Exploring small scale experiments for potential change within our health care systems

Introduction and context

Through the Healthy Communities Together (HCT) project, the Solidarity Network and partners are working with marginalised communities to map and explore the relationships and potential for change within healthcare systems. Conversations with marginalised population groups resulted in a set of three overarching principles for the tackling health inequalities work:

- **Equity not Equality -** People have different starting points and one size fits all is not equality, yet our systems are often rigid. We have been successful in designing systems better for certain access needs or elderly patients, how do we apply these principles to inclusion health groups?
- **User centred design -** The people that use our systems know how to make them better; we must collaborate to make best use of our resources. We need to build practice around getting representative patient populations involved in designing our practices.
- **The NHS is for everyone -** This is our starting principle – different access needs should be accommodated, and compassion should be at the start and end of our design.

Population groups were asked their ideas for a series of small-scale proof of concept 'experiments' that could be tried to test the effectiveness of these principles in practice, whilst remaining agile and not altering systems. Primary Care were invited to come on a journey to support in testing these experiments and their effectiveness – to try working differently for a period of time and reflect on the impacts. The ideas were designed to be simple - typically actions that were already being taken in part - and human, so those involved see the benefits and want to do more.

This report relates to HCT GP Practice Experiment 1. This came about because marginalised communities report that they often don't understand their conditions, medications or referrals. The experiment sought to give more time in appointments to take an open questions approach to assessing what understanding someone has taken away from an interaction, asking checking back questions such as 'can you talk me through your medication?' In line with principles of simplicity and humanity, the initial experiment premise was to extend General Practitioner and other relevant appointments (e.g., with Advanced Clinical Practitioners) from 15 to 20 minutes, with the additional 5 minutes being used for 'checking back understanding' and to capture

patients' reflections on their experiences of the extra time through an in-person survey at the Practice.

Despite effort, enthusiasm and willingness from all those involved in this experiment, it did not happen as planned and there were significant challenges in refining the experiment design and delivery which mean the experiment has not been possible within the scope and timescales. In this reflective report, we explore the interlinked and complex factors that contributed to this outcome. This learning report summarises project activity between June 2024 and May 2025, and highlights and reflects on key challenges to support future discussions.

Approach to Experiment 1 delivery

Due to reduced capacity in the Healthy Communities Together (HCT) team, Nifty Sustainability CIC (Nifty) were contracted in June 2024 to support and co-facilitate Experiment 1. Initial discussions between Ellie Rogers (Leeds GATE), Ellen Hill (MESMAC) and Nifty resulted in a proposal for Nifty to facilitate and evaluate the experiment along pre-designed lines (see Appendix A). Bramley Health (which encompasses Bramley Village Health and Wellbeing Centre, Middleton Park GP Surgery and Cottingley GP Surgery), had previously offered to host the experiment. Nifty's role involved liaising with clinicians and practice management at Bramley Health and Leeds GATE to support and adapt experiment and research design, co-develop relevant documents (e.g., clinician briefing sheet), facilitate the experiment in line with practice guidance on logistics and then lead the analysis to develop outputs.

Initially the intention had been to run the experiment for a number of months and MESMAC anticipated the team member attending the participating practice(s) for a full day 3 times a week. Given available financial resource and capacity in the Nifty team, we agreed 3 x 3-hour sessions in practice(s) at different times of day over the experiment period. After conversations with the Bramley Practice Manager and Assistant Practice Manager, it was decided the experiment should be focused on Middleton Park GP Surgery (the Practice) as it has a larger patient base than Cottingley GP Surgery and a more relevant demographic than Bramley Village Health and Wellbeing Centre.

Project timeline

Initially, the project had been intended to run between May and July 2024 with reporting in August 2024. Table 1 below summarises actual project timescales with reflections on key enablers and challenges.

