SOCIAL POLICY RESEARCH FOR CORNWALL

A wake-up call for General Practice

Dr Peter Levin (PhD)

The growing proportion of General Practitioners working only part time at their surgery is a wake-up call. To retain the loyalty of patients they should pay attention to continuity of care, triage procedures and patient participation, as well as their work-life balance.

Introduction

Data on General Practice websites in Cornwall reveals that only one GP in five works full time at their surgery. Another one in five is a locum who has worked at the surgery for six months or more, and the remaining three in five are listed as part-time GPs. Part-time attendance is clearly widespread.

The shortage of GPs in the UK is getting more acute, reflecting both a failure to train and recruit enough younger doctors and early retirement of older, experienced ones. High house prices in some areas keep away those who haven't already got a foothold in the owner-occupied sector.

At the same time, as the population gets older there are increasing numbers of patients for GPs to care for, especially people living with frailty or with long-term and complex conditions.

All too often, under these conditions, disagreements and conflicts arise: over the provision of services, for example, and seeing our preferred doctor. We patients must cherish our GPs and find ways of resolving such issues through collaboration rather than getting embroiled in confrontation. This report suggests how this might be achieved.

The British Social Attitudes survey highlights the need for action

The latest report of the British Social Attitudes survey makes sobering reading. The analysis of its findings published by the King's Fund and the Nuffield Trust in March 2022 sums it up. In 2021, satisfaction with GP services dropped significantly, from 68 per cent satisfied to 38 per cent: an unprecedented fall of 30 percentage points, reaching the lowest level recorded since the survey began in 1983. While 30 per cent of respondents were 'quite' satisfied, only 9 per cent

were 'very' satisfied. 'Satisfaction with GP services is now the lowest of any NHS service with the exception of dentistry.'

We don't know how far these figures are primarily a reflection of the COVID-19 pandemic, but they lead us to ask: Is all well in general practice?

Generational change and GPs' move to part-time working

The preference for part-time working, especially among GPs who have young children, clearly reflects a desire for a work-life balance that the demands of working full-time as a GP don't allow: these demands include not only seeing patients but dealing with paperwork, keeping up to date with developments in the field, playing a part in Primary Care Networks, meeting targets for practices set by central government and NHS England, and – crucially – avoiding burning themselves out, all while managing to see their young children before bedtime on some evenings a week and supporting their own elderly relatives.

The Eleventh National GP Worklife Survey 2021 carried out by Professor Kath Checkland and her colleagues at the University of Manchester found that GPs were reporting the greatest stress from increasing workloads, increased demands from patients, having insufficient time to do the job justice, paperwork (including electronic), long working hours and dealing with 'problem patients'. Over a third of GPs said there was a considerable or high likelihood of them leaving 'direct patient care' within 5 years. Among those aged 50 or over this proportion rose to 60%: four-fifths of them said it was highly likely that they would be leaving.

Current data on 53 practices across Cornwall show that nine have no full-time GP, while across all 53 for every full-time GP there are more than three part-timers. In addition there are nearly as many locum GPs who have worked in the practice for six months or more as there are full-timers. (This information is taken from the 'GPs' earnings' section of the practices' websites. The total figures are 106 full-time, 309 part-time and 96 locums.)

There is little evidence as to the impact that working part-time in the practice might be having on the quality of care that GPs provide, but it raises some questions. Does being present at the practice only 2-4 days a week make it difficult for a GP to provide continuity of care for some patients? And if a practice does not include a full-time GP with long experience, might that lead to problems of leadership within the practice and a lack of 'organizational memory'?

The evidence on continuity of care is mixed. In West Cornwall, the 2021 national GP patient survey (see below) found that at one of the two practices currently with no full-time GP 85% of patients usually got to see or speak to their preferred GP when they would like to, while at the other only 43% did.

In their report on their Continuity Counts Project (2021), Denis Pereira Gray and his colleagues say it is 'a common misconception that … good levels of continuity could not be provided by part time GPs'. Although some GPs pointed out their lack of availability when working in a local hospital, for example, 'most general practitioners in most general practices now work part-time and there are many examples of practices providing good GP continuity'.

However, the Nuffield Trust research report Improving access and continuity in general practice (2019) noted that practices with a higher proportion of patients seeing their preferred GP had, on average, lower levels of part-time working. (They also had higher levels of seniority payments, indicating staff with more experience and a lower turnover of staff.)

