Communicating effectively with policy makers

SPCR Masterclass; 20 November 2025, 10-11.30am

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HOPE

Health Organisation, Policy & Economics

Session overview

- What is policy engagement and why does it matter?
- Conceptual tools: Cairney & Kwiatkowski's (2017) framework for effective communication
- Breakout discussion about your policy communication goals
- Practical guidance: Writing, formats, channels, and resources
- Action planning: Concrete next steps you can take

My background/context

- 2011-2015: PhD HSCA2012, CCGs
- 2015-2023: RA/RF (HREP understanding commissioning system; NHS Test Beds…)
- Policy Research Unit (PRU)Comm / PRUHSSC
- GP Access (NIHR Policy Research Programme)
- Health and Care 2022 Post-Implementation Review
- Written evidence HCB21, verbal evidence to HoL peers; 2022: verbal evidence to ‘Fuller Stocktake’, written evidence to HSCSC expert panel on HSC workforce
- Course Unit Lead: MPH Introduction to Health Policy

NIHR | Policy Research Unit
Health and social care systems and commissioning

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Team SharePoint Area

We provide evidence to inform policy on health and social care systems and commissioning to maximise outcomes for service users

Featured projects

Commissioning & service delivery

The Place Project: Delivering integrated neighbourhood services – understanding commissioning and service design within places

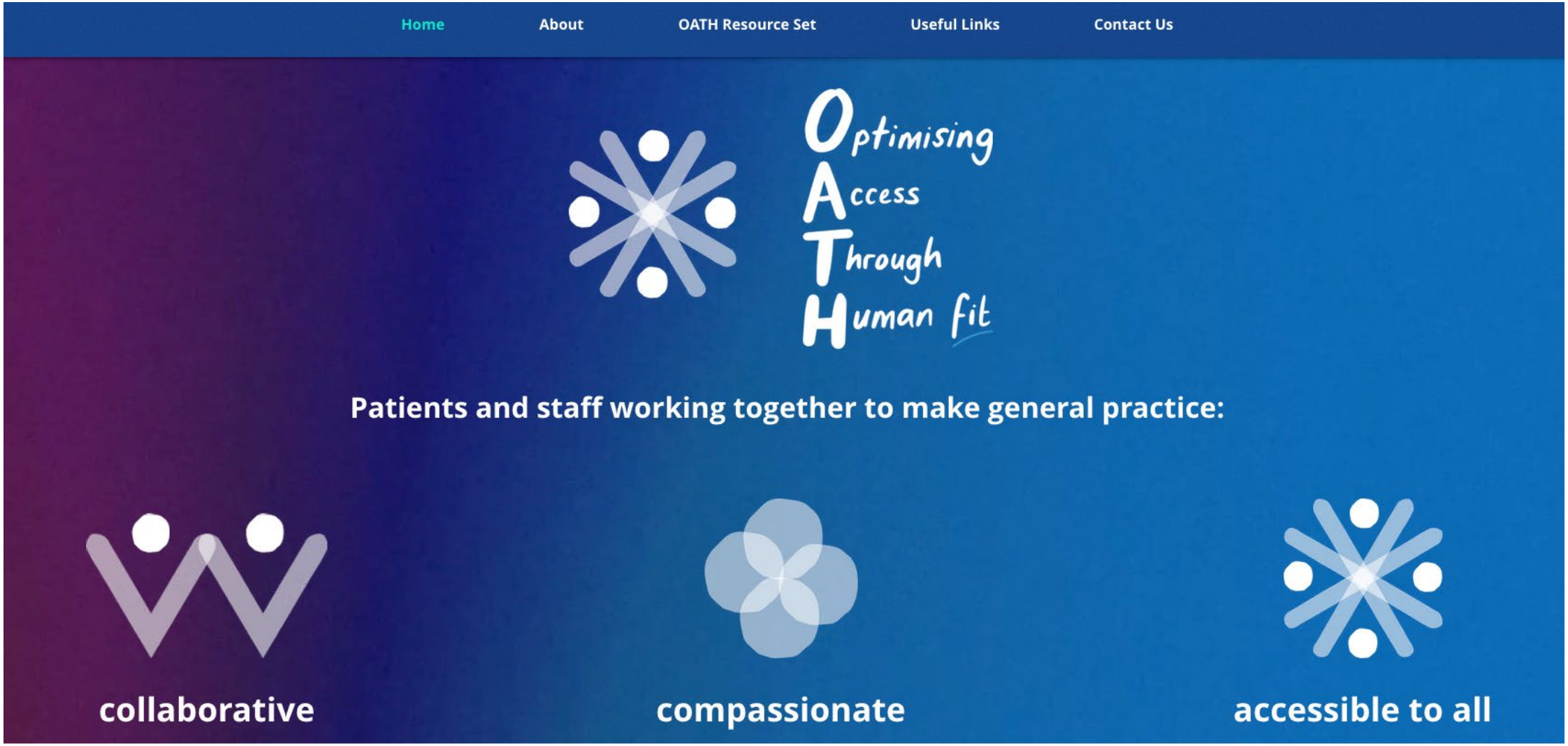
System design, governance & accountability

Provider Collaboratives: What are the purposes and aims of provider collaboratives?

System finance & economics

Bending the Spend: What prevents commissioners from spending more on out-of-hospital care?

https://pru.hssc.ac.uk/



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This study/project is funded by the NIHR Policy Research Programme (project reference NIHR202311). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

https://www.oath-access.com/

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OATH Resource Set

Infographics

Easy to read infographics to explain the problem of access, and access as human fit.

Animations

Short, digestible animations explaining the research and key concepts.

Tools

Interactive tools and guide to explore access as human fit with patients and general practice.

Access the set

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Policy engagement

- What do we mean by policy engagement?
- The ‘evidence gap’ (and ‘messiness of reality’)
- Even excellent research has zero impact without effective communication

Why engage/communicate with policy makers?

