary	Arrival and registration	n/a
10.00-10.05	Plenary	Participants seated	n/a
10:05-10:15 (10 mins)	Plenary	<p>Welcome presentation (Ipsos Chair)</p> <ul style="list-style-type: none"> Housekeeping What to expect Reminder of why their input is important <p>Introduce the patient journey, or pathway (initial access, triage/prioritisation, streaming and onward care, team based working and proactive care), and how this links to the participant journey and the workshops</p> <ul style="list-style-type: none"> Highlighting the stages of the journey we will be focusing on today (initial access and triage) Recapping on case for change / current challenges of the current system (specific to initial access and triage) 	<p>Remind participants of why we are here and orientate them with regards to the overall process.</p> <p>Introduce the patient journey or pathway.</p>
10:15-10:30 (15 mins)	Plenary	<p>Presentation: London's populations and needs – Datapwa Mujong</p> <ul style="list-style-type: none"> Outlining how populations and needs vary from borough to borough. Introduce concept of health inequalities and equitable outcomes. Input from those with lived experience: Quotes from parallel engagement with patient advocacy groups Explain the importance of thinking about all types of people, in all kinds of situations, where sometimes people's needs are not necessarily clinical. 	To explain the range and diversity within London's populations and to introduce the concept of health inequalities. TBC (in terms of how we do this) but to bring in the voices of those with Lived Experience from marginalised and vulnerable groups so that participants are encouraged to think beyond themselves and people like them. Slightly longer presentation (15 mins, not 10 like the others) to accommodate – and not rush through - the voice of lived experience.
10:30-11:00 (30 mins)	Tables	<p><u>Welcome and introductions at tables (10 mins) - Facilitators</u></p> <p>Welcome to our table! Before we get started let's do some quick introductions. Please can you each share:</p> <ul style="list-style-type: none"> Your name What part of London you live in <p><u>Discussion: London's populations and needs (20 mins)</u></p> <p>We just heard a bit about London's populations and needs, how this varies</p>	To allow participants to reflect on the range and diversity within London's population and also the needs of the many different groups. This is important so that they are encouraged to consider wider needs in their deliberations and, eventual, recommendations.

		<p>across London, and about health inequalities. What did you think about that presentation?</p> <ul style="list-style-type: none"> • Did anything stand out to you? • What do you think this means for planning the future of primary care in London? <ul style="list-style-type: none"> ○ Probe on some of the non-clinical factors presented: age, transport links, English language levels, mental health needs, Socio-economic status • Did the information about health inequalities make sense to you? • Why do you think health inequalities are important to consider as we think about the future of primary care services in London? <ul style="list-style-type: none"> ○ Facilitator gauge group understanding of this concept and clarify if needed. 	
11:00-11.15 (15 mins)	Gallery	Break (tea/coffee)	n/a
11:15-11.25 (10 mins)	Plenary	<p>Presentation: Access – Caroline Clarke, London Regional Director</p> <ul style="list-style-type: none"> • Introducing the proposed changes to access: increasing digital access for those who can use digital platforms but maintaining offline access routes for those who can't (i.e. digitally excluded, those with communication challenges). • Trade-offs: introduce some of the trade-offs at a high level. (<i>ability to better manage demand, consistency, easier and more convenient access for many, a more comfortable setting and freeing up capacity VS, loss of human element, limitations around what information can be collected, safeguarding risks, potential for a two-tiered system</i>) 	To introduce participants to initial access, and the increased use of digital to support a more sustainable primary care service going forward. To explore the trade-offs, benefits and risks
11:25-12:30 (1hr 5mins)	Tables	<p>Discussion: Access – Facilitators (30 mins)</p> <p>What did you think about the 'Access to primary care' presentation just now?</p> <ul style="list-style-type: none"> • What stood out to you? Why? • Did anything concern you? Why? • Did anything make you feel hopeful? Why? <p>We heard that one ambition is to increase the use of digital access routes for most patients (while keeping offline routes for those who might need them):</p> <ul style="list-style-type: none"> • How do you feel about this ambition? • READ THROUGH HOMERTON HOSPITAL EXAMPLE • What concerns would you have in using an app/website, a digital pod or a 	Encourage participants to discuss and deliberate the inherent trade-offs that decision makers are grappling with, and voice what matters most to them and what would need to be in place (as they talk through different example patient journeys and reflect on the voice of lived experience).

		<p>centralised number to access primary care? (Remember, offline options would still be available)</p> <ul style="list-style-type: none"> • What would encourage you to use these digital access routes? <ul style="list-style-type: none"> ○ What would be needed to make it easy? (capability) ○ What would you want to be able to do via an App or website, or digital pod? (opportunity) ○ What would be needed for digital routes to be a more appealing option, rather than phoning or walking in? (motivation) • How can offline routes be most accessible and useful to those who can't use digital routes? <p>For all changes there would be some key benefits and opportunities, and some risks or downsides. These 'trade-offs' should be balanced as best as they can be, to ensure that the overall change is acceptable.</p> <p>Let's think about those key trade-offs are.</p> <p>DURING THIS DISCUSSION, FACILITATOR WRITE THE TRADE-OFFS IDENTIFIED ON THE FLIP CHART</p> <p>What are the key positives here?</p> <p>How important/valuable is this benefit? Who will this benefit the most? How might this help the whole primary care system work better?</p> <p>What are the potential risks or downsides?</p> <ul style="list-style-type: none"> • How significant would this be if it happened? • What could be done to avoid or minimise this risk/downside? • Who would be affected? <p>FACILITATOR PRIORITISE SPONTANEOUS SUGGESTIONS, BUT IF NEEDED PROMPT WITH THOSE SHARED IN THE PRESENTATION.</p> <p>Last time we spoke about the four C's: let's revisit them now. FACILITATOR POINT TO PRINT-OUT OF FOUR C'S.</p> <p>When thinking about accessing primary care, which is the MOST important of these four C's?</p> <ul style="list-style-type: none"> • Why is this the most important? What is the impact if this is not in place? • Is this always the most important? What if your need is: <ul style="list-style-type: none"> ○ Urgent / not-urgent 	
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		<ul style="list-style-type: none"> ○ Routine / not-routine ○ Sensitive or personal ○ What if you are unsure what the issue or your needs are? <p>If these changes were put in place tomorrow, what would you want to know so that you could have trust in the quality of the care you'd receive?</p> <p>IF NEEDED, FACILITATOR REFER BACK TO ANY CONCERNS THEY RAISED AT THE BEGINNING OF THIS DISCUSSION</p> <ul style="list-style-type: none"> ● Why might this affect your trust in the process? ● What could help build your trust in this? <p><u>Activity: patient personas (35 mins)</u></p> <p>We've just discussed how changes to access may affect us, and our own feelings about the four C's, but it is important that we also consider the needs and priorities of other patients, so that we can make recommendations that are best for all citizens of London.</p> <p>To help us do this, we are going to now meet some example patients:</p> <p>FACILITATOR SHOW AND TALK THROUGH EACH PERSONA – 3 PER TABLE ACCORDING TO PRE-SET ROTATION.</p> <p>For each persona, probe:</p> <ul style="list-style-type: none"> ● What might make it harder/easier for them to access primary care? ● Which of the four C's might be most important to this patient, during the access stage? Why? ● What route might they prefer to use, and why? (phone call, walk-in, practice website, NHS App, digital pod, centralised phone number) ● What might encourage them to use digital routes? <ul style="list-style-type: none"> ○ What would make it easy? (capability) ○ What would they want to be able to do via an App, website or digital pod? (opportunity) ○ What would be needed for digital routes to be a more appealing option, rather than phoning or walking in? (motivation). ● Can you think of any risks associated with digital routes that we haven't already talked about: PROBE: people might go straight to urgent care; people 	
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		<p>might fall through the cracks; digital requests being actioned in a suitable amount of time.</p> <ul style="list-style-type: none"> Looking back at the trade-offs we discussed, how might these patients be affected by them? Do these patients make you think of any other trade-offs? <p><u>Person specific prompts – swapping the actors and the factors:</u></p> <ul style="list-style-type: none"> <u>Someone with ESL:</u> what if Janike was someone worried about calling a centralised number (just wanting to get through to their own GP) / what if Janike was able to access the NHS App and someone who would prefer to report their symptoms that way. <u>Someone with a ongoing headache:</u> What if Meghan was someone who was very anxious, especially about health related symptoms / what if Meghan was older and lived alone. <u>Elderly patient with a UTI:</u> What if Michael didn't have someone to drive him / What if Michael was a young female who was almost certain that she had a UTI given that she gets them regularly and is very time poor so wants a quick response <u>Teenager in MH crisis:</u> What if Jai was someone who was being domestically abused at home, and was worried about using a phone or an App. <u>Child with fever:</u> What if the child was much older (say 12) and Li was a working full time and would prefer not to have to take time out of work to take him in person but still wants to speak to someone about the child's condition. <u>Someone visiting London from out of town:</u> What if Jackson lived in London and valued the relationship with his registered GP practice. <u>Teenager seeking contraception:</u> What if Jasmine was worried about whether she had consented to intercourse with a boyfriend who is much older than her, and wanting to speak to someone about this / what if Jasmine was concerned that the pharmacist wouldn't have anywhere private to discuss her needs. 	
12:30-12:45 (15 mins)	Plenary	Feedback of emerging themes from breakouts	To allow participants to hear the range of views across the whole room.
12:45-13:45 (60 mins)	Gallery	Lunch (Participants encouraged to add questions to a 'question wall' via post-it notes, so the team can review for any needed clarifications)	n/a