Patients' preferences

We do know, from a report by the Health Foundation *Access to and delivery of general practice services* (2022) that some patients have a definite preference to see 'their' GP every time while others do not, while some prioritize seeing their preferred GP only for 'major' concerns. The Nuffield Trust research report cited above distinguishes no fewer than 17 different situations in which a patient will accept a longer wait if they can see a GP who, for example, is 'their own doctor' or one who 'knows them well'. Tellingly, for a routine check-up, an individual would be prepared to trade off an additional wait of 3.5 days to see a GP rather than a nurse (p.17). That report also notes that the value that a patient attaches to continuity of care is likely to vary from time to time and over their lifespan.

One of the questions asked in the 2021 national GP Patient Survey, an independent survey run by Ipsos MORI on behalf of NHS England that uses a questionnaire sent out to over two million people across the UK, was: 'How often do you see or speak to your preferred GP when you would like to?' Over the UK, 45% of respondents answered 'Always or almost always' or 'A lot of the time', but 55% answered 'Some of the time' or 'Never or almost never'. Evidently there is considerable unmet desire among the population for greater continuity of care, in the sense of seeing or speaking to 'their own' doctor.

What follows from the findings of the Health Foundation report and the responses to the GP Patient Survey is a simple recommendation: when a patient approaches a practice for a consultation he or she should be asked whom they want to see.

Continuity of Care: types and definitions

The Improving Continuity of Care Toolkit published by the Royal College of General Practitioners defines Continuity of Care as follows: 'What is Continuity of Care? It is when the patient sees the same GP (or members of a clinical team) repeatedly over time.' (p.5)

However, the Toolkit goes on to identify four types of Continuity of Care: relational, episodic, informational and managerial. Only 'relational' – 'building good patient-professional relationships that benefit both the patient and the professional' – seems to correspond to the definition in the Toolkit and the wording of the question in the GP Patient Survey.

The triage process

When a patient approaches a practice, there is no straightforward formula for allocating them to the 'correct' clinician. From the practice's point of view, they have to be 'sorted'. Decisions have to be arrived at about which clinician or other member of staff a patient should be directed to. Triage is the name given to this sorting process.

In the normal course of events, with a daily stream of patients approaching the practice, triage involves taking decisions – as to which queue to see a clinician a patient should be placed in, and whether they should 'jump' the existing queue in part or totally. To be able to reach such a decision one has to make – very rapidly – two judgements: a judgement as to the relative urgency with which the patient needs to be seen; and a judgement as to the resources that should be allocated to them, especially the time of a clinician who is appropriate and available.

The role of the medical receptionist

Invariably the first person that a patient meets on contacting the practice premises is a medical receptionist. As I have noted elsewhere, some medical receptionists are extraordinarily good at their job. They are empathetic, skilled at putting patients at their ease. They have a sense of where a patient draws the line at providing intimate details to someone who is not a doctor or nurse, for example, and they know it is not their role to diagnose. With their experience of patients

and of how the practice works, they are able to form a judgement that, for example, the person a patient should see is a GP or a nurse or allied health professional, and be confident that their judgement will be backed up by the clinicians; and they will be able to explain the reasoning behind their judgement to the patient in a way that makes sense to them and is not patronising.

Other receptionists are not so gifted. There are some who learn to interpret their job specification as being to protect 'their' doctors. So their role becomes akin to that of the school prefect, exerting discipline on the unruly demanding mob of junior children at their door. They may feel justified in directing the patient to a non-GP member of staff on the grounds that 'we are a multidisciplinary team now'. They can make the experience of attending a practice and seeking help from one's GP a stressful and humiliating one.

What are patients told? On one West Cornwall practice's website we read:

> [The] Surgery operates a full triage system. Your call will be answered by a fully trained medical receptionist who has capacity to signpost to relevant clinicians dependent on your need. Once your call has been assessed by the receptionist, it will then be filtered to the relevant member of our clinical team. The Clinician will then contact you via telephone to discuss your medical issue, they will then arrange follow up care for you appropriately either face to face or over the telephone.

Exactly what training to assess a patient's call do medical receptionists receive? The criteria for getting a job as a medical receptionist are low. There are no set entry requirements, as the NHS official guidance makes clear: 'Employers usually expect good literacy, numeracy and IT skills. They may ask for GCSEs or equivalent qualifications.'

As for in-post training, the guidance merely says: 'You will get the training you need to do the job. This includes an introduction to the department, how to use the IT and phone equipment and the procedures to follow. You may also have training in customer care.'

There is a lesson to be learned here from experience in acute hospitals. As one geriatric consultant put it, 'with inexperienced clinicians at the front door ... of course decision making is going to be affected' (p.25). If the front doors of general practices are manned by inexperienced medical receptionists, some of

whom could be little more than school-leavers, it cannot be realistic to expect them to develop and perform their role successfully without careful and continuing training and mentoring.