Dates	Activity	Reflections, enablers and challenges
June 2024	• Introductions to the work, Nifty preparing proposal • Getting rolling meeting, Nifty, MESMAC representative and Leeds GATE representative.	• Useful background, aims and motivations for the experiment shared.
July	• First contact with Bramley Health. Online meeting arranged with Practice Manager and Assistant Practice Manager. • The Practice Manager was enthusiastic but unable to attend due to other commitments. He later emailed with some additional information, but we remained unclear on how he envisaged the experiment running.	• Time and resource challenges for Bramley Health especially with regards to availability of leadership in scoping meetings meant some important aspects of the experiment design and logistics were unresolved.
August	• Useful phone call with the Practice Manager who clarified his expectation that the experiment should take place over one day at Middleton Park GP Surgery with active recruitment of members of the Leeds GATE community. • Update email sent to MESMAC and Leeds GATE outlining the approach	• Intention was to maximise learning on impacts and outcomes for target community within resource limits. • Highlights problematic dynamic of Practice Manager(s) and other decision makers/gate keepers being able to determine format of the experiment
September	• In person meeting with Practice Manager and Assistant Practice Manager to firm up logistics for the experiment. Date suggested as 22nd October. • Email received from new HCT Coordinator seeking clarification on the new experiment design • Attended TARGET meeting at Middleton Park GP Surgery	• The TARGET meeting highlighted gaps in communications and concerns around the experiment design and impacts on other patients and appointment availability. • Evidence of competing priorities, structural barriers and resistance to change related to pressure from existing operational demands. • Different ideas about how the experiment should and/or could be designed and run were emerging at this stage

October	• Met with HCT Coordinator to update on experiment and the challenges we were facing – she relayed these to Leeds GATE. Both HCT Coordinator and Leeds GATE representative were keen to revisit the design, so the experiment was over a number of days rather than just one
	• Nifty requested meeting with Leeds GATE group to discuss ideas
		• Key challenges around misunderstandings and differences in perceptions of partners involved were forming particularly in relation to:
		  ○ Experiment design and scope
		  ○ Logistics and feasibility for the practice
		  ○ Nifty's role in facilitating experiment design
		• It was clear that it would have been beneficial to have key individuals across roles from the Practice involved in the early stages to co-design the project and ensure all relevant knowledge was shared
		• Nifty highlighted challenges and proposed a co-design session with members of the Leeds GATE community and with representatives from different areas of Middleton Park GP Surgery (including Care Navigators, clinical practitioners and Practice management).

November	• Meeting between HCT Coordinator, representative from Leeds GATE and Nifty to relay concerns raised by the Practice staff around the impact of increasing appointment times. • Leeds GATE representative suggested we could develop a 'template' of more open questions to ask during 15 minute appointments rather than extending appointment times to 20 minutes. • There was also potential to fund sessional GP capacity for Middleton Park Surgery for a few hours while the trial was on so capacity for other patients was impacted less. • Email sent to the Practice Manager and Assistant Practice Manager to update them on these ideas and try to arrange a time for a co-design workshop.	• Attempts to respond to structural barriers around appointment times were made in proposing alterations to experiment design. • It proved difficult to find a day that worked for both the Leeds GATE community and for representatives from the Practice and we discovered that the Assistant Practice Manager had left her role leaving a gap in capacity and coordination at the Practice, so this meeting did not happen until the New Year

January 2025	• Facilitated co-design workshop with 4 members of the Leeds GATE community, CEO of Leeds GATE and 3 representatives from the Practice.	• Challenges around differing expectations of the experiment were very evident here. The impacts of historical marginalisation, power dynamics and structural barriers meant that it was difficult to achieve the aims and outcomes from the workshop in terms of co-designing the experiment. • However, clear actions for each party came out from this process and the experiment was co-designed as a 2-week period where double appointments would be offered for patients whose records indicated they were from marginalised/target communities. The additional time was to be used to ask 'checking back' questions.
February	• Ongoing communications around logistics for the experiment including additional questions, dates and any support needs	• Despite the seemingly positive outcome from the January workshop, there was a notable drop off in communications at this point from both Leeds GATE and Middleton Park GP Surgery. We emailed both parties to remind them about the actions.
March	• Guidance document received from Leeds GATE included questions which extended beyond the intended 'checking back' questions for the additional appointment times to e.g., interpersonal communication from healthcare staff • Ongoing email contact with the Practice around logistics for the experiment and sharing of additional questions with Practice staff	• The broader questions reflected the experiences of the Leeds GATE community, however, this posed a challenge where Practice representatives had previously shared that some of the broader questions were either already part of standard practice (e.g. interpersonal skills) or not appropriate from a risk/care perspective (e.g. Is there anything else? How's the family?).
April	• As a follow up to emails, Nifty spoke 1-2-1 with the Practice Manager and he explained the Practice representatives had felt quite attacked at the group discussion in January and was a bit	• Email as a means of communicating was challenging, 1-2-1 calls were better, but difficult to exchange views across different groups. We were keen to get the experiment going