13:45-13:55 (10 mins)	Plenary	<p>Presentation: Triage and prioritisation – Will Huxter, Regional Director of Commissioning, NHS England – London Region</p> <ul style="list-style-type: none"> • Explain what triage is. • Implementing joined-up digital systems and databases. This includes easier sharing of patient records to support triage and prioritisation. • Improved prioritisation and routing of cases after initial contact. This may include using automation and AI tools to support initial routing/prioritisation. • A more consistent approach to triage 	To introduce participants to the concept of segmenting patients according to their need (i.e. prioritisation) to support a more sustainable primary care service going forward. To introduce the role of AI tools in supporting decision making.
13:55-15:00 (1hr 5 mins)	Tables	<p><u>Discussion: triage and prioritisation (30 mins)</u></p> <p>What did you think about the ‘triage and prioritisation’ presentation just now?</p> <ul style="list-style-type: none"> • What stood out to you? Why? • Did anything concern you? Why? • Did anything make you feel hopeful? Why? <p>We heard that they key ambition here is to quickly assess the needs of a patient, and how urgent their need is, using digital tools to support decision making, more joined-up data, and a consistent approach to triage.</p> <ul style="list-style-type: none"> • How do you feel about this ambition? • What factors (aside from clinical need) should influence triage decisions? <p>How do you feel about digital tools (including some AI), being used to support the triage decision making process?</p> <ul style="list-style-type: none"> • What tasks would you feel comfortable with AI tools supporting? What tasks would you feel are going too far with AI? • Would this affect any of the four C’s? • What would you want to know to have trust that this would result in good quality care? <p>How do you feel about more joined up data, so that more information about patients is available to support triage?</p> <ul style="list-style-type: none"> • What would you want to know to have trust that this would result in good quality care? • Would this affect any of the four C’s? <p>How do you feel about more consistency in the triage process?</p> <ul style="list-style-type: none"> • Would this affect any of the four C’s? • Thinking about triage, where do you feel consistency is most/least important? • What would you want to know to have trust that this would result in good quality care? <p>Activity: Patient personas (35 mins)</p>	Encourage participants to discuss and deliberate the inherent trade-offs that decision makers are grappling with, and voice what matters most to them and what would need to be in place (as they talk through different example patient journeys and reflect on the voice of lived experience).

		<p>Now we are going to repeat our example patient persona activity, as we did for access. Then at 3pm we will have a break.</p> <p>FACILITATOR SHOW AND TALK THROUGH EACH PERSONA – 3 PER TABLE ACCORDING TO PRE-SET ROTATION.</p> <p>For each persona, probe:</p> <ul style="list-style-type: none"> • What information would be important to consider during the triage process for this patient? <ul style="list-style-type: none"> ○ Clinical and non-clinical factors? • Which of the four C’s might be most important to the triage decisions for this patient? Why? • (IF RELEVANT) How might joined up data sets affect the triage decisions for this patient? How might this patient feel about that? • (IF RELEVANT) How might automated tools, such as AI tools, affect this patient’s triage process? How might this patient feel about that? <p>Well done everyone – we are going to pause for a refreshment break now. Please come back here at 3.15pm.</p>	
15:00-15:15 (15 mins)	Gallery	Break (tea/coffee)	n/a
15:15-15:40 (25 mins)	Tables	<p><u>Continued triage and prioritisation discussion... (25 mins)</u></p> <p>Ok, lets reflect again on the point around consistency in triage. Having discussed the personas...</p> <ul style="list-style-type: none"> • Where might consistency in the triage process feel more/less important? Why? • Which parts of the triage process should /should not be consistent? Why? <p>In this final session of the day, we are going to consider the benefits and concerns related to different potential changes to the way triage is done.</p> <p>DURING THIS DISCUSSION, FACILITATOR WRITE THE TRADE-OFFS IDENTIFIED ON THE FLIP CHART</p> <p>Digital tools to support decision making (refer to slide with benefits and concerns)</p> <ul style="list-style-type: none"> • How do we feel about the benefits listed here? Can you think of any other benefits that are not listed here? • And how do we feel about the concerns? Can you think of any other concerns? 	As above

		<ul style="list-style-type: none"> To what extent do the benefits outweigh the concerns, or vice versa and why? <p>Data being joined up across services</p> <ul style="list-style-type: none"> How do we feel about the benefits listed here? Can you think of any other benefits that are not listed here? And how do we feel about the concerns? Can you think of any other concerns? To what extent do the benefits outweigh the concerns, or vice versa and why? <p>A consistent triage offer</p> <ul style="list-style-type: none"> How do we feel about the benefits listed here? Can you think of any other benefits that are not listed here? And how do we feel about the concerns? Can you think of any other concerns? To what extent do the benefits outweigh the concerns, or vice versa and why? 	
15:40-16:00 (20 mins)	Plenary	<p>Wrap up – Chair</p> <ul style="list-style-type: none"> Chair summarise key themes they have observed over the day Specialists respond to key questions from the question wall Chair thanks everyone and says what to expect tomorrow 	Close the first workshop and remind participants of the next steps.

Appendix D: Workshop 3 Discussion guide

Sunday 14th July, 10:00-16:00

Workshops 2 and 3 (full weekend, in person): Participants deliberate the options for change, with [accessible stimulus](#) designed to draw out the trade-offs and elicit public expectations. There will be opportunity for Q&A with field specialists as well as hearing directly from people with lived experience. Participants will be mixed up again on tables so that they are exposed to a range of views.

Timings	Setting	Activity	Objectives
9:30-10:00	Plenary	Arrival and registration	n/a
10.00-10.05	Plenary	Participants seated	n/a
10:05-10:15 (10 mins)	Plenary	Welcome presentation (Chair) <ul style="list-style-type: none"> Housekeeping What to expect Reminder of why their input is important Recap from previous day Recap of the participant journey presented in Workshop 2 Highlighting the stages of the journey we will be focusing on today (streaming, receiving care, team based care and proactive care) Recapping on case for change / current challenges of the current system 	Remind participants of why we are here and orientate them with regards to the overall process.
10:15-10:35 (20 mins)	Tables	Welcome and introductions at tables (10 mins) Welcome back everyone! Let's do some quick introductions before we begin. Please may you each share: <ul style="list-style-type: none"> Your name What borough of London you live in? <u>Reflections on Workshop 2 (10 mins)</u> Since yesterday's workshop, has anyone had any reflections, or come to today's workshop with any new thoughts or questions? <ul style="list-style-type: none"> What stood out to you from yesterday's discussions? 	To explore participants initial reflections to what they have heard.
10:35-10:55 (20 mins)	Plenary	Presentation: Streaming, redirection and onward care - George Verghese, Primary Care Partner Member, South East London ICB <ul style="list-style-type: none"> Directing patients directly to the right service when appropriate, sometimes without a GP appointment first (e.g. a physiotherapist, mental health team, pharmacist). Use same day access hubs as an example. Recap of the range of roles within primary care: Pharmacist, physio, podiatrist, social prescriber, OT etc Prerecorded video lightning talks from some of these roles. How might their way of working change, what are they capable of that participants might not know. <ul style="list-style-type: none"> Community pharmacist Allied Health Professional Physician Associate 	To introduce participants to streaming and onward care, and the increased utilisation of the wider primary care team to support a more sustainable primary care service going forward. To explore the trade-offs, benefits and risks. Slightly longer presentation (20 mins instead of 10 like most of the others) to accommodate the video lightning talks.

