Access Improvement Plan Guidance 2025/26

Background

Across NW London, we want patients to know they will get high quality, timely, care at their local GP practice.

The NW London Improving access specification aims to support general practice services to develop models which build resilience and make effective use of resource. This should mean better access, best use of clinical time, reduced waiting times, and increased continuity and proactive care for those that need it. The first year of delivery will focus on the responsiveness of general practice, build the foundations of a model to provide high quality continuity of care, and drive better use of digital tools to promote access.

Access Improvement plan

To support improvement across the system, the access specification in 2025/26 NW London ICB asks PCNs to work with their constituent practices to develop access improvement plans.

This plan will need to be submitted to the ICB by **30th June 2025** at the latest. Submission of this plan is a condition of the release of payment to PCNs. PCNs are encouraged to use the template below and attached to complete their plans, but submission in other formats will also be accepted.

Plans will not be subject to formal assessment, but checked to ensure that they include:

- ✓ an **overarching model for access** that describes how the PCN will meet the requirements of the specification, outlining what will be developed/delivered at both PCN and practice level
- ✓ a locally-agreed **approach to triage and navigation** – with a focus on managing same day and next day demand
- ✓ detail of the internal Standard Operating Procedures to **managing online consultation** – including safety netting to ensure urgent online consultations are dealt with in a timely way
- ✓ plans to **engage with patients** throughout the year and how engagement responses will be fed back into service improvement
- ✓ detail of **how funding will be apportioned** to support delivery
- ✓ local **measures of success**
- ✓ expected **timeframes for delivery**
- ✓ consideration of how these plans will **improve health equity**

In developing their plans we would expect PCNs build on local data on both demand and capacity and a sound understanding of the demographics and clinical needs of their population. PCNs should reflect on whether they have the right skills, knowledge and infrastructure they need to support the delivery of high-quality care and should make reference to the model of modern general practice. The plan should include the activities, and assessment measures that will be used to drive improvement. It should also be clear on who is responsible for delivering against each of the activities and the timeframes for doing so.

Context

PCN Overview

The South Westminster Primary Care Network (PCN) is the largest PCN in London, supporting around **86,000** patients. It serves a diverse population and includes several specialist practices. The practices within the South Westminster PCN:

- Belgrave Medical Centre
- The Belgravia Surgery
- Victoria Medical Centre
- Pimlico Health @ The Marven
- King's College Health Centre
- Millbank Medical Centre
- Dr Hickey Surgery (specialized for homeless individuals)

The population served by this PCN is quite diverse, including students, staff from King's College London, and homeless individuals . The PCN offers a range of services, including out-of-hospital care, routine appointments, and specialist support roles.

1. Self-Declaration – condition of participation

In submitting this plan, I confirm that our PCN and all constituent practices are already:

- delivering all GMS/APMS core contract requirements,
- using the full functionality of cloud-based telephony systems during core hours, including the use of call-back, waiting times, and queuing messages signposting patients to online options,
- providing clear and consistent signposting and information on website home pages related to the PCN and constituent practices, to promote the use of online consultation, the NHS App and Pharmacy First,
- ensuring online consultation software/systems and digital telephony systems are switched on through core hours with no caps,
- accurately coding activity using the standardised categories (GPAD),
- signed up for the 'safe surgeries' initiative https://www.doctorsoftheworld.org.uk/safesurgeries/, and
- working to improve uptake of the Friends and Family test and are submitting results and taking action on findings.

Signed (on behalf of the PCN): ….  ……

Print Name: …Dr Jan Maniera……

Job title: … Clinical Director & Deputy Chief Medical Office……

1. Model of delivery

Our model aims to deliver high-quality, timely, and equitable access to primary care across South Westminster by building a sustainable, digitally enabled, and patient-centred system. The model is designed to:

- Improve responsiveness to same-day and next-day demand
- Enhance continuity of care for patients with complex or long-term needs
- Reduce variation in access across practices
- Promote digital inclusion and self-service through the NHS App
- Free up clinical time by diverting non-clinical and transactional demand to appropriate services