Active signposting and care navigation

With the active encouragement of NHS England (on an undated web page), the Practice Managers Association has developed training schemes for medical receptionists in what is termed Active Signposting:

> The key objective ... is to help patients access the right care at the earliest opportunity. It is a new system of 'triage', carried out at the first point of contact with the GP Practice by non-clinical staff under direction of the clinical team.

> [Outcomes] will include a more streamlined GP workload, improving efficiencies in terms of access to services and patient satisfaction. It will achieve this by releasing valuable GP time and resources. Staff will actively manage requests for GP appointments and safely redirect inappropriate GP consultations to the most appropriate care provider.

> Active Signposting is a tool to develop the skills and career paths of non-clinical staff. Staff will move away from a passive role and have a more direct impact on patient health outcomes. The skills and abilities needed ... are valuable in other new non-traditional roles such as Document Management, HCA and Care Navigation.

> After training staff will be confident in advising and referring patients to care providers who work ... within the practice team or to external care providers.

The language employed here is significant. Active Signposting is portrayed as a means for non-clinical staff to move away from 'a passive role', instead 'actively managing' requests for appointments, 'redirecting' patients, and developing their 'skills and career paths', while 'releasing valuable GP time and resources'. What we do not see is any reference to listening to patients or offering them choices or discussing with them why a request to see a doctor might be 'inappropriate'. It will be for the staff alone to judge whether a request is 'inappropriate'.

Essentially, NHS England is endorsing the selling of Active Signposting to non-clinical staff as a means by which they can exercise power.

Improving continuity of care: using the GP Patient Survey and identifying a role for patients

As noted above, the question in the national GP Patient Survey 'How often do you see or speak to your preferred GP when you would like to?' elicited the response 'Some of the time' or 'Never or almost never' from 55% of respondents. Clearly there is work to be done in many practices to improve on that figure. Might patients be able to help? The Improving Continuity of Care Toolkit has a section (accessed via p.45) on 'Engaging with your PPG' (Patient Participation Group), but anecdotal evidence in Cornwall is that a number of practices do not actually have a PPG, while where they do exist their profile is low. And in only a minority of localities is there contact among the PPGs. Where a PPG is active, there is invariably at least one 'activist' person who has identified an issue that galvanizes them and others.

Arguably, PPGs are ineffective for two reasons. One is that they lack information. If personal experience is any guide, they do not routinely receive any form of report from the practice (including any report on the findings of the GP patient survey). Secondly, as a result of this lack of information, apart from drawing on members' personal experience and other individual stories they are unable to put forward useful suggestions on issues affecting their fellow patients.

An example illustrates this. There is currently an absence in Cornwall of a service that practice nurses formerly provided for the removal of earwax. This service was particularly valued by elderly patients suffering from hearing loss. If the PPG had been informed about this change, it would have had an opportunity to ask the practice to record how many patients had requested the service and been turned away, so there would have existed some measure of the need for it. This could have been used to campaign for restoration of the service.

If the Improving Continuity of Care Toolkit is to be applied for the direct benefit of patients, and the PPG is to be used as a means of involving them (although PPGs are usually far from representative of a practice's patients), clinical and non-clinical staff need to join together with patients in identifying and publicizing salient issues. They need to identify those patients to whom those issues will be of concern, and offer them the opportunity to get involved. The PPG, with its unrepresentative membership, will rarely be a suitable vehicle for that involvement: a *focus group*, literally a group focused on that particular issue, is

called for. But the PPG should be in a position to sponsor and oversee a focus group when an issue calling for one arises.

For example, the PPG should insist that the practice makes its GP Patient Survey findings available to it as soon as they are published. If any of the responses suggest that there are shortcomings, the PPG should go on to sponsor a focus group to investigate and report. Under the aegis and supervision of the PPG, that focus group could circulate a more focused survey: tailored to older people living with frailty, for example.

It would be helpful too if the area Healthwatch took an active interest in the running of PPGs and focus groups. It is an anomaly that PPGs are left so much to their own devices.

Conclusions

1. Continuity of Care, mutuality and the technical mindset. As noted above, the Continuity of Care Toolkit identifies four 'types' of Continuity of Care: relational, episodic, informational and managerial. 'Relational' is manifestly different from the other three, focusing as it does on interpersonal relationships while the others take the form of concrete and specific actions. It also embodies a different kind of role for the GP, in that building a relationship is a two-way endeavour, in which patients as well as GPs are actively involved, whereas the other kinds of action are what staff do to or for patients, who remain effectively passive.