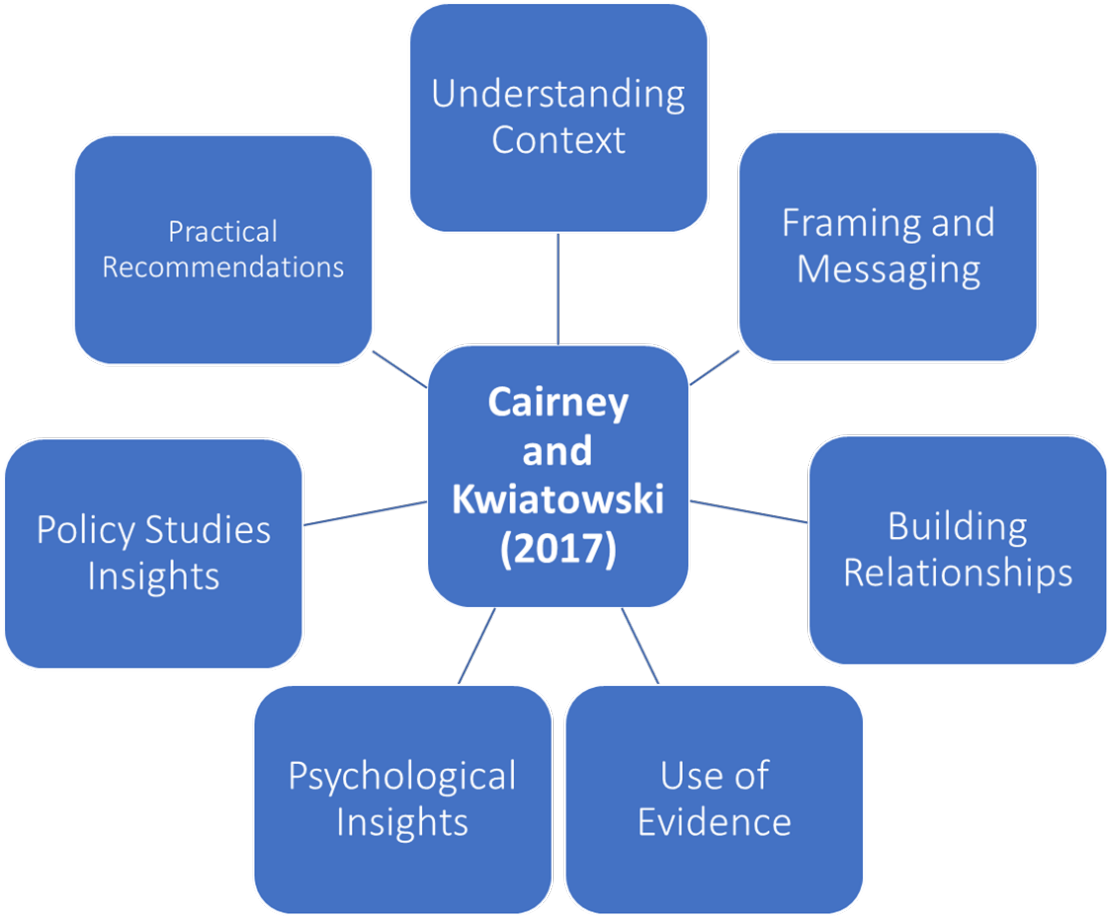
- Intrinsic: societal impact, fulfilment, intellectual satisfaction
- Extrinsic: resources, policy influence, network building, practical application
- Reflect on your motivation…
  - (There's no single "right" reason - but understanding your motivation helps shape your approach and sustain engagement over time)

Conceptual tools

Oliver and Cairney (2019) - Eight recommendations

(1) Do high quality research;
(2) Make your research relevant and readable;
(3) Understand policy processes;
(4) Be accessible to policymakers: engage routinely, flexible, and humbly;
(5) Decide if you want to be an issue advocate or honest broker;
(6) Build relationships (and ground rules) with policymakers;
(7) Be ‘entrepreneurial’ or find someone who is;
(8) Reflect continuously: should you engage, do you want to, and is it working?

Cairney and Kwiatkowski (2017) - How to communicate effectively with policymakers



Cairney and Kwiatkowski (2017) - How to communicate effectively with policymakers

1. Understanding Policymakers' Context

- Cognitive overload
- Time constraints

2. Framing and Messaging

- Framing effects
- Narratives and stories

3. Building Relationships

- Trust and credibility
- Engagement and interaction

4. Use of Evidence

- Evidence-based communication
- Tailoring evidence

Cairney and Kwiatkowski (2017) - How to communicate effectively with policymakers