<p>10:55-11:10 (15 mins)</p>	<p>Gallery</p>	<p>Break (tea/coffee)</p>	<p>n/a</p>
<p>11:10-12:30 (1hr 20mins)</p>	<p>Tables</p>	<p><u>Discussion: Streaming, redirection and onward care (40 mins)</u></p> <p>When do you feel a GP appointment is <u>most</u> important? Why?</p> <ul style="list-style-type: none"> • When is it important that you see your own GP, rather than another GP nearby? Why? • How would you feel about being directed to a GP at a different practice, if it meant you had an appointment sooner? <ul style="list-style-type: none"> ○ What would make you feel more comfortable with this? • Can you think of groups of people or individuals who might really value seeing their own GP, and why? And what about groups of people or individuals who might be more comfortable seeing a GP at a different practice, and why? <p>FACILITATOR SHOW PRIMARY CARE WORKFORCE HANDOUT</p> <p>How do you/do you think others might feel about being redirected to a different professional/specialist, without a GP appointment first?</p> <ul style="list-style-type: none"> • When would this feel fine to you? Why? • When would this not be ok for you? Why? • Do you feel differently depending on what professional that is? • If you were offered the choice of going straight to the appropriate specialist, and being seen sooner, or waiting to see your GP first, what do you think you/others might do or consider? <ul style="list-style-type: none"> ○ What would you want to know to have trust that this would result in good quality care? ○ What would make you feel comfortable going straight to another professional, without a GP appointment? ○ What would encourage you to do so? <p>How would you feel about being seen virtually, through a video call or phone call, whether that be with a GP, or another professional?</p> <ul style="list-style-type: none"> • When would that feel ok to you? • When would this not be ok for you? Why? <ul style="list-style-type: none"> ○ What would you want to know to have trust that this would result in good quality care? <p>Let's think about the four C's again. FACILITATOR POINT TO PRINT-OUT OF FOUR C'S.</p>	<p>Encourage participants to discuss and deliberate the inherent trade-offs that decision makers are grappling with, through a prioritisation exercise and voice what matters most to them and what would need to be in place (as they talk through different example patient journeys and reflect on the voice of lived experience).</p>

	<p>When thinking about which professional you see, how and when you see them, which is the MOST important of these four C’s?</p> <ul style="list-style-type: none"> • Why is this the most important? What is the impact if this is not in place? • For which patients or groups might consistency and continuity be most important and why? (SPONTANEOUS FIRST THEN PROBE ON: people with long term conditions, mental health problems, families with complex needs) • Is this always the most important? What if your need is: <ul style="list-style-type: none"> ○ Urgent / not-urgent ○ Routine / not-routine ○ Sensitive or personal ○ What if you are unsure what the issue or your needs are? <p><u>Activity: Getting patients to the right professional for their needs (50 mins)</u></p> <p>Now we are going to stop thinking as patients for a moment, and we are going to imagine we are professionals in the primary care system. We have a series of patients who we know a small amount about following their triage process.</p> <p>FACILITATOR PIN PATIENTS TO FLIPCHART</p> <p>We have a range of different options that we can offer each of these patients.</p> <p><u>Don’t worry – we are not aiming to make clinical decisions here, we are not doctors!</u></p> <ul style="list-style-type: none"> • We want to see which patients might be able to go straight to a suitable specialist, which might need a GP first, or maybe another solution. • We’ll be discussing <u>when</u>, <u>where</u> and <u>how</u> they might be able to do so. • We’ll be thinking of the four C’s, and discussing what needs (other than clinical) should be considered. <p>FACILITATOR HAND OUT OPTIONS BOXES.</p> <p>What do we think the best solution is for each of these patients?</p> <p>Facilitator prompt participants to ‘think aloud’, and ask them to explain each decision, or explain when they are stuck, why they are stuck.</p> <ul style="list-style-type: none"> • Why have you chosen this option for this patient? • What factors/characteristics are you thinking about when making a decision? • Is there more information you would find helpful to make the decision easier? <p>Challenge, if they have not used some options, or overused others:</p> <ul style="list-style-type: none"> • Why haven’t you used this option? 	
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		<ul style="list-style-type: none"> ○ What would you need to know to have confidence directing a patient here? ○ What might this patient feel comfortable with this solution? ● You've used this option a lot: <ul style="list-style-type: none"> ○ Why does this feel like the right option more often than other options? ○ What are you concerned about with other options? ○ Do you think some of these patients could receive different outcomes instead? <p>Probe 'what if's' to explore how actors/factors change decisions:</p> <ul style="list-style-type: none"> ● What if...Arna wasn't 3, but instead 10 and could communicate what happened. Would that change your decision? ● What if...Bea was not receiving chemotherapy. Would that change your decision? What if...Bea does not wish to travel for an appointment, as she is feeling unwell due to her chemotherapy? Would that change your decision? ● What if...Chidi was autistic and finds it hard to communicate, especially with new or unfamiliar people. Would that change your decision? ● What if...Patrick was younger? Would that change your decision? What if...Patrick works full-time and his job is not very flexible around taking time off for appointments? Would that change your decision? ● What if...Jill was very anxious about seeing anyone other than their GP. Would that change your decision? What if this is the third issue Jill has raised in the last two months when she is normally a low-level user of services. Would that change your decision? ● What if...Yarik's first language was not English. Would that change your decision? ● What if...Matt was about to go travelling and wants to speak to someone about his situation before he goes? Would that change your decision? ● What if...Prita had dementia and lived alone. Would that change your decision? What if Prita was taking medications for something less personal. Would that change your decision? ● What if...Alice lived alone. Would that change your decision? What if Alice was 50, rather than 80. Would that change your decision? ● What if...Noah's family did have a car. Would that change your decision? ● What if...Greg hadn't already tried self help. Would that change your decision? ● What if...Zeireen was not already diagnosed with asthma and these were new symptoms. 	
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		Would that change your decision? What if Zeireen had more severe asthma and has had episodes in the past where she has ended up in hospital. Would that change your decision?	
12:30-13:30 (60 mins)	Gallery	Lunch	n/a
13:30-13:40 (10 mins)	Plenary	<p>Presentation: Team based working (i.e. Integrated Neighbourhood teams) and proactive care - Agatha Nortley-Meshe - London Regional Medical Director for Primary Care</p> <ul style="list-style-type: none"> • Introduce the concept of team based working and what this could look like • Explain how this is different from now, and the goal. • Explain how this fits with the rest of onward care • Introduce some of the dilemmas / choices that decision makers are grappling with to invite participants to grapple with them too 	To introduce participants to streaming and onward care, and the idea of utilising care teams to provide holistic care to particular groups of patients. To explore the trade-offs, benefits and risks.
13:40-14:15 (35 mins)	Tables	<p><u>Discussion: Team based working and proactive care (30 mins)</u></p> <p>What did you think about the presentation just now?</p> <ul style="list-style-type: none"> • What stood out to you? • Did anything concern you? • Did anything make you hopeful? <p>We've heard about the aim for these teams to provide more 'holistic' care, centred around the patient rather than – by default – the GP.</p> <ul style="list-style-type: none"> • What did you think about this ambition? • Can you think of any benefits/downsides? • How important, if at all, does this holistic approach seem to you? • How important, if at all, is it that these different organisations are better integrated so that they can work together as one team? • Who might benefit the most from this approach? Who might be at a disadvantage? Why? • Do you have any concerns about this new way of working? <p>Thinking about <i>how</i> these teams would work presents a number of different options.</p> <ul style="list-style-type: none"> • What are your thoughts around how to determine who is most appropriate for integrated neighbourhood team based care? (clinical condition or other characteristics?) Why? • For patients receiving care from integrated neighbourhood teams, how important/unimportant is it for teams to be co-located (which might mean some patients have to travel further)? What about if they 	Encourage participants to discuss and deliberate the inherent trade-offs that decision makers are grappling with, and how wider use of care teams could lead to a more sustainable primary care service which better addresses patients holistic needs. Explore what matters most to them and what would need to be in place (as they talk through different example formats of team based working).