The clue to building two-way relationships is contained in two short quotations from GPs reproduced in the Toolkit (on the PPG Slide Deck, accessed via p.46):

> 'Seeing a clinician you know and trust, who knows and cares about you.'

> 'I know my patients well and they know me.'

What these quotations bring out is the *mutuality* involved in developing the GP-patient relationship. They entail the patient getting to know the GP as well as the GP getting to know the patient. And what we are witnessing here is the GP in a pastoral role. The GP is being a shepherd, not a technician.

Unfortunately healthcare professionals and practice staff are being taught to view interactions with patients with a technician's mindset. They are literally being equipped with a 'Toolkit'. Under the guise of Active Signposting for example, non-clinical staff are to 'actively manage' requests for appointments and 'redirect' patients, while 'releasing valuable GP time and resources'. Again, we do not see

any reference to listening to patients or offering them choices or discussing with them why a request to see a doctor might be 'inappropriate'. It will be for the staff alone to judge whether a request is 'inappropriate'. This is characteristic of the technician's approach.

With the distinction between pastoralist and technicians' mindsets in mind, the findings of patient surveys appear in a different light. Preference for seeing a doctor over a nurse is not just a matter of 'appropriate' skills: at the appointment a 'pastoralist' GP is more likely to observe and probe anxieties that lie behind the patient's reasons for requesting a consultation, and to ask open-ended questions, such as 'how are you feeling?' as well as exploring what lies behind the visible symptoms you are exhibiting.

Interestingly, it is hard (impossible?) to find in the continuity of care literature any reference to the desirability of receiving continuity of care from a nurse.

The analysis of processes in the Improving Continuity of Care Toolkit shows a great deal of use of technical language. A process is 'a set of connected activities, material and/or information flow that transform a set of inputs into a defined output'. A process will be 'mapped': if patients or local people appear on the map at all it is only as 'stakeholders', a term which, as it happens, can readily be used to exclude from participation many who challenge the views and decisions of those in positions of power.

There is a striking contrast here with a contribution to the Toolkit (p.46) from One Care, a GP federation and Community Interest Company that represents and supports 80 member practices who provide healthcare for around 1 million patients across Bristol and the surrounding region. For One Care, processes should provide opportunities to hear patients' views, to check clarity of messaging, to gather their experience and their expertise as patients, and to enlist their help when carrying out surveys. Any process map should include opportunities such as these.

2. The role of the Practice Manager. The role of the practice manager, especially in a practice where there is no full-time GP, is a crucial one in setting the style of a practice: making it welcoming to patients, and encouraging them to provide feedback on their experience and showing what the practice is doing to follow it up. They should provide reports to the PPG (including the findings of the GP patient survey), highlight any issues that arise, and ask the PPG to help with

understanding what patients say about their experiences. They should invite PPG members to review the style and content of newsletters and in particular to test how easy it is for a non-expert patient to book an appointment with their preferred doctor and generally navigate the practice's website to find information that they need. Computer-savvy patients may be interested in helping with this.

Practice Managers should be alert to the language used in communications from their professional body, which might encourage them to use a more authoritarian style of behaviour (and writing) towards patients, their own staff and clinical staff than is warranted in a patient-friendly practice.

It will necessarily be part of a Practice Manager's job description to ensure that new recruits to the reception team are familiarized with the patient-friendly ethos of the practice, and trained and mentored to be sensitive to what patients are telling them (and not telling them) when booking appointments. Practice Managers themselves should be trained in training and mentoring new recruits and regard it as their business to check that standards are being maintained.

A Practice Manager should have enough self-confidence not to be thrown on to the defensive when challenged, and to be able to manage the practice on co-operative lines rather than as a hierarchy. Possession of political (small 'p') skills will be a huge advantage, as will having an enquiring mind rather than being a stickler for following the rules.

3. A role for patients. As One Care has recognized, many patients have experience and expertise simply by virtue of being, or having been, patients. When it comes to taking decisions about the services that a practice provides, they are stakeholders. If they can be consulted at an early stage in decision-making, this will avoid the confrontation that inevitably arises when they learn only after the event that crucial decisions have already been taken.

Patients who have a general interest in the working of the practice can join the practice's Patient Participation Group. At present the only qualification required is that one must be registered with the practice. A PPG can, as One Care suggests, check clarity of messaging and encourage patients to respond to surveys.

When a specific issue arises, such as the withdrawal of a service, or an opportunity presents itself, the PPG and practice can collaborate in taking the initiative to set up a focus group to address that issue or opportunity. And if there arises a threat to the practice, such as the retirement of some of its GPs which could potentially

result in a surgery's closure, a focus group can investigate the situation, make recommendations and – if appropriate – campaign to ensure the community does not lose the practice or fail to gain a replacement.

