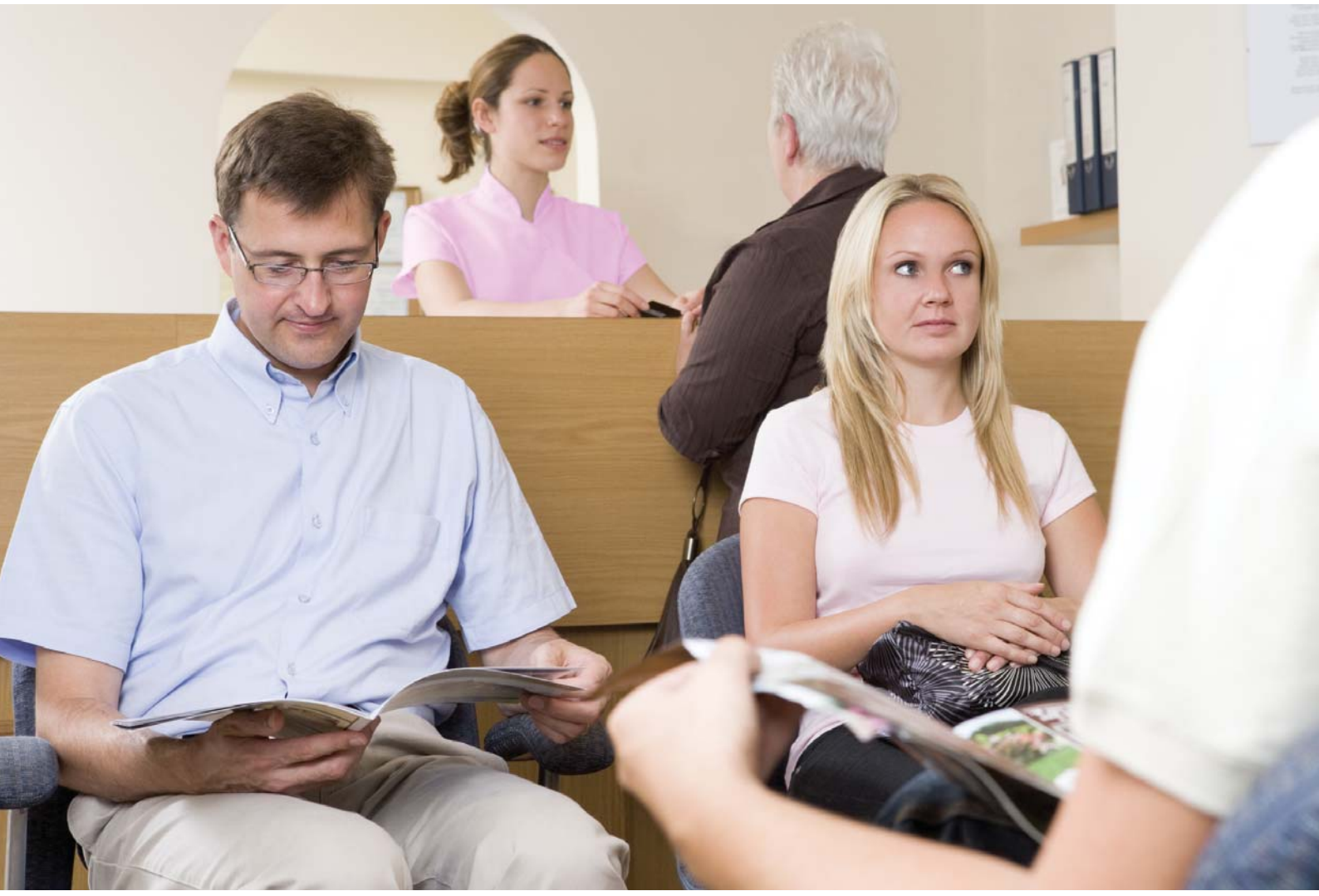
Developing general practice: Listening to patients

June 2009



BMA

Foreword

The UK public rightly has high and constantly evolving expectations of what the NHS and general practice can deliver. GPs work in partnership with patients and local communities and see meeting these expectations as a vital part of their role. Some GPs may find themselves frustrated by the financial and physical limitations of their surgeries. Nevertheless, with a growing emphasis on patient choice, it is more important than ever for practices to engage their patients in discussion about their expectations and aspirations and respond if possible to their wishes.