		<p>were connected virtually instead (which might mean that some patients don't have to travel as far?)</p> <ul style="list-style-type: none"> • For patients receiving care from integrated neighbourhood teams, what are your views on who should coordinate the care? (care coordinators or GPs)? What would be the implications of this? • And what about continuity for patients given that they might be cared for by teams? How important is this and who would provide that continuity? • How might the integrated neighbourhood team way of working improve or worsen health inequalities? Why? How important is this? <p>Q&A prep (5 mins)</p> <ul style="list-style-type: none"> • Agree 1-2 questions for the Q&A 	
<p>14:15-14:30 (15 mins)</p>	<p>Plenary</p>	<p>Rapid Q&A</p>	
<p>14:30-15:00 (30 mins)</p>	<p>Tables</p>	<p><u>Discussion: Team based working and proactive care (continued) 30 mins</u></p> <p>How might the Four C's be important when planning how integrated neighbourhood teams are set-up?</p> <ul style="list-style-type: none"> • How can teams improve convenience? What risks are there to convenience? • How can teams improve continuity? What risks are there to continuity? • How can teams improve choice? What risks are there to choice? • How can teams improve consistency? What risks are there to consistency? • Which of the four C's might be most important for patients cared for by these teams? <p>What support or information might patients need to adjust to this model, if they are cared for by an integrated neighbourhood team?</p> <ul style="list-style-type: none"> • What might they need to know to have confidence that this approach will result in quality care for them? • What concerns may they have? <p>Lets think now about proactive care (15 mins)</p> <ul style="list-style-type: none"> • What are your thoughts on the different models for a more proactive approach to care, sometimes reaching those who might not usually access services? • As you can see, the resources could be quite substantial. How do you feel about this, especially given that this would mean taking resource away from somewhere else? <p>We are going to have quick comfort break now. Please come back here by 3.15pm.</p>	

15:00-15:15 (15 mins)	Gallery	Break (tea/coffee)	n/a
15.15-15.35 (20 mins)	Tables	<p><u>Discussion: Team based care and proactive care (20 mins)</u></p> <p>We are going to spend the last session in our tables looking at the trade-offs around team based care and proactive care.</p> <p>DURING THIS DISCUSSION, FACILITATOR WRITE THE TRADE-OFFS IDENTIFIED ON THE FLIP CHART</p> <p>What are the key benefits here?</p> <ul style="list-style-type: none"> • How important/valuable is this benefit? • Who will this benefit the most? • How might this help the whole primary care system work better? <p>What about the potential trade offs?</p> <ul style="list-style-type: none"> • How significant would this be if it happened? • What could be done to avoid or minimise this risk/downside? • Who would be affected? <p>FACILITATOR PRIORITISE SPONTANEOUS SUGGESTIONS, BUT IF NEEDED PROMPT WITH THE FOLLOWING TRADE-OFFS:</p> <ul style="list-style-type: none"> • + <i>utilising the wider workforce</i> • + <i>more joined up care</i> • + <i>holistic, person centred care</i> • + <i>reduction of health inequalities</i> • + <i>minimalising hand offs and referrals</i> • - <i>lack of continuity for some</i> • - <i>shift away from 'family doctor' model</i> • - <i>some may have to travel further to access care</i> • - <i>organisational cultures, systems and infrastructure</i> • - <i>information sharing across teams/organisations</i> <p>Looking at these positives and downsides, how do you feel about the overall ambition?</p> <ul style="list-style-type: none"> • What are the key things you would want NHS leaders to keep in mind when planning how to implement team based care? 	As above.
15:35-16:00 (25 mins)	Plenary	<p><u>Letters from the future (Chair to lead) (20 mins)</u></p> <p>Welcome back for the final session of the weekend! Well done everyone, we are so grateful for the hard work you have put into these discussions!</p> <p>To round off the weekend we are going to do one last activity in this room.</p> <p>I'd like you to imagine you have time travelled forwards 10 years. Take a moment to imagine what primary care could or should look like then,</p>	Allows participants to 'come out' of the deliberation and summarise in their own words/images what they would like the future to look like in terms of how people receive primary care. This powerful, participant led activity is fun and is not only a nice way to close, but also creates material for

	<p>how might we have solved the challenges facing primary care today?</p> <p>I'd like you to then use the paper on your tables to write a short letter from the future describing how the primary care system has changed, and how it feels to be a patient in the future.</p> <p>If you would do prefer not to write, feel free to draw a picture.</p> <p>CHAIR GIVES 10 MINS FOR PARTICIPANTS TO DO THIS. FACILITATORS FLOAT AROUND THE ROOM, ENCOURAGING ANYONE WHO LOOKS STUCK.</p> <p><u>Wrap up and close (5 mins)</u></p> <p>Thank you again everybody!</p> <p>A few words from NHSE London representatives</p> <p>A reminder that the next and final workshop is here, on the 27th July. We really look forward to seeing you again then, and hope you are well in the meantime.</p>	<p>analysis and snippets of their work can be included in the outputs.</p>
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Appendix E: Workshop 4 Discussion guide

Saturday 27th July, 10:00-16:00

Workshop 4 (full day, in person): Following an analysis of previous discussions (using live transcriptions which aid more detailed and thorough analysis), we will play back a set of draft expectations for participants to refine in small groups. Our tried and tested process enables the generation of [granular expectations](#), which decisionmakers find incredibly useful when translating findings into implementation. Consensus voting, and the capture of dissenting voices, will complete the sessions.

The group of 100 participants will be randomly allocated to one of four ‘topic groups’ and informed at the start of the day of which group they are in, which will also be indicated on their name badge:

- Access (25 people)
- Triage and prioritisation (25 people)
- Streaming, redirection and onward care (25 people)
- Team based care and proactive care (25 people)

Each topic group will work on a set of expectations on behalf of the whole 100, however there will be opportunity for the wider group to input as the outputs are crafted and developed.

The expectations for each topic groups will also include those around public communications and further engagement.

Timings	Setting	Activity	Objectives
9:30-10:00	Plenary	Arrival and registration	n/a
10:00-10:05 (5 mins)	Plenary	Welcome presentation (Chair) <ul style="list-style-type: none"> • Housekeeping • Reminder of why their input is important • Recap of the participant journey presented in Workshop 1 and how this has defined the topic groups • Explain the process of recommendation forming 	Remind participants of why we are here and orientate them with regards to the overall process.
10:05-10:10 (10 mins)	Plenary	Presentation: Playing back the key themes (Chair) <ul style="list-style-type: none"> • Sharing of a high-level summary of views from across the workshops on each of the four areas discussed with regards to the patient journey, drawing out areas of consensus as well as areas of divergence. • Empowering participants to take these and review, adapt, improve – on behalf of all Londoners. 	To ground <u>all</u> 100 participants in the range of views expressed across the board, what mattered most to people as they discussed the four areas and what people felt would need to be in place going forward as well as any red lined voiced. This also helps increase buy-in to the sets of recommendations/expectations that people are <i>not</i> going to be working on throughout the day.
10:10-10:20 (10 mins – this is not a mistake! We are telling participants that we have just 5 mins to move to rooms so that they don't	Move to breakout rooms	We are now going to split into groups, and each group will be working on one of four topics. You can see on your name badge, which group you have been allocated to (i.e. 1-4) Please check that, and then follow the signs to your room.	n/a

wonder off (☺)		<p>Facilitators will be along the way if you have any questions, or are not sure where to go.</p> <p>FACILITORS TO STAND ALONG THE ROUTE TO ROOMS, ONE BY THE MAIN ROOM DOOR, TO USHER PARTICIIPANTS ALONG THEIR WAY.</p> <p>FACILITATORS SHOULD ALSO HAVE A COPY OF THE GROUP ALLOCATION LIST.</p>	
10:20-11.10 (50 mins)	25 participants per breakout room split into groups of three-four	<p><u>Reviewing summaries</u> Welcome to our room everyone. In this room we will be covering [topic].</p> <p>You will see on the handouts that we have pulled together an outline of the key themes and views we have heard from the earlier workshops, specific to [topic].</p> <p>Facilitator to present the key themes for the topic area building on the more high-level version shared in the plenary (10 mins)</p> <p>Participants split into GROUPS OF THREE to review and discuss the summaries and to collect their thoughts to the questions in their packs on post-its.</p> <p>ASK HALF OF THE GROUPS TO START AT THE TOP AND WORK THROUGH TO THE BOTTOM, AND THE OTHER HALF TO START FROM THE BOTTOM AND WORK UP</p> <p>FACILITATORS TO PROACTIVLY ENGAGE WITH GROUPS, EACH COVERING 3-4 GROUPS, TO ENSURE PARTICIPANTS STAY ON TOPIC / TO TIME. GIVE THEM AROUND 40 MINS TO REVIEW DRAFT EXPECTATIONS AND RESPOND TO QS IN THEIR SMALL GROUPS.</p>	To provide participants with a more detailed playback of the findings in relation to their topic only, and also to gain buy-in to these detailed accounts. This is important so that participants begin to own the expectations
11:10-11:30 (20 mins)	Gallery	<p>Break (tea/coffee)</p> <p>Facilitators to move the chairs around in a horseshoe for a group of 25</p> <p>Facilitators to group the post-its by themes, ready for the next session</p>	n/a
11.30-12.30 (60 mins)	Whole groups of 25 in breakout rooms	<p><u>Drafting the expectations (60 mins)</u></p> <p>In this session, we are going to look at the themes that came up across your small group discussions and edit the drafts into something closer to a final set of expectations.</p> <p>We are going to go through the clusters of themes.</p>	To allow participants to draft recommendations/expectations and to take on board differences, agreeing what to take forward as a group.