	taken aback because they had approached the experiment with enthusiasm. • The document with additional questions from Leeds GATE was shared for comment • The Practice Manager replied with comments on the Leeds GATE guidance document. He remained willing to facilitate the experiment but had returned to the idea of conducting it over just 1-day and adding an additional 5 minutes to the appointments as opposed to doubling the times over the two-week period as agreed in the January discussion.	and so proposed a finalised design trying to meet the needs of both parties and sent it to Leeds GATE and the Practice Manager for agreement (see Appendix C). The Leeds GATE representative responded positively but we received an out of office from the Practice Manager. • There were considerable frustrations at this point. There had been good progress after the January meeting despite the challenges of that session, and a plan had been put in place for the experiment. • While the Leeds GATE guidance had been beyond the scope of the experiment, it felt like a missed opportunity that the Practice Manager did not engage more meaningfully with it as a further chance to understand and engage with the needs of the Leeds GATE community.
May	• The Practice Manager responded positively to our proposed experiment design when back in the office but had reverted to actively approaching members of the Leeds GATE community for appointments. • We met with the HCT Coordinator to discuss producing a detailed learning report from the process given the timeline for the experiment was now not possible. • In our most recent email exchanges, the Leeds GATE representative looped in the Inclusion Health Lead at ICB, and made reference to work at East Park surgery in Leeds who have a tiered system of appointments where patients are screened and categorised into different tiers based on their clinical and social vulnerability.	• Following discussions with HCT Coordinator, MESMAC and Leeds GATE representatives focused on how best to collate learning and develop an alternative output from the work given the timescales and the increased likelihood that we would not get consensus on the experiment design.

	• The Inclusion Health Lead and the Practice Manager emailed to suggest meeting and discussing this.	

Table 1: Timeline of project activities with reflections on experiment enablers and challenges

Exploring the learning

Some clear themes have emerged throughout this work as presenting challenges to the experiment being designed, conducted and evaluated in the way that was planned, with some misunderstandings, at the beginning of this work, around how much of the design of the experiment had already been agreed. Some of these could have potentially been avoided or reduced with a rigorous, robust and early co-design process for the experiment to really make sure everyone is on the same page and feeling heard although there was evidence of structural barriers that would have remained difficult to overcome.

Our headlines are:

- A meaningful and genuine co-production process starting at an early stage in the experiments and involving representatives from all relevant parties is absolutely essential so that everyone is on the same page regarding understanding and expectations of the process and has had chance to feed their ideas and concerns into the design.
- While the experiments are meant to be agile, they will still likely have an impact on a resource strapped healthcare system and will face structural barriers that are hard to overcome. This needs to be taken into account and staff from across all areas of organisations need to be involved in co-design to contribute ideas to reduce this impact and address these barriers.
- Early on in the process there needs to be space for people to air their concerns and past experiences and feel heard around injustices they and their community may have faced. This would make moving forwards with an experiment easier and more future focused.
- It is difficult to isolate one small aspect of the health system to experiment with, when it is all very interlinked in terms of patient experience, systems and processes and wider health and care system pressures.
- A useful next step might be to coordinate an Adaptive Action approach to give space for lived experience alongside systemic challenges in exploring how to overcome historical and structural inequalities.

In this next section, we summarise the challenges faced throughout the process which resulted in the above learning points. We have broadly separated them into mismatches in understanding and expectations, the broader context of a resource constrained system, historical marginalisation and scope creep and interlinked systems.

Mismatches in understanding and expectations

Throughout the project there was evidence of mismatches in understanding and expectations between those involved.