5. Psychological Insights

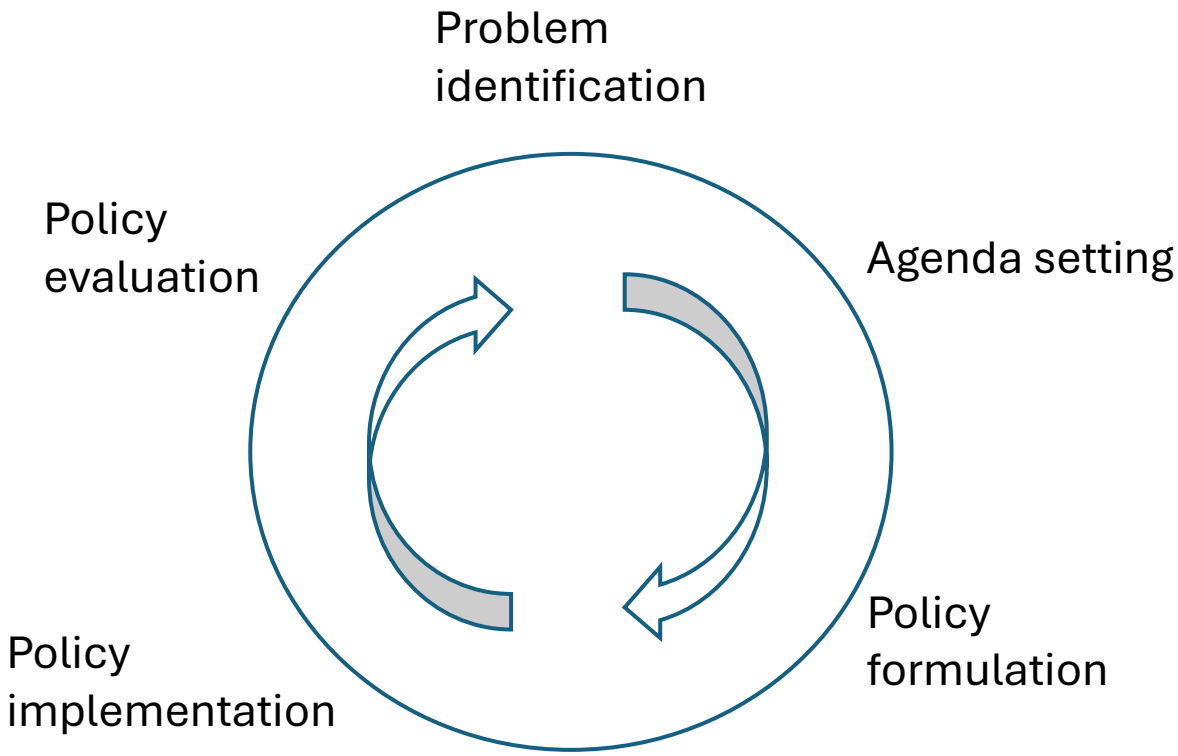
- Cognitive biases
- Emotional appeals

6. Policy Studies Insights

- Policy cycles
- Institutional context

7. Practical Recommendations

- Clarity and simplicity
- Repetition and reinforcement
- Feedback mechanisms



Putting it together

- All seven elements work together:
  - You can't frame effectively without understanding context
  - Relationships enable you to tailor evidence appropriately
  - Practical recommendations can be supported by psychological insights
  - Evidence use is shaped by policy cycles and institutional context
- The framework can be understood as an integrated approach to communication

Breakout (10 mins)

In your breakout group, discuss 2-3 of the following questions that resonate most with you:

1. **Your priorities:**
    - What aspects of policy communication feel most important or urgent for you right now?
    - What feels most challenging or unclear?
2. **Your audience:**
    - Who do you think could benefit from knowing about your research/work?
    - If you're not sure - how might you find out? What questions could you ask?
3. **Your approach:**
    - Thinking about Cairney & Kwiatkowski's framework, which elements do you feel most confident about?
    - Which elements feel most challenging for your context?
4. **Your questions:**
    - What would you most like to know about communicating with policy makers?
    - What practical support or resources would be most helpful?

No need to answer all questions - focus on what's most relevant to your experiences and interests. One person be ready to share 1-2 key themes from your discussion.

Communicating with policy makers

Applying the framework in practice:

- What makes communication challenging?
- What do policy makers actually need?
- How to write effectively
- Choosing the right format and channel

Communication challenges

- Academic communication norms vs policy communication needs
- Different timeframes (years vs weeks/days)
- Different languages (academic vs operational)
- Different success metrics (rigour vs actionability)

Policy maker needs

- Clarity over comprehensiveness
- Solutions/options over problems
- Timeliness over perfection
- Relevance to current agenda
- Actionable insights
- Brief evidence of credibility

Three Cs

- CLEAR: Simple language, logical structure, key messages upfront
- CONCISE: Respect time constraints, prioritise ruthlessly
- CONTEXTUALISED: Connect to current policy agendas and priorities

Understanding your audience

- Who are you communicating with?
  - Ministers/senior officials (strategic level)
  - Civil servants/policy analysts (evidence synthesis level)
  - Local commissioners/managers (implementation level)
  - Parliamentary committees (accountability/scrutiny level)
- What do they need from you?
- What decisions are they facing?
- What's their prior knowledge?

Message framing

- Lead with policy relevance, not research process
- Frame as opportunity/solution, not just problem
- Use narratives and stories strategically
- Connect to existing policy priorities

Policy brief

- What is it: Short document (1-4 pages) translating research for policy action
- When to use: Responding to consultations, proactive engagement, post-publication
- Core components:
  - Executive summary/key messages (the "if they only read this" section)
  - Context/problem definition
  - Evidence summary (minimal methods, focus on findings)
  - Policy implications/recommendations
  - Your credentials/contact

Structure: the inverted pyramid

- Most important information first
- Assume readers will stop at any point
- Headlines and subheadings to chunk up and signpost
- Bullet points to summarise
- Use of pull-out boxes for key statistics/quotes

Language

- Short sentences
- Avoid jargon and acronyms; define essential technical terms
- Use specific examples over abstract concepts
- Quantify where/if possible
- Remove caveats from main text (can add in footnotes)

General recommendations/ideas

- Offer specific, actionable recommendations
- Include different options with trade-offs
- Consider feasibility and cost
- Link to existing policy levers
- Avoid:
  - Saying "more research needed" (unless with specific question)
  - Provide recommendations beyond your evidence
  - Ignore political/practical realities

Other communication formats/modes

- Written formats:
  - Policy briefs (detailed)
  - Policy commentaries/evidence summaries
  - One-pagers/briefing notes
  - Consultation responses
  - Evidence submissions to inquiries
  - Op-eds/blog posts
- Verbal communication:
  - Expert testimony to committees
  - Briefing meetings with officials
  - Roundtables and workshops
  - Conference presentations
- Visual communication:
  - Infographics
  - Data visualisations
  - Short videos/animations

Choosing a mode

- Match to:
  - Urgency (inquiry deadline vs relationship building)
  - Audience seniority (one-pager for minister vs longer brief for policy team)
  - Topic complexity
  - Your relationship with recipient
- Multi-channel approach can be effective (repetition and reinforcement)

Responding to calls for evidence/enquiries

- How to find opportunities (parliament.uk, gov.uk consultations, professional bodies)
- House of Commons: Guidance for giving written or oral evidence to a House of Commons select committee: https://www.parliament.uk/globalassets/documents/commons-committees/witnessguide.pdf

Call for Evidence

Egg donation and freezing

Terms of reference for the call for evidence:

The Committee invites written submissions through the inquiry website addressing any or all of the issues raised in the following terms of reference by 9 January.