We are working towards a standardised clinical triage model across all practices, supported by trained receptionists using care navigation protocols. This is supported by:

- A centralised triage hub (eHub) operating from 8am to 6:30pm
- Use of digital tools such as PATCHS for asynchronous triage
- Structured information gathering and consistent signposting to appropriate services (e.g., Pharmacy First, FCP, ANP, GP)

Continued development of a shared care navigation SOP across the PCN to ensure parity between online, telephone, and walk-in access

Online consultations are managed centrally via the eHub, which triages and resolves PATCHS submissions on behalf of all practices. The SOP includes:

- Red flag prompts for urgent concerns
- Escalation criteria for clinical review
- Queue monitoring by care coordinators and team leads
- Routing of complex or continuity-sensitive cases back to the patient's registered practice
- Daily clinical supervision and audit of triage decisions
- Safety netting protocols to ensure timely follow-up and escalation where needed

This model is tailored to the needs of our population, which includes:
- A high proportion of working-age adults (62%)
- 24% of patients from non-English-speaking backgrounds
- Significant variation in long-term condition prevalence and digital literacy

Demand currently exceeds clinical capacity, with 27% of appointments used for non-clinical needs. The eHub GP-led, triage model allows us to:
- Optimise use of clinical time
- Improve access for digitally confident patients
- Maintain continuity for those with complex needs
- Reduce inequalities by offering multilingual and accessible engagement routes

This in turn allows South Westminster the capacity in practices to see patients who benefit the most from the continuity of care and the relationship with face to face interaction with healthcare staff

-

2. Approach to improvement

We will introduce the following workstreams to improve access and responsiveness across the PCN:

- Digital Access Hub Development: Continual improvement of the eHub model and the interaction with RH practices to manage increased volume of online consultations and triage more PATCHS submissions centrally
- Receptionist Training Programme: 100% of reception staff will be trained or supported in care navigation and digital tools to support triage and patient signposting
- Continuity of Care Framework: Identification and flagging of the top 2% of patients with long-term conditions or complex needs for continuity tracking
- NHS App Promotion Campaign: Targeted outreach to increase NHS App registrations by 10%
- Monthly Audit and associated Learning Cycles: Regular audits of clinical time, appointment mapping, and triage outcomes to inform continuous improvement
- Patient Engagement Events: An community event and an annual survey to gather feedback and co-design improvements

Objective	Target
90% of calls answered within 10 minutes	By March 2026
90% of e-submissions responded to by next working day	By January 2026
2% of patient list flagged for continuity	By December 2025
10% increase in NHS App registrations	By March 2026
1 annual patient survey + 1engagement events	Throughout 2025/26
Monthly clinical time audits and appointment mapping reviews	June 2025 – Jan 2026

Activities delivered at practice or Federation\PCN level:

Practice Level
- Implementation of continuity flags
- Access Audit production
- Continuity audit production
- Day-to-day triage and patient messaging
- Staff rota adjustments

- Coding accuracy
- Telephony performance
- On-line consultation performance

Federation\PCN Level
- Implementation of continuity flags
- Access Audit production
- eHub triage and SOPs
- Training programme coordination
- NHS App campaign materials
- Audit templates and analytics
- Patient survey design and analysis
- Facilitating the Shared SOPs for care navigation and online consultation

These workstreams directly align with the NWL and DES access metrics:

- Responsiveness: Centralised triage and trained receptionists will support the efforts to ensure 90% of calls and e-consults are handled within target times
- Continuity: Flagging and auditing high-risk patients supports the 2% continuity requirement
- Engagement: Surveys and events meet the patient feedback and co-design expectations
- Digital Enablement: NHS App promotion supports the 10% uptake target and may reduce phone demand

Barriers to having achieved this already:

- Variation in digital capability across staff and practices limits consistent triage and coding.
- Patient awareness and trust in digital tools remains low in some communities, requiring targeted engagement
- Staffing constraints and competing priorities limit capacity to implement new SOPs and audits without dedicated funding