		<p><u>SUPPORT FACILITATOR TO LIVE-EDIT DURING THE DISCUSSION.</u></p> <p>LEAD FACILITATOR TO RUN THROUGH THE SUMMARY / DRAFT EXPECTATIONS DRAWING ON THE THEMED POST-ITS (35 mins)</p> <p>Where there is a strong theme / consensus:</p> <ul style="list-style-type: none"> - How do you want to update the summary to reflect this expectation/recommendation? - What do we need to add / remove? - Why is this important to you? <p>Where there's disagreement / conflicting suggestions:</p> <ul style="list-style-type: none"> - Ask if participants from the relevant group(s) feels comfortable building on the point - How do you feel about these different views? Is there a middle-ground? - If not, which version do we want to reflect in our recommendations? USE SHOW OF HANDS WHERE NEEDED. <p>Where something hasn't been addressed by the post-its:</p> <ul style="list-style-type: none"> - This hasn't come up across your feedback – why do you think that is? - Are there any changes you would want to make? <p>Use any final time to address any miscellaneous post its (e.g. suggestions which have come up but are not part of a broader theme)</p> <p>INVITE THE SPECIALISTS TO SHARE A FEW REFLECTIONS (10 mins) Around halfway through the session invite specialists to share a few reflections. This is an opportunity for them to offer check and challenge to the group:</p> <ul style="list-style-type: none"> - Flagging areas where more detail would be helpful - Highlighting where feasibility may be an issue. - Encouraging participants to think about areas they may have missed <p>Further editing (15 mins) Invite the group to reflect on the feedback received from specialists and to consider whether to make further changes to their expectations.</p> <ul style="list-style-type: none"> - Are we happy with these recommendations? - Are these specific areas we would like input from others on? 	
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		<p><u>Agree group presenters</u> After lunch, we are going to hear what recommendations the other groups have produced. We will be able to share our thoughts during a discussion, and using post-it notes. This will happen in the main auditorium so please return there after lunch.</p> <p>IMPORTANT TO IDEALLY HAVE A PARTICIPANT PRESENT.</p> <ul style="list-style-type: none"> • Push for this if you think people could succinctly do it – but if no willingness in the group, facilitator to do this on the group’s behalf. 	
12.30-13.30 (60 mins)	Gallery	<p>Lunch</p> <p>EACH SUPPORT FACILITATOR TO SHARE THE MASTER VERSION – SHOWING WHERE CHANGES HAVE BEEN MADE AND AGREED - WITH THE CHAIR VIA EMAIL AND CHAIR TO UPLOAD ONTO LAPTOP.</p> <p>Michelle.Mackie@ipsos.com</p>	n/a
13.30-14:15 (45 mins)	Plenary	<p><u>Introduction by Chair (5 mins)</u></p> <p>As your facilitator will have explained before lunch, each group will now share their amended draft recommendations with the room. You will have 5 minutes each to present, and we have the slides from your room ready to go.</p> <ul style="list-style-type: none"> • If there are any that you had conflicting views about, or very strong views, feel free to elaborate on the reasoning for those. • Also let us know if your group were a bit stuck/unsure of one of your recommendations, so the room know you’d like advice on it. <p>Note down your feedback on post-it notes during the presentation, and these will be taken to breakout rooms for the next session.</p> <ul style="list-style-type: none"> • After the presentation we will take a mic around the room to hear a few suggestions from you. • Remember: if you disagree with anything presented, that is ok, but be respectful. <p><u>Topic group presentations (40 mins)</u></p> <ul style="list-style-type: none"> - Access (5 mins for presentation, 5 mins for feedback) 	<p>To provide an opportunity for the group of 100 to feedback on the draft recommendations/expectations, raising any missing points, misinterpretations, or even emphasis that needs to be placed on particular words. This check and challenge is also useful for the topic groups, to ensure that they are on the right track.</p>

		<ul style="list-style-type: none"> - Triage and prioritisation (5 mins for presentation, 5 mins for feedback) - Streaming, redirection and onward care (5 mins for presentation, 5 mins for feedback) - Team based care teams and proactive care (5 mins for presentation, 5 mins for feedback) <p><i>The feedback will be gathered via roaming mics, with people voicing their feedback, and also on post it notes that people can jot down thoughts as they hear each set of draft recommendations/expectations. These will be collected up by facilitators.</i></p>	
14:15-14:20 (5 mins)	Move to breakout rooms	<p>Participants are asked to move back to their topic group rooms</p> <p>ONE FACILITATOR GATHER FEEDBACK POST-ITS FOR THEIR GROUP, COLOUR CODED FOR EACH TOPIC.</p> <p>OTHER FACILITATORS HELP PEOPLE GET BACK TO THEIR ROOMS.</p>	n/a
14:20-15:00 (40 mins)	Whole groups of 25 in breakout rooms	<p><u>Feedback review (40 mins)</u></p> <p>FACILITATOR HAVE DRAFT RECOMENDATIONS ON SCREEN TO LIVE EDIT THROUGHOUT THIS SESSION.</p> <p>Well done everyone, especially to our presenter!</p> <p>We have the post-it notes with feedback from the other groups, and now we are going to spend some time reviewing those, and deciding how, if at all, to amend our recommendations to reflect these views.</p> <p>Remember we want to do our best to represent the wider views of the whole 100 people, not just this smaller groups views. But we also want to aim for clear and concise recommendations, so will have to make some tough decisions occasionally.</p> <p>FACILITATOR TO GROUP POST-ITS AND TO GO THROUGH THEM ONE BY ONE.</p> <ul style="list-style-type: none"> • What do we think of this suggestion/feedback? • Is this helpful? 	Allows participants an opportunity to make collectively agreed changes in line with the whole group's feedback.

		<ul style="list-style-type: none"> • Hands up if you think we could tweak/amend/add a recommendation to address this – how? • Hands up if you think we do not need to make any changes - why? • Push for general agreement on a solution, and edit recommendation live. <p>REPEAT THE ABOVE, ASKING FOR NEW VOLUNTEERS TO READ OUT A POST-IT. IF TOO SLOW, FACILIATOR CAN TAKE OVER READING THEM OUT.</p> <p>Well done everyone! We will now have a refreshment break. Please go to the main room by 3.15.</p>	
15:00-15:15 (15 mins)	Gallery	Break (tea/coffee)	n/a
15:15-15.45 (30 mins)	Plenary	Final expectations are presented back to the room with voting for level of support for each of the four sets using digital voting pads / slido as back up	
15.45-16.00 (15 mins)	Plenary	Reflections from commissioners Thanks and close (Ipsos Chair)	Provides an opportunity for the commissioners of the public engagement to say a few words about how the findings will be taken forward, and to thank participants for their immense contribution.