- What are the short and long-term health impacts of donating or freezing eggs and embryos and to what extent are they sufficiently researched and understood?
- Whether the counselling provided ahead of egg donation is adequate to ensure informed consent, including of potential health impacts?
- What level of compensation / payment should be provided to egg donors, if any?
- What evidence is there, if any, of vulnerable women being encouraged into egg donation or egg freezing?
- Is the regulatory regime on advertising as it applies to egg donation and people wishing to freeze their eggs or embryos sufficient?
- What has been the impact of changes to the release of donor information, including support for the families involved, and whether further legislation is required?
- Whether the existing legislative framework, including the Human Fertilisation and Embryology Act 1990, is effective in safeguarding the best interests of those undergoing treatment for egg donation or egg or embryo freezing?

The Committee is also keen to hear individuals' experiences of egg donation and egg freezing. Submissions from individuals will be treated in confidence and not published unless there is separate agreement to do so.

Written evidence submitted by The Policy Research Unit in Health and Care Systems and Commissioning (HSC0748)

Professor Kath Checkland, University of Manchester – corresponding author,
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Professor Pauline Allen, London School of Hygiene and Tropical medicine
Professor Stephen Peckham, University of Kent
Ms Melissa Surgey, University of Manchester

The Policy Research Unit in Health and Care Systems and Commissioning (PRUComm) is funded by the NIHR Policy Research Programme [PR-PRU-1217-20801]. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

We undertake research exploring the operation and development of NHS and social care systems. Current research is exploring:

- *The development and operation of Integrated Care Systems*
- *The development, operation and impact of Primary Care Networks*
- *The role of Community Health Services in demand management*
- *The 11th national GP Worklife Survey, exploring GP job satisfaction and sources of pressure*
- *The operation of the Quality and Outcomes Framework Quality Improvement domain*

This evidence is based upon research evidence derived from PRUComm and other studies and from our own and colleagues' experience of working within the NHS. This evidence has been previously shared with Jonathan Walden and colleagues from DHSC. ***We would welcome the opportunity to provide oral evidence to the Committee.***

1. *Summary of key points:*

Main conclusions:

- **History and our own research suggests that proper governance and accountability as well as the efficient management and oversight of the NHS requires some separation between responsibility for planning services and their provision, with an important role for a 'ring holder' with the power and authority to make decisions about the optimum distribution of resources. Providers cannot undertake this role. (section 7)**
- **At ICS level urgent guidance is required as to:**
  - **the principles by which decision making will occur in ICS statutory bodies;**
  - **the governance and accountability structures required;**
  - **and the mechanisms which will be put in place to avoid conflicts of interest and ensure that decisions are made in the interests of the local population.**
- **A local 'ring holder' is also required at Place level. If the exact make up of local Place-based committees is to be a matter for local 'Places' to decide for themselves, the shape of the governance and accountability framework at this level, and the principles by which decisions are made must be rapidly made clear, in order to avoid Places making decisions about structures which need to be undone in the future. Statutory responsibility and accountability must sit with a Place-based committee which is independent of providers and free from conflicts of interest.**

These conclusions derive from the following observations:

System management and ICSs

- Regional organisations have a necessary co-ordinating and planning role maintaining a balance between (between providers, commissioners etc) in local systems. (**section 3**)
- System management is an important regional regulatory role ensuring the essential principle of accountability and governance independent from direct service. (**section 3**)
- The introduction of ICSs as described in the White Paper raises a number of issues that need to be resolved including (section 4):
  - The division of functions between ICSs and their lower tiers (Place) of administration lacks detail about which tier should carry out which function.
  - There is no indication about how decisions will be taken in the event of disagreement between members, nor how ICSs' decisions can be guaranteed to be taken in the interests of patients, as opposed to providers. Where does final responsibility lie if consensus is not reached? What is the formal governance arrangement?
  - Conflicts of interest are likely to arise as NHS organisations are being tasked as members of ICSs with making strategic decisions which concern themselves. In particular providers will face tensions between responsibility for financial viability and their strategic planning role.

Place-level functions

- As in previous reorganisations there is a danger that many local CCG functions and responsibilities are overlooked. CCGs have a broad range of operational roles within local place-level health economies. It is important that these are explored, their utility interrogated and the geographical scale over which they need to be carried out considered, because there is a danger that if they are not specified they will be forgotten. (**section 5**)
- It is not clear who will undertake many of the current CCG responsibilities in relation to: PCNs; primary care contracts; payment processes (eg. Additional Roles Reimbursement Scheme); local practice support on staffing; PFI; employment issue;, overseeing contracts, etc. **(section 5)**
- There significant implications for primary care commissioning including:
  - The shape of primary care representation at ICS level
  - Some functions will be delegated from ICSs to 'place-based collaborations', which will have primary care 'provider leadership' represented (p15), but whether it is envisaged that these delegated functions will include those relevant to primary care commissioning
  - Lack of clarity in relation to the proposed ICS pooled budgets including primary care funding and the delegation of resources for primary care to Place level.
  - Pooled provider budgets for primary care have been rejected by GPs and the current contractual arrangements for PCNs preclude pooled budgets.
  - Management of PCNS is contractually based and needs localised management
- The draft White Paper implies (but does not state) that many of the day to day operational and planning functions will be delegated to local place based committees or provider collaboratives of some kind. The form, role, responsibilities, accountability and governance of these are not currently specified (section 6).
- Lack of clarity of roles and functions at Place level means that many skilled and experienced CCG managers will leave the NHS or seek roles at ICS level. This will mean a loss of established relationships and expertise in supporting primary care.
- Some of the unspecified and informal facilitative roles undertaken by CCGs will be lost. Given that these are usually locally specific, sometimes impossible to measure or specify, and often invisible to those at higher levels of management, it is possible that their loss could generate unanticipated service disruptions.