-

Measures	Baseline	Change required	How this will be achieved
90% of calls answered within 10 mins	81% * Based on SWPCN practices average from April 2024 - 2025	9%	- Call demand mapping - Staff rota realignment - Cloud telephony alerts - Monthly dashboard reviews Practice Level: rota changes, staff training Fed\PCN Level: dashboard analytics, shared SOPs, Call Waiting and Queue customisation
90% of e-submissions are responded to by end next working day.	There is no single baseline metric for this as there is no link between Patchs and S1. eHub is baselined as processing **94% of e-submissions within 12 hours**; which are then passed onto the practices for further action. Practices have processes in place to ensure Patchs are not aged or overlooked	Maintain eHub throughput and monitor practice processes	Central triage hub (eHub) - Queue monitoring and escalation - GP led triaging model - Communication and escalation SOP between eHub and RH practices Practice level - sitrep reporting on outstanding Patchs

SNOMED coding in the appointments ledger to record direct clinical care	HCL 15% inconsistent and 3% unmapped	100%	Refresher coding training Monthly audits of appointment ledger Fed\PCN Level: training materials, audit templates
Audit of use of clinical time	New activity	100%	- SystmOne data analysis - Review of appointment utilisation - 5 patients per 1,000 audited monthly Practice level: conduct audits, return to the PCN in timely manner Fed\PCN Level: provide audit framework and reporting tools. Host Lessons Learned workshop with the analytics
Continuity flag for at least 2% of the patient list is in place		2%	Identify top 2% of LTC/frequent attenders - Flag in SystmOne Practice Level: flagging and reviews Fed\PCN Level: provide support tools
Review of a 10% sample of the identified population	One off audit	10%	A one-off Continuity audit of 10% of the top 2% of high risk patients will be conducted between November 2025 - January 2026. Practice level: Identify the patients and conduct the audit Fed\PCN Level: Support with the informatics and host the Lessons Learned event
Increase registrations on the NHS App by 10%, or locally agreed measure	Varied by practice	Increase by 10%	-`
Patient engagement via annual survey and engagement event	4 Pan-Westminster PPG events per annum	1 survey + 1 events	- PPG-led and community co-designed sessions - Feedback loop into PCN Board Practice level: promote event, gather feedback Fed\PCN Level: survey design, analysis, reporting, host event

3. Patient engagement

In 2025/26, we will deliver a structured, inclusive, and proactive patient engagement programme that includes:

- Three Pan-Westminster Patient Participation Group (PPG) meetings, held as hybrid events to maximise accessibility. These we hope will be co-chaired by a recruited Patient Chair and supported by a Patient Engagement Coordinator

- Targeted outreach to three under-represented groups in the PCN, in collaboration with the Health Equity team and local community organisations

- Ongoing communications through practice websites, Envisage screens, social media, and printed materials to promote engagement opportunities and share outcomes

Our 2025/26 plan builds on several key insights from the previous year:

In-person engagement is more effective than digital-only approaches for many patients, particularly those from marginalised communities

Language and accessibility support significantly increase participation, as demonstrated in our access focus groups and community events

Patients value transparency and follow-up, so we are embedding feedback loops into all engagement activities and publishing outcomes online and in practices

Co-design improves service relevance: feedback from 2024/25 PPGs and access focus groups directly informed SOPs for PATCHS, telephony, and additional access

Current engagement routes include:

- Pan-Westminster PPG: 4 meetings held in 2024/25 with up to 17 attendees per session and 28 on the mailing list
- Patient engagement events: Two events in 2024/25 engaged over 50 patients, including representatives from ARRS teams, VSCEs, and local businesses
- Access focus groups: Held both in-person (e.g. Abdul Mageed Trust, Abbey Centre) and virtually, these sessions reached marginalised communities
- Practice websites, Envisage screens, and social media: Used to promote services and engagement opportunities

These routes have proven effective in gathering feedback, raising awareness of services, and informing service design. However, we recognise the need to expand reach and improve representation, which is why we are investing in targeted outreach and hybrid formats.