Within the healthcare team, there was evidence of differences in opinion and gaps in communication. This was particularly evident at the TARGET meeting in September where we had expected to co-design elements of the experiment with staff such as a clinical briefing document. The meeting was not very well-attended, and the Practice Manager wasn't available to answer questions from the Practice side as he was attending a different meeting. It quickly became clear that the staff that were present weren't aware of the experiment and our plan for the meeting, focusing on co-design of e.g., a clinician briefing sheet wasn't appropriate. We were challenged about various aspects of how we were expecting the experiment to run and didn't have the answers. Much of the power and intention in this experiment was held by the Practice Manager who had obvious competing demands for his time.

We explained how the Practice Manager envisaged the experiment through extending appointment times to 20 minutes and actively recruiting the Leeds GATE community. The Care Navigator team were deeply concerned about the impacts this would have on other patients through a reduction in available appointments in an already stretched system. For example, they were concerned about setting aside appointments on the experiment day for the Leeds GATE community and the impacts that would have on other patients requiring appointments. They were also concerned about reducing the number of appointments to 3 per hour if lengthened to 20 minutes as opposed to 4 per hour when 15 minutes. These represented structural barriers which were hard to overcome in a stretched system and presented a tension with the agile nature of the experiment.

There were also a lot of questions we were unable to answer around what 'types' of appointments we needed to extend (e.g., routine / sexual health) and whether there were particular areas that the Leeds GATE community felt were lacking clarity.

Most meeting attendees were Care Navigators, who were understandably concerned with the logistics of the appointments and the impacts on other patients. There was one Advanced Clinical Practitioner (ACP) at the meeting who was able to bring her experience of the appointment context. The ACP was very supportive of the experiment but also said she already asked those kinds of 'checking back understanding' questions and said it would really depend on the individual whether another 5 minutes of appointment time would be beneficial for that.

This meeting highlighted gaps in knowledge and communication in the Practice around the experiment, which we had not been aware of. Even where there was enthusiasm for the experiment, there was some mismatch between practice staff, leadership and clinicians. It made us reflect on the importance of co-design and involving all relevant parties in this at the earliest possible stage, as well as the power dynamics within the practice.

The Practice Manager was also keen to actively recruit members of the Leeds GATE community on just one day, whereas the Leeds GATE community wanted to run the experiment for longer and evaluate the impacts of the extended appointments on everyone who experienced them, in the spirit of what benefits marginalised communities is likely to benefit others as well. In an email the Leeds GATE representative reiterated that they had been working on the notion of a week for the experiment and every appointment was extended by 5 minutes for everyone because:

- *'we believe making things better for people on the margins benefits everyone and that whilst these issues have a fiercer impact on our communities they are felt across all communities*
- *the experiment therefore becomes about good practice in primary care which benefits everyone and is an easier "sell" to the primary care board*
- *these areas also experience high levels of deprivation and are priority areas for health and LA so it would also meet lots of different objectives to try and support people in these areas'*

Indeed, the timescale for the experiment changed a number of times throughout the process – when we started discussions with MESMAC and Leeds GATE we understood they were promoting the experiment over a longer period but when we managed to speak to the Practice Manager he was certain a day would be better. As we were trying to take into account the needs of all parties we went with this until the HCT Coordinator expressed concern. After our co-design workshop in January, we had all agreed on a two-week period, but a lack of engagement ensued, and the Practice Manager had reverted to his original plan of just one day when he got back in touch. This highlighted the innate power imbalances where the Practice was able to ultimately determine the format of the experiment.

There were also differing ideas between healthcare representatives and Leeds GATE, which remained unresolved throughout the process. For example, representatives of the Practice said they already did the sort of things the experiments were designed to test e.g., the Care Navigators said they already check people's communication

preferences and ACPs said they already asked the kinds of 'checking back' questions that were promoted in the experiment. The Leeds GATE community were able to recount many times when this wasn't the case, and we were all agreed that likely some people within the healthcare system did act in this way and there were likely others that don't, and it is hard to change how everyone operates.

The Leeds GATE community wanted healthcare practitioners to ask open questions and check in on their broader lives. Healthcare representatives explained this was a risk for them in case of e.g., significant disclosures which they would then not have the capacity and resource to address the issues safely.