Appendix F: Full expectations for Access

- The NHS in London should invest in improved digital access routes for primary care, including an improved NHS App, with the aim of encouraging most patients to use this access route over time. However, to be acceptable to patients:
 - Digital access must be a choice, and offline access routes must be maintained and well-publicised to those who can't or don't want to use digital routes.
 - There must always be an option to speak to a human if required.
 - The NHS App must be properly invested in and managed so that it is reliable (always works), and easy to use (simple design).
 - The NHS App should be useful, allowing patients to book appointments, manage prescriptions and test results, webchat with professionals, and see their medical records.
 - Changes should be introduced gradually to allow patients and staff time to adjust. There must be feedback mechanisms as it is implemented to catch any issues.
 - There must be a public education campaign to help patients build awareness, trust and confidence in using the NHS App.
- When educating the public there should be one strong consistent national message, designed and delivered nationally. These messages should ALSO be delivered locally by trusted community leaders (Faith groups, GPs, schools) local councils (but still nationally consistent) and should be adapted to local language needs – to ensure inclusivity.
- There should be a strong media campaign using a range of channels including national broadcasts, TV, Radio, leafleting, social media, billboards at bus stops, etc.
- Messages must include:
 - How to use the App,
 - That data is secure and systems are safe (messenger must be trusted IT, relevant ministers);
 - The advantages/reasons to use it;
 - Reassure that offline routes still available.
- If a patient using the NHS App decides they need to speak to a human instead, it is acceptable for this to be a call handler but TRAINING is key:
 - Training basic health so they know how and when to signpost to a clinician;
 - Training in basic IT to troubleshoot App problems and / or use the App on your behalf if you can't;
 - Training should be consistent borough to borough.
 - Training must be reviewed and updated regularly.
 - Minimum of 12 hour phone line-opening hours, as long as it is every day (7 days incl. bank hols)
 - Calling support must be free.
 - Staff must be able to identify as NHS. UK based service.
 - If you can use live chat to speak to the human, this should not replace the option to phone.

In relation to standardising the NHS App the following must be considered:

- User interface must be simple, easy to use, streamlined.
- Standardisation of options for everyone, as long as these options include accessibility choices (language, dyslexic friendly).

- Actual practice webpage has more flexibility than the App. Local services and tailoring can be done on the practice website, rather than the app.
- Standardised app could have a 'Local Services' button, where the local tailoring can be done.
- Parents and carers should have the ability to link accounts, so that they can manage their own, and their dependants' care, when logged into the account.
 - BUT this must be responsibly managed, needing proof of caring role. Replicate banking checks for
 - Auto-unlinks age 16, unless there additional needs or vulnerabilities. (Some felt 18 is better) .
 - Option to un-link, under the age of 16, via an anonymous helpline (in case of abuse at home, foster/social care, strict culture).
- All practices and primary care services should offer digital access routes, and in doing so there needs to be consistency, for example:
 - There should be one App for all Londoners (the NHS App), not multiple versions that differ between areas and practices.
 - Practice websites are the place for local tailoring, where they can have locally specific content. BUT this must be in a controlled way, so the overall style and website structure is consistent.
 - All practices should treat digital routes equally so that patients don't need to worry about whether they will be seen quicker if they phone or if they use the NHS App.
 - All digital access routes should have the same features available (such as booking appointments or repeat prescriptions).
- Roll-out should done borough by borough, to allow for learning BUT this roll out must be controlled, with deadlines for each stage and learning.
- Roll out should begin in boroughs that are different from each other (e.g. Hackney and Richmond), for broader learnings that apply to many different boroughs.
- If deadlines slip during roll-out, there should be transparency about why to support re-planning and learning.
- There must be transparency with patients, and with roll-out governance.

We recognise that digital access routes need to be able to hold patient data to work effectively, however trust and security is paramount, therefore:

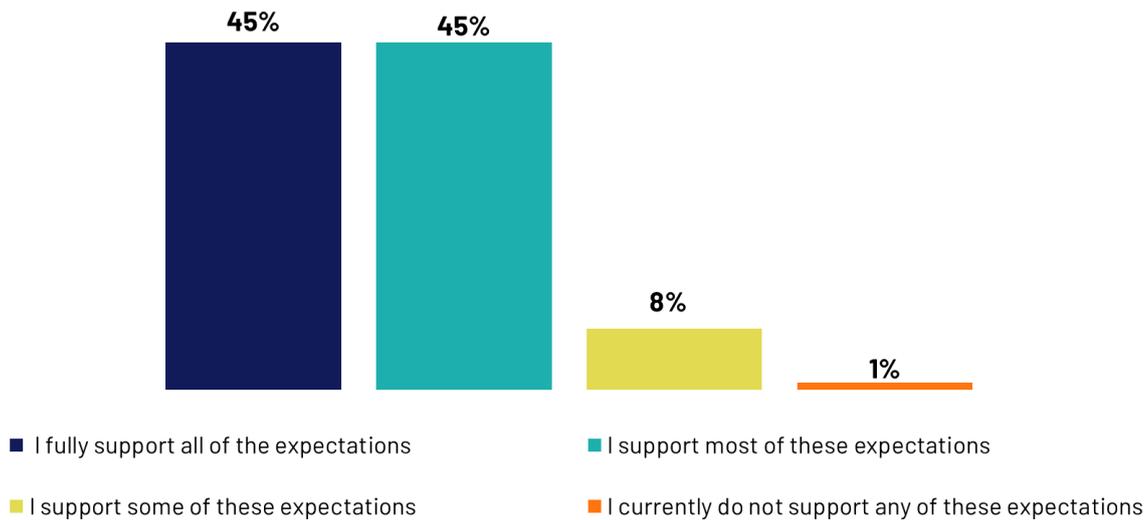
- There must be transparency about data security for digital access systems. Whichever tech company is designing and managing the App, should have a public statement about who they are/what they do, and what will happen if there is an issue. They should be familiar to the public.
- They should be a trusted provider, transparency about selection of provider, evidence of track record. Public to be informed but not consulted.
- The NHS App should feature facial ID and/or 2-factor-authentication, or equivalent, to make it secure. Should replicate security options as banks (fingerprint, face, or code).
- There should be a verification process for call-backs, so patients know it is not a scam caller. A code verification system should be used to confirm it is an actual NHS call.
- To ensure public confidence in linking more patient information to the NHS App information should only be shared with those who ABSOLUTELY need to know, and patients should have the option to opt-out on a case by case basis.
- Pods should be in a range of location types, to meet different patient needs: Some should be in 24/7 accessible locations, some should be in more private locations. The type of pod matters:
 - **If it has the testing equipment**, it should be in a clean, private, well maintained, staffed, secure location.

– **If it is just an access route**, it should be an a more constantly available location.

- For trust in a centralised phone number, wait times must be no longer than 5-10 minutes, with call back options, and transparency about the real waiting times. A missed callback should be re-attempted within 30mins, and if that is missed, options should be shared in another format (e.g. SMS, voicemail).

Voting support for access expectations

At the end of the final workshop, participants voted on their levels of support for the set of expectations developed by their fellow participants.



Appendix G: Full expectations for Triage

There must be a consistent approach to triage across London, using the same system and technology, and with the same prioritisation rules, and this should be powered by data.

To ensure trust and confidence:

- Data should be stored and shared accurately, safely and securely with NHS professionals.
- Triage should consider social factors (if they are known) alongside clinical factors, to ensure vulnerabilities, access barriers, and additional needs are considered when deciding onward care.
- Checks are in place to ensure biases are not built into the system and factors are treated sensitively.
- Patients should be able to see who has accessed their records, when and for what purpose. There should be clear options for opt out (with clear consequences explained) and clear process on how to raise concerns or complaints.

AI tools should be adopted by the NHS in London to improve the efficiency and accuracy of triage, with a particular benefit being the ability to spot patterns and flag 'at risk' patients and patients with long-term conditions, for a clinician to review.

However, it is vital that:

- Any new AI functionality is rigorously tested and evaluated before being implemented across London and continually reviewed to ensure consistency and accuracy. This should include patient and professional feedback.
- AI tools must be trained with central/aggregated past and present data, updated regularly with new data, and use data that mirrors London's diversity to avoid bias. Individual patient data should be updated in real time.
- When using a webchat feature on the NHS App, patients must know whether it is an AI tool responding, or a human.
- There needs to be an audit trail to follow decision making with triage outcomes that can be should be sense checked and agreed by patient. Patient has ability to send a message back to confirm/ask further questions/feedback.