We will embed patient voice through:

- Co-production: Include patients in shaping survey design, communications, and delivery processes
- Recruitment of a Patient Chair or Vice Chair: This role will help define PPG agendas and ensure sessions reflect patient priorities
- Feedback loops: All engagement activities will include mechanisms for patients to see how their input has influenced decisions
- Community partnerships: We will work with local organisations to co-design outreach strategies and engagement materials that are culturally and linguistically appropriate

This approach ensures that engagement is not tokenistic but embedded in the way we plan, deliver, and evaluate services.

4. Costs

South Westminster PCN will use the £2.50 NWL Improving access fund to deliver against these metrics.

Workstream	Resource required	Funding allocation	Timescale
Accessibility Audits		PCN share of initial £150k based on list size	16-Feb-26
Patch Performance	Practices need to process the online consultation queue in order to meet the response by next workng day target. Practices should put in place processes to monitor any outstanding or carried over online consultation requests	20% of LIS funding	19-Mar-26
Continuity Audit	Staff will use own knowledge of their patients, to identify those with complex needs who may not be highlighted through data sources but would equally benefit from continuity or need multi-agency support. Every practice will identify and flag the 2% high risk patients for continuity on a rolling basis during the year. AUDIT : Practices/PCNs audit whether patients received continuity of care from the assigned team	10% of LIS funding	20-Feb-26
GPAD data improvement	Code every direct clinical care interaction with patients (remote or f2f) on their GP appointment ledger or via a unique SNOMED code for clinical activity outside of the appointments ledger.	10% of LIS funding	19-Jan-26
Care Navigation Workshop and SOP	Practices need to engage and participate in two meetings and a workshop to develop a visual SOP for care naviation and signposting	20% of LIS funding	16-Feb-26
NHS App promotion	Outreach via text campaigns, events, posters - Digital champions in practices Practice Level: patient promotion Fed\PCN Level: campaign materials, analytics	20% of LIS funding	20-Mar-26
Digital Skills for Practices	2 staff per practice made available for 2 digital skills learning events	10% of LIS funding	19-Aug-26
Patient Engagement	Practice level: promote event, gather feedback Fed\PCN Level: survey design, analysis, reporting, host event	10% of LIS funding	19-Mar-26

5. Expected outputs

This transformation is expected to deliver the following benefits:

- To Practices and the PCN:
  - Reduced administrative burden through centralised triage and streamlined digital workflows
  - More efficient use of clinical time, enabling GPs to focus on complex cases
  - Improved staff satisfaction through clearer SOPs and better workload distribution
  - Enhanced data for planning and quality improvement through regular audits

- To Patients:
  - Faster access to care via improved telephony and online consultation response times
  - Greater continuity for patients with long-term or complex needs
  - More inclusive and accessible engagement opportunities
  - Increased confidence in using digital tools like the NHS App

- To the System:
  - Reduced pressure on urgent and emergency care through better same-day access

- Increased use of Pharmacy First and other community services
- Improved health equity through targeted outreach and co-designed services

6. Health Equity

South Westminster PCN is part of Healthcare Central London (HCL) and serves a highly diverse population with significant health inequalities.
In certain communities, individuals are experiencing premature mortality due to various factors such as poverty, substandard housing, and low-paid or unstable employment. These factors adversely affect both physical and mental health. This issue has persisted over time, and the gap in health and life expectancy inequalities has widened in recent years. Furthermore, different communities have diverse experiences with the health and care services we provide, leading to significant disparities in health outcomes.

Key challenges include:

- A life expectancy gap of up to 18 years between the most and least deprived areas of Westminster
- High prevalence of long-term conditions (LTCs) such as diabetes and hypertension in Black, Asian, and deprived communities
- Digital exclusion among older adults, low-income households, and non-English-speaking populations
- Underrepresentation of marginalised groups in traditional engagement routes (e.g. PPGs)

Objectives of the HCL Health Equity Programme

1. **Address Health Inequalities**: Implement a structured approach to tackle health disparities across the four Primary Care Networks (PCNs) in Central London.
2. **Enhance Health Outcomes**: Improve health outcomes for all individuals and reduce the disparity in healthy life expectancy between the most and least healthy communities.
3. **Population Health Management**: Utilize population health management techniques to minimize unacceptable variations in outcomes, access, and experiences.
4. **Collaborate with partners for wider improvements**: Work with partners to contribute to broader economic and social improvements.