Throughout the process we felt like we were bouncing back and forth between these different parties and had limited scope for being able to facilitate a way forwards amongst these differences. When we thought we were making progress, key players would revert to earlier ideas, and we felt like we went backwards.

The broader context of a resource constrained system

It was clear throughout the process that there are huge resource constraints within the healthcare system and the key people involved in the experiment were frequently too busy to respond or meet, leaving gaps between communications and scope for focus being lost.

Across the three sites of Bramley Village Health and Wellbeing Centre, Middleton Park GP Surgery and Cottingley GP Surgery, they reportedly receive 500-600 calls per day, and Middleton alone typically has 100+ people calling before 8am for only 14 available 'on-the-day' appointments. In a meeting to discuss the experiment design, staff at Middleton Park GP Surgery highlighted concerns around the impact the experiment would have in extending appointment times on their already acutely stretched system and the patients that are using it.

Staff at Middleton Park GP Surgery were also concerned about the impact of the experiment on those who needed appointments given that increasing appointment times to 20 minutes reduces available appointments by one per hour. They explained that they would need to pre-warn patients that fewer appointments would be available while the experiment was running.

Historical marginalisation

The impacts of historical marginalisation were clear particularly in our co-design workshop in January with representatives from the Leeds GATE community and the Practice, where we heard stories of previous negative experiences of healthcare. While

those representing the Practice were not directly involved in these experiences, the Leeds GATE community members clearly needed to use the opportunity to recount these stories with the healthcare representatives involved. This led to healthcare representatives feeling attacked when they are trying to contribute to making the system better through the experiment.

In notes responding to Leeds GATE guidance for the experiment (see Appendix B) around interpersonal communication, the Practice Manager stated:

'... this is part of clinical staff statutory and mandatory training. This should not change for any patient that comes in to see us? Again this focuses on clinical staff skillset as opposed to the study of understanding care for set demographics. Our clinical staff have internal and external appraisals to check on them, I cannot see them being onboard if the focus is on them. This was evident in the meeting at Leeds GATE, it was felt scrutiny on clinical decision making was being highlighted?'

This, in particular, felt like a missed opportunity. Despite healthcare representatives being enthusiastic about the experiment, they did not engage meaningfully with the lived experience of the GATE community and with their suggestions and guidance for how it come be improved. Structural barriers and competing priorities seemed insurmountable at this stage.

Scope creep and structural barriers

While Experiment 1 was clearly focused on what happens within the appointment and extending the time available to ask 'checking back' questions, it was hard to separate this from the rest of the system. For example, at the Middleton Park GP Surgery 'TARGET' meeting, representatives of the Surgery discussed things that they felt were already in place to make it easier for marginalised communities to access healthcare systems, such as interpreters, rather than focusing on the extended appointment times.

In addition, the guidelines produced by the Leeds GATE community after the discussion group included many other aspects of the patient experience such as the welcome, pre-appointment checks and the manner of the practitioner. The Practice Manager explained:

'The above set of questions are more aimed at our clinician's competence. We have very few complaints about not doing any of the above, this is an expectation of our clinical professionals and therefore is a focus on them as opposed to improving care for a set demographic?'

Concluding remarks

Despite effort, enthusiasm and willingness from all those involved in this experiment, significant challenges meant it was not possible to deliver it within the scope and timescales expected. We have explored these here through the themes of mismatches in understanding and expectations, the broader context of a resource constrained system, historical marginalisation and scope creep and structural barriers. Some of these could have been avoided with a rigorous, robust and early co-design process for the experiment to really make sure everyone is on the same page and feeling heard although there was evidence of structural barriers that would have remained difficult to overcome. We hope the learning from the process will be valuable in informing future interventions and suggest that an Adaptive Action approach could be relevant here to give space for lived experience alongside systemic challenges in exploring how to overcome historical and structural inequalities.

Appendices

Appendix A – Nifty proposal for our role in the process

As per our discussions, please find below a summary table presenting our agreed timelines, proposed activities, resource requirements and costings for managing the project, engaging with clinicians and practice management, supporting research design, leading the analysis, and developing outputs.