Another role for the PPG would be to keep a watching brief on how the practices' patients are being supported by social care services on which they are depending. Given that health and social care are in the process of being brought together in integrate care systems, it is important that the interface between them should be monitored. The experience of patients discharged from hospital should be monitored. While GPs will no doubt be sharing their experiences with other members of the Primary Care Network, a survey promoted by the PPG of patients' experiences could yield valuable information on how well integrated primary care and social care are in practice.

The PPG would also be a useful means of informing patients about developments such as the introduction of Primary Care Networks, to which most practices now belong. Many practices now have allied health professionals 'billeted' on them, but their websites give patients little or no information about how this new system works, often adding names to the foot of the staff list with no explanation.

In short, PPGs offer practice managers access to a two-way communication channel with their thousands of patients. It would be good to see them make use of it.

4. Refining triage. I conclude with an example of how patients can contribute, through a PPG or focus group, to setting up a new form of triage process in a general practice. In September 2020 NHS England and NHS Improvement published the latest version of Advice on how to establish a remote 'total triage' model in general practice using online consultations. It said:

> Total triage means that every patient contacting the practice first provides some information on the reasons for contact and is triaged before making an appointment. It is possible to do this entirely by telephone but using an online consultation (OC) system is likely to [achieve] further efficiency and benefit. Total triage is important to reduce avoidable footfall in practices and protect patients and staff from the risks of infection.

The process described in the official advice offers a number of opportunities for involving patients, whether through a PPG or focus group. They are shown in the left-hand column in the table below, taken from that advice.

Official advice to practices on setting up a 'total triage' system	Tasks that a Patient Participation Group could undertake or assign to a specialist focus group
Check how likely your patients are to be digitally excluded.	Examine how this check is carried out and independently check the results obtained. Help to ensure that digitally excluded patients do not receive a poorer service than those who are digitally capable.
If you have the space and resources, consider providing a safe space for patients to access a computer at your practice.	Advocate that a safe space should be provided and contribute to finding one if necessary.
Map the current process to identify bottlenecks and opportunities, ideally with input from patients/carers.	Provide such input from patients/carers by monitoring how the total triage process is working, and surveying their experiences..
Design for equity and ensure there are routes for non-digital users. Admin staff can use a short web form or template in the clinical system to take non-digital users through the same process over the phone or in person	Observe how the needs of non-digital users have been provided for, and feed back observations and suggestions to the practice.
Use 'test patients' and team simulations to get familiar with the system and check IT/logins are working.	Help to recruit a group of patients to test how the system is working and feed back to the practice.
Encourage staff to submit their own test OC requests to see how it works from the patients' perspective.	Check whether OC requests by staff are responded to in the same way as those submitted by actual patients.
Provide clear guidance to patients on how to use the service, what to expect and what happens behind the 'scenes' e.g. who will see the OC, how to expect a response.	Check whether the guidance provided to patients is indeed clear, note problems and suggest how they might be resolved.

Reassure patients about how they can access services and that face to face care always remains available when clinically appropriate. Explain the benefits of a triage approach to improve access to care from the right person at the right time, using a consultation approach that is personalised to their needs (and that this may not be online).	As fellow patients, note how and by whom the terms 'clinically appropriate' and 'the right person' are defined, observe how reassuring the 'reassurance' proves to be, and whether the 'consultation approach' is not structured to limit patient choice, and suggesting improvements.
Send an SMS to all patients with the same wording. Inform your PPG, patient groups and other stakeholders. Use social media or webinars to explain the new system and help familiarise patients with the technology. Consider how you will raise awareness within your local communities.	Assess the clarity and effectiveness of the practice's messaging and the information sent to patients. Collaborate with the practice in raising awareness within local communities.
Tailor language and messaging to fit with your practice population needs, avoiding technical wording. Promotion needs to be sustained. Use local champions and social prescribers as facilitators to support patients with the technology. Find out what support is available locally to help patients go online.	Contribute to the process of tailoring language and messaging to fit with the needs of the local population, paying special attention to the needs of patients living in areas of high deprivation. Identifying opportunities to act as local champions and facilitators where possible.
Patients need to know if decision-making is being automated (where a person is not involved in the process) and agree to it – they must have the option to have the decision reviewed manually.	Support patients where necessary in asserting their right to know about the automation of decision-making by the practice.
Seek feedback from patients, carers and staff to improve the service.	Ensure that there are channels of communication for patients, carers and staff to say how they have found the experience of using the new system.