Key HCL Health Equity Programme workstreams and projects which support equitable access and outcomes for patients include:

- **Health Inequalities Local Enhanced Service**: Through partnership working, community outreach and engagement, we aim to increase prevalence of asthma, COPD and diabetes, identifying residents who may be living with these conditions, but who have not received a diagnosis and are therefore unlikely to be receiving the necessary care and support they need to effectively manage these conditions. We are targeting our efforts at areas of highest deprivation and global majority groups, e.g., Black and Asian. Through hyper-local community engagement projects in each PCN, we aim to improve access to primary care for identified target cohorts. Through these projects, we aim to strengthen links between VCS organisations and primary care, leading to improved access and health outcomes for our most vulnerable residents. Learning and community insights will help inform future neighbourhood health team (NHT) plans.
- **Cancer prevention & early diagnosis**: Primary care is working on several projects with system partners to increase uptake of cancer screening programmes, particularly for groups who have been identified through population health data as having the lowest uptake.

- **Westminster Integrated Neighbourhood Team (INT) and Octopus**: The 'Octopus' brings together partners from across health, local authority, VCS and academia to strengthen partnership working and address health inequalities. 'Connector' roles including the Community Health & Wellbeing Workers (CHWWs), Care Navigators, Health & Wellbeing Coaches and Social Prescribers are working with system partners to address the wider determinants of health and improve health and wellbeing of our residents. As part of the Westminster INT Long-Term Conditions workstream, we are working on projects to address health inequalities and improve access to primary care, including participating in a PocDoc (point of care testing) pilot. HCL is working in partnership with Public Health to equip the VCS sector with knowledge and skills to raise awareness of symptoms and to signpost residents to services through community outreach, e.g., Diabetes Primary Prevention training for VCS organisations; blood pressure reading training for Community Champion teams.

Access Plan and Health Inequalities

There are clear synergies between the work that is being undertaken through the HCL Health Equity Programme and the primary care Access programme. We will identify opportunities for better alignment of community engagement and outreach efforts across the programmes, including ensuring that the patient voice is captured and that our Patient Participation Groups are more representative of the local population. By analysing demographic data of service users, we will begin to build a clearer picture of who is and isn't accessing our services and their outcomes, to inform targeted interventions. Community insights and feedback from each programme will inform the other.

This Access Improvement Plan embeds equity throughout its design and delivery:

- **Targeted Continuity of Care**: Practices will flag the top 2% of patients with complex needs, prioritising those from deprived and global majority backgrounds for continuity interventions

- **Multilingual and Inclusive Communications**: All patient-facing materials will be reviewed for accessibility and translated where needed. Envisage screens in practice will display content not regularly seen by digitally excluded groups

- **Community-Based Engagement**: Events will be held in trusted community venues (e.g. Abbey Centre), and outreach will be co-designed with local partners to reach underserved populations

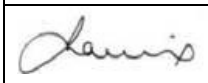
- **Co-Production with Lived Experience**: A pilot advisory board will involve patients from marginalised groups in shaping services, ensuring cultural relevance and trust

By embedding these approaches, the plan aims to:

- Reduce variation in access and outcomes across demographic groups
- Increase uptake of services among underserved populations
- Build trust and engagement with communities historically excluded from service design

7. Authorisation

The PCN leads and a nominated lead for each constituent Practice

Signature	Name (Printed)	Role	Organisation
	Dr Jan Maniera	Clinical Director & Deputy Chief Medical Officer	South Westminster PCN
A.M. Gaffney	Amanda Gaffney	PCN Business Manager	Healthcare Central London Ltd

Date: ___30th June 2025_____

Once signed and dated by the PCN representatives and each constituent practice, the plan should be submitted to the ICB via the Local Services mailbox (nhsnwl.localservices@nhs.net), with a clearly defined subject on the email: ***ImprovingAccess_Plan and Declaration_XXPCN_Submission Date***

Submissions should be made by ***30 June 2025*** *at the latest.*