Many GP practices across the UK already work very hard developing and improving their non-clinical services in response to their patients' wishes, which is why in March 2009 the BMA General Practitioners Committee (GPC) launched a nationwide consultation asking GPs and stakeholders to share their experiences in this area. The intention was to share best practice among the profession. This publication contains some of the examples that were sent to us and which we hope will help support practices looking to make changes in this area.

The GPC feels it is important for practices to focus on 'customer service', and patients who are made to feel welcome by their practice are more likely to remain loyal to their GP, reinforcing the doctor-patient relationship and continuity of care, which is so important in general practice. Practices that maintain such a focus will be ready for practice accreditation, whenever it comes, and the patient-informed appraisal outlined in the revalidation proposals.

We know there is no ideal 'one size fits all' model of general practice. Providing quality NHS general practice that suits local patient need is our strength and responding positively to patients and providing good services is an essential part of this.

This publication was developed with the assistance of the BMA's Patient Liaison Group and with the input of GPs, patients, practice managers and patient groups. It is a testament to the hard work of GPs and practice staff who, in consultation with their patients, are helping to ensure that UK general practice provides a service of which we can all be proud.

Laurence Buckman
Chairman, GPC

'I get appointments when I want. I see the doctor of my choice, which is always good for people with ongoing problems as it saves covering the same old ground with a doctor not familiar with you. I am actually listened to and not rushed in then rushed out as quickly as possible... I do not want to change the clinic. I do not want a large merger or a polyclinic as it will only make for a poorer patient service. I do not want to be taking a number in a endless queue of faces. I don't want to see different doctors each visit. I like my local surgery with familiar faces and surroundings it is the right size.'
Patient

With special thanks to the following patient groups:
Age Concern and Help the Aged
Diabetes UK
National Association of Patient Participation
National Osteoporosis Society
Patient Liaison Group, BMA
Royal National Institute for Deaf People (RNID)

A series of how-to guides is being developed by the Department of Health with practices, PCOs and patients, which should complement the content of this GPC publication. These more practical documents may be useful for practices that wish to investigate further the measures discussed in this paper.

'"Patient involvement and consultation" are just words which recognise a process in which many of us patients, our GPs and their practice staff are already involved in various ways such as patient participation groups, practice questionnaires and other more informal means. Such processes in evaluating and, when appropriate, improving our patient experience, also offer the means by which we are able to feel valued, involved and supportive of our local surgeries. We patients are also able to gain an insight into the various aspects of providing true quality patient care both now and in the future.

In this way, through involving us as patients, we are also enabled to recognise and acknowledge the way in which our GPs are best able to provide the variety of services that best meets the needs of the local population. If such actions are the outcomes of patient consultations, they can only help to maintain the focus on the doctor-patient relationship, which is at the heart of this document.'
Carol Basham, Patient Liaison Group, BMA

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Patient involvement

Patient groups

While ad hoc patient focus groups can be an effective way of gaining patient input into specific practice decisions, more formal patient participation groups (PPGs) are used by over a third of practices to harness patients' ideas and views on practice developments.[1] The GPC strongly supports their use and would encourage all practices to follow their example. The BMA's Patient Liaison Group and the National Association for Patient Participation have both produced extensive guidance on patient participation groups.

www.bma.org.uk/patients_public/
www.napp.org.uk/

> *'High quality general practice is of great importance to so many people and Patient Participation Groups (PPGs) should be seen as an essential component. PPGs can feed back the wider patient perspective, improve communication and support health promotion work. Working in partnership with their practices, they can identify and argue for improvements that will bring the greatest benefit to patients. Practices have nothing to fear, and much to gain, from an effective and well-motivated PPG and we applaud the BMA General Practitioners Committee for actively encouraging the formation of more, and better, PPGs.'*
>
> *Graham Box, Chief Executive, National Association for Patient Participation*