Weeks	Activity	Days	Cost Director = £500pd Researcher = £300pd
1 to 12	Project management • Kick off and on-boarding • Contracts management • Data sharing and GDPR • Comms throughout	2 Director 1 Researcher	£1000 £300

1 to 2	Research design and logistics
	• Finalise research/experiment design inc. Qs for clinicians, practice management and patients
	• Survey design, capturing patient feedback (form for use in person)
	• Confirm non-identifiable quantitative/demographic data available/required
	• Confirm logistics and set-up: dates/times (with practice manager), location/space in practice
	• Co-producing clinician brief sheet:
	  ○ Purpose of the work
	  ○ How to ask questions
	  ○ Examples of questions to be asked
		1 Director
		1 Researcher
			£500
			£300

3 to 5	Data collection – baseline
	• 1-2-1s with clinicians and other relevant staff
	• Attending practice meeting:
	  ○ Introduce the research
	  ○ Share clinician brief
	  ○ Capture snapshot baseline data
		1 Director
		2 Researcher
			£500
			£600

6 to 9	Data collection - experiment • In practice sessions capturing patients' feedback (3 * 3hr sessions at different times of day)	1 Director 3 Researcher	£500 £900

	• Survey ongoing • Initial analysis – looking for themes and gaps as we go • Post experiment 'check in' with clinicians and practice management staff (1-2-1s/survey update)		
9 to 10	Analysis of findings • Collating data from across sources • Thematic analysis	1 Director 1 Researcher	£500 £300
11 to 12	Deliverables • Write up research summary (max 4 sides A4/short slide deck) • Co-present findings	2 Director 1 Researcher	£1000 £300
	Total days	8 Director 9 Researcher	£4,000 £2,700
	Total cost		**£6700**

Appendix B – Leeds GATE guidance document (with comments from Practice Manager in bold)

Appointment Guidance

Pre appointment Checks

- Does the patient have all contact details filled in? When were they last updated? **Should be done by Admin anyway, no need for clinician to check / patient responsibility**
- Does the patient have any communication preferences recorded? **Can inform admin if update needed / if noticeable clinician can add in consultation**
- Does the patient have any Long-Term Conditions and are they participating in any management plans around this? **Included in clinical notes**
- Has the patient been referred for any secondary appointments and what happened? **Included in clinical notes**
- Has the patient missed any appointments? **Unless safeguarding relevant or care has been delayed the clinician would not check**
- Have they attended all screening offers? (Over 40, mammogram, cervical, AAA etc) If not could this be discussed? **Yes this could be discussed but often invites are done external from the surgery, e.g. AAA**
- Could this be a patient that is frail (regardless of age)? **Clinician would not anyway in consultation**
- Is there any opportunity to screen for alcohol and drug use if NHS health checks not up to date? **Frequent asked question for consultation but for the day we could add this as a standard question**

Interpersonal Communication

- Welcoming manner – giving a warm welcome and enquiring how patient and patients family are. **Should be done as standard alongside patient history and family history**
- Making eye contact and using open body language
- When in conversation, only focusing on the patient not screens – **Agreed, however often information or documentation need from clinical record**
- Affirming and validating patient experience
- Active listening
- If any checks need to happen, explaining why and what will happen and seeking consent
- If needing to use the computer, explaining why and what you are doing – **As above**

The above set of questions are more aimed at our clinician's competence. We have very few complaints about not doing any of the above, this is an expectation of our clinical professionals and therefore is a focus on them as opposed to improving care for a set demographic?

Questions for the appointment

General

- How are you?
- How are your family?
- What's been happening for you?
- How does that make you feel?
- Tell me what happened…
- Is it better if…
- I enjoy seeing you
- Take care
- Its okay to cry

As previous, this is part of clinical staff statutory and mandatory training. This should not change for any patient that comes in to see us? Again this focuses on clinical staff skillset as opposed to the study of understanding care for set demographics. Our clinical staff have internal and external appraisals to check on them, I cannot see them being onboard if the focus is on them. This was evident in the meeting at Leeds GATE, it was felt scrutiny on clinical decision making was being highlighted?

- Explaining medical conditions in everyday language – what is happening in the body – **agreed, this was the overall aim of the experiment to start with, on the day we can provide further focus here.**
- What were you hoping from today's visit? **Happy to include in the starting point of the consultation but cannot be a guarantee this is what the outcome will be.**

Administrative

- Can I check your contact details are up to date?
- Can I check if you have any communication needs – are you able to speak on the phone? Would you be able to read a letter? What is the best way to contact you?