Communications and engagement support and resources

- Policy@Manchester – UoM's policy engagement unit
  - Exist to get research evidence into legislation, regulation, and policy agendas
  - Do so through a variety of channels – including articles, publications, and call for evidence responses
  - Similar units in other Universities
- POST – the Parliamentary Office of Science and Technology
  - Provides impartial research and evidence summaries to Parliamentarians
  - Produces POSTnotes – 2-page evidence briefings for lay audience
- OHID – Office for Health Improvement and Disparities
  - Track current health policy priorities
  - Understand the policy agenda your research could inform
  - Monitor data releases and reports
- Parliament.uk - for consultations and inquiries

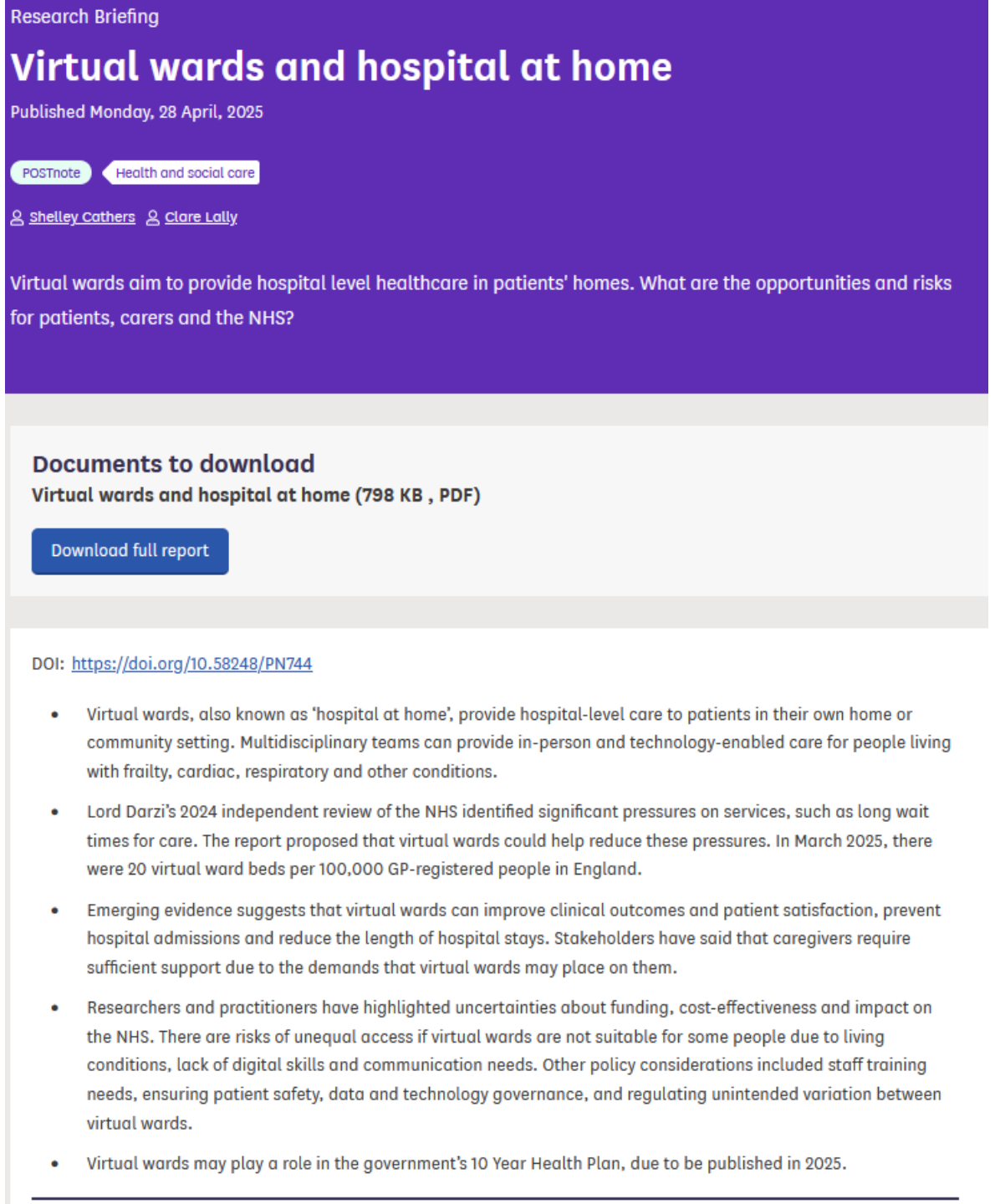
Clear headline/policy relevance

Linked to further info/detail

Bullet points/scannable

Benefits and issues… balanced

Specific timing - linked to Darzi review and 10 Year Plan



Research Briefing

Virtual wards and hospital at home

Published Monday, 28 April, 2025

POSTnote | Health and social care

Shelley Cathers Clare Lally

Virtual wards aim to provide hospital level healthcare in patients' homes. What are the opportunities and risks for patients, carers and the NHS?