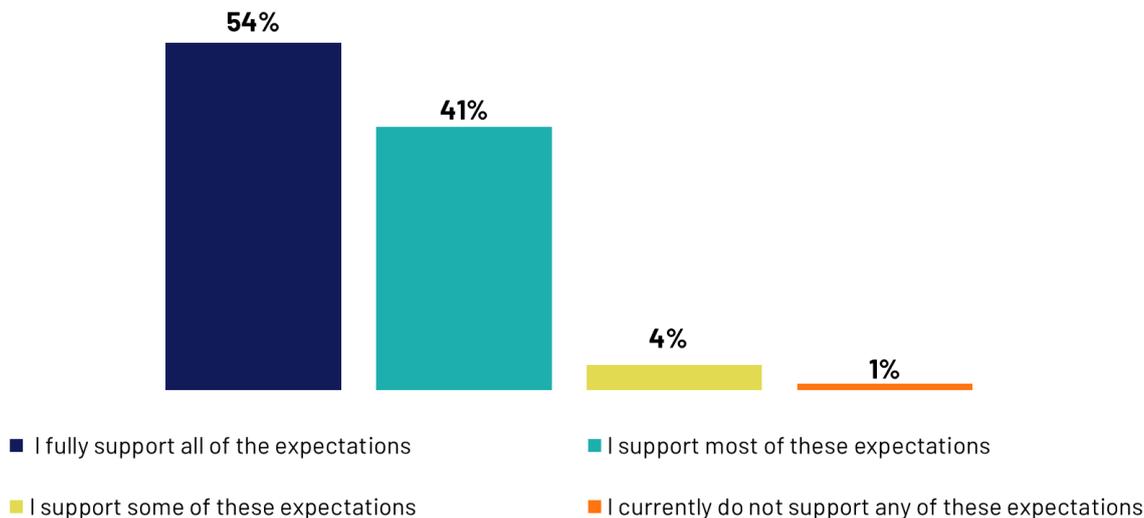
- There should be random spot checking by a human (e.g. care coordinator?) to check on AI decisions. This will be monitored and reviewed as roll out continues.

With a move to increased digital triage, and therefore an assumed reduction in human interaction, we expect that:

- Screening questions for digital triage should ask pragmatic wellbeing questions (not too many/option to skip – group split on whether to skip or not-) and flag the need to speak to a human if answers are pertaining to mental health.
- During screening, if multiple-choice answers aren't working, there should be an option for open text, or an 'I don't know' option, if patients don't know how to answer a question.
- Vulnerable patients should still have some direct interactions with a person during triage, so that mental health and social issues may be picked up on.
- The system must be simple to use and have accessible options, such as having multiple language options and auto-translate, including understanding the use of slang and picking up on misspelling.
- There is 24/7 access to triage AI system but out of hours (7pm – 7am) it must clearly state that you cannot be connected to a human.
- Public education campaign on how to use the system, including videos. Ensuring simple and easy to understand language (e.g. clear explanation of 'triage').
- There must be an option to speak to a human and offline options

Voting support for triage expectations

At the end of the final workshop, participants voted on their levels of support for the set of expectations developed by their fellow participants.



Appendix H: Full expectations for Streaming

The NHS in London should continue to expand and encourage use of the wide range of primary care roles available, however it should be recognised that this is not yet widely supported. To increase patient confidence in, and satisfaction with, this approach, we recommend:

- Patients are offered a choice of where to go and / or who to see so that they can weigh up what matters most to them. This might mean waiting longer or travelling further, but that choice would be the patient's. To make an informed choice the need to know wait times and location.
- If patients are streamed to other roles (including a different GP), this must result in shorter timelines to assessment/treatment. Capacity with the system must be considered.

- If being streamed to pharmacists, availability of a private consultation space should be considered.
- Distance to travel should be factored in and must be reasonable:
 - Reasonability is about time taken to travel by local transport – 20-30mins and must be direct public transport. Can be exceptions when more specialist services.
 - AI in the long term could be used to work out the distance to different services recognising every borough is different and there are different transport links. Patients should have the option to indicate if travel is difficult for them and the AI should ideally be able to look at their history and circumstances.
 - For those with mobility issue triaging should take into account that they might not be able to travel further. Options like dial a ride should be considered. Transport must be reliable.
 - There needs to be education on where transport links are and how best to access services
- Implementing an inclusive public education programme about the different roles in primary care – and what they are able to do - so that patients are more trusting in the wider range of roles in primary care:
 - This should be delivered by NHS/Govt.
 - There should be a simple and direct approach using multiple channels including NHS app notifications, leaflets, education in schools, campaigns, radio and GP practices. Also, the campaign should make use of social media to engage younger people.
 - Any campaign needs to be engaging and interesting and clearly focussed on the benefits e.g. patient case studies and stories to make the campaign come to life.
 - To ensure inclusivity there should also be targeted approaches e.g. messages through hostels, outreach services and local community networks who work with seldom heard groups.

It is important that patient data is joined up across primary care services to reduce the burden on patients having to repeat their story. However, this must be shared safely and securely.

- The NHS must explain in clear terms how data is used so that patients understand this.
- In particular, patients want reassurance that there is no commercial gain.
- Data should be assigned different levels of sensitivity and have a clear and transparent audit trail (for patients) which can't be edited and changed. Patients should be able quickly query anything they are not happy with. There should be use of existing penalties (GDPR) if inappropriate use of data and making sure proportionate. There were some concerns about fining NHS and some felt individuals or departments should be made accountable. Patients and local patients who are impacted by any misuse should be informed with openness about any data breaches.
- Should be audited annually externally via independent body (ICO or similar to Ofsted).
- There should be also be an oversight committee within NHS, London and Borough level accountability. Members must declare interests and have diverse membership (reflecting the diversity of London Boroughs). The oversight committee should sit below the independent body.
- There needs to be training for all NHS staff involved in data use and sharing to ensure best practice.
- Access to data should be on a needs to know basis and patients should have an audit trail to see which services have access to their data and for what via NHS App and/or an independent body for those not on the app.
- Use of AI to help audit how data is being used.

Choice is important and patients should be given the option to opt out of their data being shared if they don't feel comfortable with this.

- There should be public education to make patients make informed decisions - messages to provide advice on benefits and alert patients to the trade-offs of opting out.
 - The NHS in London should seek to learn from the organ donation service on opt out approach.

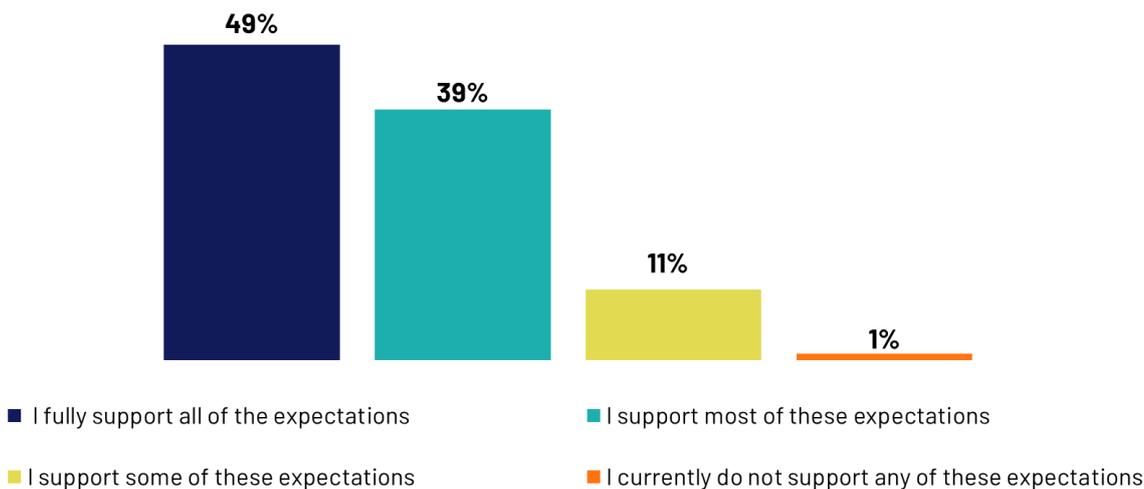
- There should be an advice helpline to support decisions.
- Options to opt out of specific types of data e.g. sensitive data should be offered.
- There should be a consistent approach across London for opt out.

The NHS should direct patients to self-care options where appropriate, however:

- Trust in confidence in selfcare is linked to trust and confidence in triage process.
- Selfcare should only be used for low-level conditions (e.g. hay fever). It is less appropriate for patients with complex needs and the triage process needs to take patient’s histories into account.
- The NHS App and NHS website need enhancing to ensure a broad level of support offered for more common and low-level health issues.
- The NHS must provide appropriate reasons and signpost patients to a reliable information source e.g. the NHS website.
- AI could be used to audit self-care and whether this has been appropriate.
- There should be follow up automated texts and/or telephone survey sent a few days later to check on the patient or clear messaging which advises people to seek help again if symptoms continue.
- The NHS should utilise general health advice (e.g. like eating well) but there were concerns that use of annual MOTs could be too costly and resource intensive (but these may be used for at risk groups e.g. for those with family histories of specific conditions)
- It is never acceptable to be streamed to a private organisation. Any streaming must be to a service offering NHS care.
- If a patient is streamed to a private health provider, they should have a choice of whether to accept this and there should be no cost to the patient and/or no additional cost to the NHS. Streaming to organisations such as charities is acceptable.