As per pre appointment checks – should be an admin process and should be checked by both admin and patient when in contact wit the surgery.

- Do you need any support with this referral? Etc – **To be added within the clearer everyday language point as above.**

Long Term Conditions

- For LTC's, if engaging with support – I can see you have xxxx and are accessing xxxx. How are you getting on? Do you have any questions?
- For LTC's, if not engaging – I can see you have xxxx. Are you aware of xxxx support on offer? Is there any reason you haven't been able to attend? Is there any support we could offer that would help you attend?
- For LTC's - How are you feeling about it?
- Is this someone who could be in their last year of life? Consideration of referral to health inclusion palliative care team

All of the above is part of standard clinical practice and should the condition a patient is presenting with be relevant to an LTC a check and reference would be made in the clinical notes. If this was to be checked for all patients attending, then the added time for appointments would be required. 20 minutes as opposed to 15 was my initial thought for additional Questions and checks.

Medication

- For medication. I can see you take xxxx. Are you confident in taking it – do you know when and how many? Have you anything you want to discuss about your medication?
- Are you taking any other medication that is not prescribed? How does it help you?

Agreed with above – can outline in the consultation for relevant medication for that condition. Issue may arise for polypharmacy patients or patients on 10+ medications as this would require a full medication review as well as the standard appointment length.

Missed Appointments

- For missed appointments. I can see you missed appointments. Was there a reason you couldn't attend? Is there anything we could do to support you to attend?

Admin / management question to be asked with focus on the support needed t get to appointments – e.g. housebound patients

Ending

- We will work together on this – short and long term solutions – I will do this and you need to do this
- Is there anything else you'd like to discuss – **Could be open ended and cause significant delays to other patients**
- Checking back the actions and the understanding – so can you tell me what's going to happen next? Can you tell me how you are going to take the medication? – **As above – this was the scope of the study to start with (5 min extra to go though this from a patient perspective)**
- If you need any support with this ask reception
- If it gets worse come back
- It was nice to see you
- Take care

Appendix C - Proposed experiment design

Based on conversations with the CEO of Leeds GATE and the Practice Manager, and a discussion group at Leeds GATE, we propose the following design for a one-day experiment at Middleton Park GP Surgery.

Questions / approach to add to clinician appointment:

- What are you hoping from today's visit?
- Explaining medical conditions in everyday language – what is happening in the body –
- Do you need any support with this referral?
- Checking back the actions and the understanding – so can you tell me what's going to happen next? Can you tell me how you are going to take the medication?

Things to check

- Have they attended all screening offers? (Over 40, mammogram, cervical, AAA etc) If not could this be discussed?
- Is there any opportunity to screen for alcohol and drug use if NHS health checks not up to date?
- Does the patient have any communication preferences recorded? (If noticeable clinician can add in consultation)

If it is possible to book double appointments, then the following could also be included:

Medication review (caveat - can outline in the consultation for relevant medication for that condition. Issue may arise for polypharmacy patients or patients on 10+ medications as this would require a full medication review as well as the standard appointment length**.)**

- For medication. I can see you take xxxx. Are you confident in taking it – do you know when and how many? Have you anything you want to discuss about your medication?
- Are you taking any other medication that is not prescribed? How does it help you?

Long Term Conditions (caveat - All of this is part of standard clinical practice and should the condition a patient is presenting with be relevant to an LTC a check and reference would be made in the clinical notes. If this was to be checked for all patients attending, then the added time for appointments would be required. 20 minutes as opposed to 15 was my initial thought for additional Questions and checks)

- For LTC's, if engaging with support – I can see you have xxxx and are accessing xxxx. How are you getting on? Do you have any questions?
- For LTC's, if not engaging – I can see you have xxxx. Are you aware of xxxx support on offer? Is there any reason you haven't been able to attend? Is there any support we could offer that would help you attend?
- For LTC's - How are you feeling about it?
- Is this someone who could be in their last year of life? Consideration of referral to health inclusion palliative care team