Documents to download

Virtual wards and hospital at home (798 KB , PDF)

Download full report

DOI: https://doi.org/10.58248/PN744

- Virtual wards, also known as 'hospital at home', provide hospital-level care to patients in their own home or community setting. Multidisciplinary teams can provide in-person and technology-enabled care for people living with frailty, cardiac, respiratory and other conditions.
- Lord Darzi's 2024 independent review of the NHS identified significant pressures on services, such as long wait times for care. The report proposed that virtual wards could help reduce these pressures. In March 2025, there were 20 virtual ward beds per 100,000 GP-registered people in England.
- Emerging evidence suggests that virtual wards can improve clinical outcomes and patient satisfaction, prevent hospital admissions and reduce the length of hospital stays. Stakeholders have said that caregivers require sufficient support due to the demands that virtual wards may place on them.
- Researchers and practitioners have highlighted uncertainties about funding, cost-effectiveness and impact on the NHS. There are risks of unequal access if virtual wards are not suitable for some people due to living conditions, lack of digital skills and communication needs. Other policy considerations included staff training needs, ensuring patient safety, data and technology governance, and regulating unintended variation between virtual wards.
- Virtual wards may play a role in the government's 10 Year Health Plan, due to be published in 2025.

Condensed summary/callout

In summary/ scannable

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Finding the 'human fit' of access to general practice

The COVID pandemic has accelerated decades of healthcare policy that focuses on speed of access in GP surgeries – seeing patients quickly takes priority over other important factors, such as continuity of care. This creates unmet and hidden healthcare needs for those patients who cannot navigate this landscape, or who place value on the continuity of their care. In turn, this adds to the demand on healthcare services by creating unnecessary work when patients' needs are not properly met.

In this briefing, we outline the concept of 'human fit' – matching the abilities of those seeking care to the abilities of those providing it. Rather than focussing on speed of access, we suggest a human fit approach could help navigate the complexity of healthcare provision by GPs, and better meet the needs of patient populations.

Policymakers could embrace and operationalise the access as human fit concept. Rather than focusing on more or quicker appointments to improve access, policies could utilise existing mechanisms like Quality and Outcomes Framework and to incentivise general practice to increase the fit with inidividuals within local populations.

In summary

- Policy on access to healthcare has historically tended to focus upon speed of access because this is one of the easiest things to measure and because it has immediate salience for patients.
- Other important aspects of access to care, such as continuity and ease of communication with the practice have tended to be neglected.
- New research has found a paradox of access problems, whereby the policy and practice focus on providing rapid access to those who ask for it both creates and obscures another problem of unmet need within the population.
- For instance, patients who cannot manage the sometimes complicated methods of contacting their GP surgery, or who value seeing the same practitioner, may simply fail to try to make an appointment, with their unmet need going unnoticed.
- A solution to this paradox may come from the concept of access to care as 'human fit'.
- Human fit is an idea that captures the complexity of access in a way that is also relatable to policy, and to the perspectives of those seeking and providing care.
- With increased pressure since the COVID pandemic to see patients quickly – without necessarily meeting their needs – a human fit approach to healthcare could help general practice achieve its fundamental purpose.
- Policymakers should adopt the idea of access as human fit and orient policies to the goal of improving fit to improve population health and sustain the healthcare workforce.
- Recognising the existence of the paradox of access problems in general practice, driven by past policies and made worse by the pandemic, would allow for relevant policies to address inequalities.

September 2023

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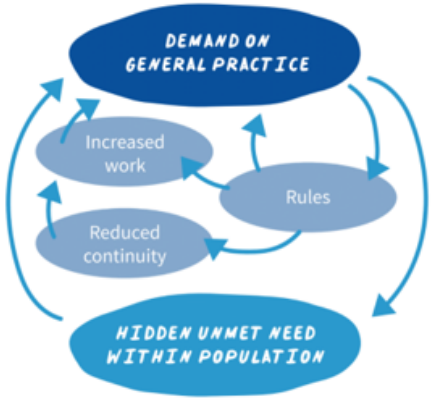
In detail

For decades, research and policy on access to health care have struggled to balance the complexity of the concept with the need for specific, measurable targets. Policies have often focused on speed of access over other important concepts, like continuity within access, and therefore aim solely for more or quicker access. Scholars have described access as the interaction or fit between the needs of the population and health services. If that type of definition is adopted, the aim of policy becomes better fit.

Advocates have called for access policy to better reflect both this complexity, and the experiences of patients and staff, in order to address longstanding problems, which are particularly linked to health inequalities. The following diagrams demonstrate the current paradoxical state of problems of access to general practice in the UK (driven in part by past policies focusing on narrow aspects of access to care) and the idea of access as human fit (which can help reorient policy to focus on the fit between people within population and the healthcare workforce).

A paradox of access problems in general practice

Our research has found a paradox of access problems, in which the focus and attention on the increasing demand on general practice both creates and obscures another problem of unmet need within the population. This has happened over time through reactive rules and policies aiming to manage demand, which largely undermine continuity in favour of speed of access. These layers of complex and varied rules generate work that takes up capacity of staff and patients to communicate and navigate. Many practice systems, in response to past policies, still have rigid processes that require patients to seek care in inefficient ways (such as making everyone call at 8:00am, regardless of the nature of the request). Those who cannot successfully navigate these rules, who value continuity, and/or who do not have the capacity to seek care through these processes, stop trying and sit with their unmet health needs hidden within the population. Paradoxically **the very processes that are keeping some of those with the most health needs away, are adding to the feeling of demand on general practice through the increased unnecessary work.**



In detail... hyperlinks, bold and coloured text to draw focus

Visual diagram for accessible communication of concepts

Understanding access within the COVID-19 pandemic

The pandemic has added to the complexity of access and worsened the above paradox, because many changes were made rapidly without full understanding of unintended consequences. Health inequalities have worsened since the pandemic, making it all the more important to apply an idea of access within general practice policy that inherently recognises the need to find a human fit for everyone in the population in order for general practice to achieve its fundamental purpose.

Access as human fit

The idea of access as 'human fit' is about matching the abilities of those seeking care to the abilities of those providing it. It is an idea that captures the complexity of access in a way that is also relatable to policy, and to the perspectives of those seeking and providing care. The left-hand side of the diagram reflects the abilities of people in the population to perceive healthcare needs, seek, reach, afford, and engage with care. The right-hand side reflects the abilities of healthcare staff to approach, accept, and to be available, affordable, and appropriate.