Voting support for streaming expectations

At the end of the final workshop, participants voted on their levels of support for the set of expectations developed by their fellow participants.



Appendix I: Full expectations for Team based care

- People in an INT would still use the same system the other groups have discussed to access help with new conditions / issues. But the care liaison officer will be responsible for co-ordinating their care in the INT.
- We are likely to be supportive of the NHS rolling out integrated neighbourhood teams (depending on how exactly they are set up) to provide joined up, holistic and person-centred care for certain patient groups or populations. In doing so, the following important considerations should be factored in:
 - It is important to ensure that there is continuity for patients (using good records) within the integrated neighbourhood team in case there is no longer be continuity with their GP practice
 - As this is a new way of working, we think it should be tested first to learn what works best to inform wider roll-out; Test in deprived areas and with specific audiences to check appetite
 - Pilot needs independent review
 - Run several pilots, of different models/groups, at the same time if you can afford it – and should build on what we're already doing
 - GPs should have access to the wider records, and a summary {and ideally patients would have one nominated GP}
- To support people who need it as they can't travel far (elderly, mobility issues, learning disabilities, people living alone, people with mental health challenges) there should be a flag and they should be asked if they need help. There should be an option to self-refer. Help includes transport and home visits.
- Provide access to INTs for High risk groups including ppl from particular groups (old and very young, homeless people, children in care, special needs, or with certain diseases (diabetics, obesity. Should be via GP or self-referral
- There needs to be a basic level of care that's the same across London (to be fair and understandable if people move house) but then individual boroughs can be flexible to meet specific extra needs local
- The job of care liaison officers (who do co-ordination) is not to make medical decisions – they will direct or redirect based on what they hear from the health professionals. It is to ensure patients get access to the care they need as agreed with their health professional (e.g. gets the physio appointment, housing solution etc). They all need the same skills and training across boroughs:
 - Organising and communication
 - Customer service/ sensitivity training / people skills / empathy
 - Diversity and inclusion training (no bias) and understand their community
 - Mental health training
 - Expertise and experience (not excluding younger people) – no medical training is needed. We understand this role already exists and it is working (without medical training) so we are happy that people do not need medical training.
 - See whole picture
 - Trauma informed training, and lived experience
 - IT skills
 - Like people / genuine
 - Taking learnings from roles that exist elsewhere to apply it here
 - MPs need to be able to contact INTs where they identify a concern
- Integrated neighbourhood teams should be digitally and data enabled: so long as the data is all in one place, the professionals don't need to be. However, given the potential extent of data sharing between individuals

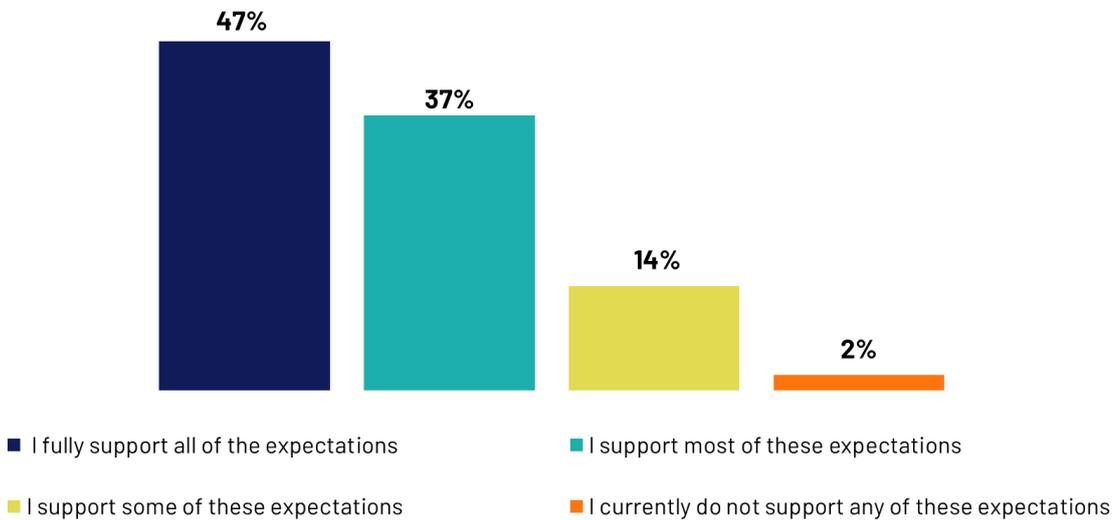
and organisations, patients should be given a choice around whether their care is managed by an integrated neighbourhood team. Some people will be happy with data sharing so they don't have to repeat themselves (eg if it's an uncomfortable topic).

- People who need and INT should be opted in automatically but then have the option to opt out
 - If patients have confidence in the INT system they are more likely to be happy to share data so the NHS must
 - NOT sell data
 - Not share data with third parties
 - Give people access to their own data at all times
 - Let people challenge or correct their records
 - Communicate the risk of opting out
- Ensure INT is a good service (reduce wait, increase service quality, ensure data security)
 - Must have a choice to go to the GP or INT and if opt out of INT still need to ensure they don't fall through the gaps – always check on vulnerable patients (eg phonecalls and visits)
 - Do more advertisements / education about what INTs are – planned and delivered over time – how it works, how to use it etc. – not introduced at short notice and without information. Make sure the message reaches EVERYONE
 - Integrated neighbourhood teams, organised at a borough level, that work in a joined-up way to provide holistic care to patients is a positive thing. However, with so many organisations involved there will need to be:
 - Monitoring and regulation of teams and quality assurance, by the funder and also by an independent body (CQC but better or a patient ombudsman) but not too many new/extra layers
 - Clear lines of accountability to reduce risks associated with patients being missed, misdiagnosed and miscommunicated to; The care liaison officer should be responsible overall (needs to be certified so all have the same skills and are accountable)
 - Strong incentives for organisations to work together in this way, e.g. changes in funding and contracts
 - The calls with the care liaison officers should be monitored for quality
 - Proactive outreach should be focussed on vulnerable populations and those who don't current engage with services (i.e. homeless people), those not already engaging in healthcare (i.e. young people, the elderly, asylum seekers, those with English as a second language, with mental health conditions) and those in most need.
 - However, people should be given a choice around how they are contacted but only using more intrusive measures, such as door knocking as a last resort, and be able to opt out of this if they want to. (contentious-compromise position-Warm up communications should be used before knocking doors) Proactive care should be regular and consistent (e.g. visible mobile clinics) but risk of overwhelm of services is a concern.
 - We expect a centralised system to coordinate this with a switchboard number associated with this. Proactive outreach should be underpinned by good community awareness raising and partnership with community groups/gatekeepers (e.g. schools, workplaces faith groups, third sector). Where existing data can be used to reduce cost and increase impact of proactive outreach, it should be used in a targeted way. Using data to do identify people at risk for more proactive care.
 - Do more to promote the value of exercise (3 x per week, 10,000 steps) and good diet (5 a day).
 - Use advertising.
 - Use every chance you have

- tell people when they are with their GP and are diagnosed with something that diet or exercise could help with
- through the care liaison officer,
- through the mobile clinics or pods – wherever your BMI and blood pressure are taken
- Use data from people’s phones / watches to give people reminders of how they can be more healthy but offer people an opt-out from this.
- Use the NHS app to make suggestions of where you can go for proactive care – should be optional (e.g. we advise you go to your GP for a diabetes check)
- BUT ALSO, need to make fruit and veg cheaper (e.g. through a voucher for low income households or prescription), make swimming pools cheaper to access - give people access to this help (e.g. through social prescribers)

Voting support for team based care expectations

At the end of the final workshop, participants voted on their levels of support for the set of expectations developed by their fellow participants.



Our standards and accreditations

Ipsos' standards and accreditations provide our clients with the peace of mind that they can always depend on us to deliver reliable, sustainable findings. Our focus on quality and continuous improvement means we have embedded a "right first time" approach throughout our organisation.



ISO 20252

This is the international specific standard for market, opinion and social research, including insights and data analytics. Ipsos UK was the first company in the world to gain this accreditation.



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By being an MRS Company Partner, Ipsos UK endorse and support the core MRS brand values of professionalism, research excellence and business effectiveness, and commit to comply with the MRS Code of Conduct throughout the organisation & we were the first company to sign our organisation up to the requirements & self-regulation of the MRS Code; more than 350 companies have followed our lead.



ISO 9001

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HMG Cyber Essentials

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