These abilities are affected by many contextual factors in society and within the healthcare system, including population health literacy and workforce capacity. As abilities vary between people, the achievement of fit will look different for different people, but will be an effort from both sides. **This view of access recognises the work already being done, and can reveal important gaps in existing efforts where fit is lacking.**

Suggestions for policymakers

Policymakers should adopt the idea of access as human fit and orient policies to the goal of improving fit to improve population health and sustain the healthcare workforce. Recognising the existence of the paradox of access problems in general practice, driven by past policies and made worse by the pandemic, would support the policy goal of reducing inequalities in access to care. **Policymakers can support access improvements by incentivising and empowering practices and patients to find closer shared access understandings and a better human fit.** Existing policy instruments, such as the Quality Outcomes Framework and Enhanced Services, could be leveraged for this purpose. The Optimising Access Through Human fit (OATH) Resource Set can help practices and patients with these efforts.

Specific suggestions for policy makers + link to resources

Dr Jennifer Voorhees
Jennifer Voorhees is NIHR Clinical Lecturer in the Centre for Primary Care and Health Services Research at The University of Manchester and a practicing GP. Her primary research interest is access to healthcare. She applied a community-based participatory research approach and multiple qualitative methods during her PhD to describe longstanding general practice access problems and critique policy, and won the won the Doctoral Prize from the Society of Academic Primary Care. This work has been foundational to the NIHR Policy Research Programme study: 'Optimising people-centred access in primary care in the context of COVID-19'.

Dr Jonathan Hammond
Jonathan Hammond is Senior Lecturer in Health Policy and Organisation at The University of Manchester. He has extensive experience conducting mixed-methods research focussed on NHS commissioning, governance and orchestration, primary care and access. He has conducted national-level evaluations of Clinical Commissioning Groups, and Primary Care Networks, and undertaken ethnographic observations in general practice with a focus on the work of GP reception staff and system organisation. He is Principal Investigator of the 'Optimising people-centred access' study.

Info about the researchers – highlights credibility

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+ contact info

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This research is funded by the National Institute for Health and Care Research (NIHR) Policy Research Programme (project reference NIHR202311). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Multiple realities of general practice access: how COVID-19 has widened the gap between patients and providers

Patient dissatisfaction with access to their general practice is increasing, but at the same time GPs and their colleagues are providing record numbers of appointments. Recent research from the University of Manchester and the University of Kent has explored this paradox, uncovering the multiple different realities of access experienced by patients, providers and policy stakeholders which may be fuelling this gap in perceptions of what is happening.

The perspectives of different stakeholders grew further apart as the COVID-19 pandemic unfolded. Changes to systems and a lack of communication left some patients feeling unsure of their role or let down by healthcare services. Some providers felt overwhelmed, underappreciated, and misunderstood. The idea that good access requires *human fit* between the needs and abilities of patients, and the capacity and abilities of the workforce goes some way towards explaining why the gap in perceptions exists, and provides a basis for closing the gap.

Adopting a human fit perspective on access would enable policymakers to support access improvements, supporting providers to work with their patients to find a shared understanding of access and a better human fit. The Optimising Access Through Human fit (OATH) Resource Set are designed to support collaborative conversations between patients and general practices about how the access fit can be improved in each particular context.

In summary

- Access to general practice in the English NHS is a longstanding, contentious issue.
- Research highlights how policy traditionally defines access as a one-dimensional issue with straightforward solutions, in contrast with the complex reality of access.
- The COVID-19 pandemic resulted in a rapid shift to remote-by-default access arrangements, and general practices scrambled to adjust. They have since continued to evolve and adapted their systems to respond to policy change, workload and workforce challenges.
- Researchers conducted a mixed-methods study (May 2021 - July 2023) to understand access changes over the pandemic, and develop resources to support practices, Primary Care Networks and patients optimise access arrangements.
- Interviews and focus groups with patients, healthcare staff, and policy stakeholders, along with non-clinical observations in general practices, highlighted multiple realities of access among stakeholder groups.
- Policy stakeholders had varied understandings of access but emphasised better data was needed, and communication about access changes to the public over the course of the pandemic had been insufficient and unhelpfully mediated by negative national media.
- The gap between patient and provider access realities was widened by the pandemic. Some patients did not understand why access to their practice had changed, or why things had not returned to 'normal'. They felt abandoned and lost trust. Some providers felt overwhelmed, underappreciated, and misunderstood.
- Policymakers can support access improvements by empowering providers and patients to find a shared understanding of access and a better human fit. The OATH Resource Set could be a helpful tool.

September 2023

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In detail

Access to general practice in the English NHS is an important, politically contentious, policy area. Various national policy initiatives to improve access have been implemented over the years, including Advanced Access and Extended Hours. Research has highlighted disparity between the real complexities of care access and the sometimes simplistic conceptualisations of access expressed through policy, which often equate good access with speed.

This briefing note draws on findings from a mixed-methods study (May 2021 - July 2023) using a community-based participatory research approach focussed on understanding how access to general practice in the English NHS changed during the course of the COVID-19 pandemic, and the development of materials that could help support practices and patients to optimise access arrangements. Data collection included: interviews and focus groups with patients (particularly those from under-reached groups), service providers, and policy stakeholders; non-clinical observations within general practice and Primary Care Network premises; and collaborative meetings with general practices, Networks, and their patients. This resulted in the development of the OATH (Optimising Access Through Human fit) resource set, available at www.oath-access.com.

Multiple access realities

Pre-pandemic access processes and systems were varied, partially resulting from local legacies of previous national policies. Practices rapidly shifted to remote-by-default and total triage in March 2020. Subsequent changes to processes and physical spaces happened at different rates and in different ways.

Policy stakeholders held varied understanding of access. Some saw access as primarily about appointment seeking, others thought about it in broader ways, such as: patients' perceptions of the availability of care should they need it, delivery of sufficiently personal and dynamic care when sought, and trade-offs between delivering 'good' access for individuals vs communities. Many believed existing variations in access had been deepened by the pandemic. **The political nature of access, and a perceived connection between the strength and frequency of negative media coverage and the pressure exerted on MPs via complaints from constituents, was seen as driving reactive and insufficiently nuanced policy responses.** A lack of sufficiently granular data on GP activity, and siloed working between policy teams, were highlighted as challenges to building a more coherent and informed policy programme.

General practice perceived an increase in demand after the first national lockdown, and many decisions to further adapt (or resist changing) their access arrangements reflected attempts to cope with this. Media narratives during the COVID-19 pandemic, which were initially supportive of the changes but became increasingly negative, were seen unhelpfully mediating patient expectations. Some felt patients had become more demanding (others felt patient requests were modest), and aggressive behaviour had increased. As a result of all of this, **some general practices feeling overwhelmed (partly due to common recruitment and retention challenges), underappreciated, and misunderstood.**

Patients from different practices reported varied experiences. While there were stories of good access, supported by strong continuity, many patients reported frustrations with appointment systems hard to navigate successfully, confusion about why things had not returned to 'normal', and in some cases a loss of trust in their practice or feelings of abandonment. **Patients reported feeling that access changes were inadequately communicated, confused or confusing, and in some cases they felt abandoned**.

The pandemic provided the conditions for these realities to drift further apart for some patients and some practices. As such, **the pandemic became an inflection point for perceptions about access to general practice, associated with feelings of dissatisfaction whether or not the access arrangements in question were a result of, a catalyst of, or perhaps little do with the pandemic itself.**

Access as human fit

An understanding of access as **the human fit between the needs and abilities of patients and the abilities and capacity of the healthcare workforce** underpinned a series of collaborative meetings between general practices, Networks, and their patients. These meetings highlighted the potential value of bringing stakeholders together to understand more about the experience and realities of others and identify steps that could be taken to help implement locally meaningful access improvements.

Suggestions for policymakers

It is important to recognise that the COVID-19 pandemic has widened the gap between the experiences and perspectives of patients and those of healthcare staff in general practice. Access as human fit helps to say why these differences matter. It moves, and refocuses, away from definitions of access that artificially prioritises speed over other aspects of care, such as continuity. Embedding this understanding throughout the levels of the system, including the policy-making level, would help support the development, implementation, and sustainability of nuanced and constructive access policy. **Policymakers can support access improvements by empowering practices and patients to find closer share access understandings and a better human fit.**

The conceptualisation of access as human fit is embedded within the OATH Resource Set – co-developed with healthcare workers and patients, and freely available from www.oath-access.com – which can constructively support collaborative conversations between patients and general practices about how the access fit can be improved locally.

This needs to be bolstered by resourced local communication initiatives from practices, and national communication campaigns that emphasise the often challenging realities of general practice provision, and the need for all stakeholders to be empathetic and considerate. In turn, this requires support through enhanced efforts to expand general practice capacity, improve morale, and support retention and recruitment to alleviate pressures associated with service capacity and provision.

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Dr Jonathan Hammond
Jonathan Hammond is a Senior Lecturer in Health Policy and Organisation at The University of Manchester. He has extensive experience conducting mixed-methods research focussed on NHS commissioning, governance and orchestration, primary care and access. He has conducted national-level evaluations of Clinical Commissioning Groups, and Primary Care Networks, and undertaken ethnographic observations in general practice with a focus on the work of GP reception staff and system organisation. He is Principal Investigator of the 'Optimising people-centred access' study.

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The right prescription? Young people, mental health and social prescribing


By Caroline Bond and Ruth Farrimond-Goff
Filed Under: All posts, Education, Health and Social Care
Posted: March 19, 2025

The mental health and wellbeing of children and young people is a growing concern amongst policymakers and practitioners, with recent data from the World Health Organisation suggesting that one in seven young people globally aged 10-19 years, experience a diagnosable mental health condition. In this article, Ruth Farrimond-Goff and Professor Caroline Bond examine the implications [...]

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When is a plan not a plan? Reflections on the NHS Long Term Plan.


By Kath Checkland and Jon Hammond
Filed Under: All posts, Health and Social Care
Posted: January 14, 2019

Professor Kath Checkland and Dr Jon Hammond of the University's Health Organisation, Policy and Economics unit (HOPE) share their thoughts on the Government's new 'Long-Term Plan' for the NHS. The new NHS Long Term Plan, and the investment associated with it, are welcome announcements but still fall short of most accepted definitions of 'plan' A full [...]

Conclusions

- **Understanding context:**
  - Timely, addresses live policy debates, respects time constraints
- **Framing and messaging:**
  - Policy-relevant framing from the first line, build and use narratives
- **Building relationships:**
  - Part of ongoing engagement, invites dialogue
- **Use of evidence:**
  - Selective use of findings, methods minimised, credibility made clear
- **Psychological insights:**
  - Concrete examples, visual diagrams, memorable concepts
- **Policy studies insights:**
  - Timed to policy cycles, understands institutional context
- **Practical recommendations:**
  - Clear, specific, actionable suggestions for policy makers

Ideas for practical next steps

- **This week:**
  - Identify one policy audience for your work
  - Find one current consultation/inquiry relevant to your research
- **This month:**
  - Draft a one-page policy summary of recent research
  - Share with colleague for feedback
  - Sign up for policy alerts (parliament.uk, relevant think tanks)
- **Next 12 months:**
  - Submit one piece of written evidence
  - Attend one policy-focused event
  - Build one new relationship with policy-engaged organisation
- **Get support:**
  - Policy unit might review drafts
  - Connect with colleagues doing policy work
  - Attend policy engagement events/training

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