PPGs can:

- help practices translate national policy drives into local changes and formulate other priorities that may be more helpful to the practice's patients
- organise practice satisfaction surveys and help with monitoring quality improvement
- improve the smooth running of the practice, perhaps promoting touch screen use or acting as mystery shoppers to check telephone access
- provide volunteer services such as patient transport and support groups
- help fundraise for the practice
- be a sounding board for potential improvements – eg in the appearance of the waiting room, media/refreshments in the waiting areas and practice communications such as newsletters
- become involved in health promotion activities and patient information, for instance by using patient information libraries
- contribute to long-term practice development strategies, as well as respond to immediate issues
- support Practice Based Commissioning service development, linking PPGs across the local area
- assume a wider role and undertake lobbying outside the surgery regarding the development of local services.

Practices must be able to demonstrate to their PPGs that, where appropriate, patient feedback results in changes.

> *'Practices need to be willing to engage and to listen, to commit and to respond. PPGs need to be able to challenge and to play the role of critical friend, without fear of being alienated as a result.'*
>
> *The National Association of Patient Participation*

The nature of PPGs varies between practices. PPGs need to consider the frequency of meetings, who will be present, the use of external speakers and how the practice will feedback its response to the group's advice and any plans for implementation. If the regular participants are not thought to be representative of the practice's patients, those involved in the group may be able to find ways to engage with a wider range of patients outside the PPG environment and feedback their views to the practice. Where practices want to find out the views of a diverse range of patients, they need to ensure that appropriate communication support, for example induction loops, translation support or easy-read text is available. In addition to practice-based PPGs, local disease-specific networks can work with practices to help inform service planning and design for their own stakeholders. Many practices now hold carers registers and practices may want to involve carers in PPGs, reflecting the important part they play in patient care.

'We have a patient participation group which has been running for about three years. The original group was set up by asking a range of patients from our list from different age groups etc if they would be interested in forming a group. This has since evolved with some members resigning and others joining. They meet about four times a year with attendance by someone from the practice (either the practice manager or one of the GPs). The secretary of the group is in contact with the practice manager on a regular basis feeding issues back to the group. They have had major involvement recently in District Nursing Services and the Dispensing White Paper. The group have proved a good sounding board for the practice to learn from.'

'We have a Patient Forum Group which meets quarterly. At each meeting one of the partners attends and gives a brief overview of their particular area of interest/expertise.

In addition, we invite our local pharmacist and dentist (both of whom operate on the site) and they are able to contribute to the meeting with details of the work they do and the services available.

The Forum has been in existence for some years now and has proved very useful. We are continually reorganising our appointments system and reviewing access in light of comments from patients. In addition, they are able to help with communication, notice boards and the general appearance of the waiting room.'

'The [patient participation] group were unhappy that public money was going into plans for Darzi centres/surgeries and that money could not be used to improve access in present surgeries throughout the borough. They wrote to the MP about this and wrote to the PCT about the lack of publicity about public consultation and that meetings were held during working hours.'

'My practice used the PPG to campaign against dispensing changes with many patients lobbying the MP and others to save the service. The pharmacist was so highly thought of by patients that the MP came to the surgery to meet him.'

A new campaign 'growing patient participation' will launch this summer. Supported by the BMA, RCGP, NHS Alliance, NAPP and the DH, the aim is to support and promote the development of PPGs. For more information, visit **www.napp.org.uk**

Patient surveys

The best way to evaluate patients' satisfaction with services is to ask them. A range of tested questionnaires are available for this purpose or practices can develop their own. Locally administered practice patient surveys were part of QOF for several years but were discontinued from 2009 and replaced with GP patient surveys, some of which included new questions testing patient satisfaction with non-clinical services including:

- building access
- telephone access
- surgery cleanliness
- whether patients feel they can be overheard in the reception area
- helpfulness of reception staff
- manners of reception staff
- ease of appointment booking and appointment waiting times

All of these issues are very important but practices can get more useful information by undertaking surveys in house, getting more patients' views and enabling active commentary rather than just box ticking. Suggestion boxes properly promoted also enable feedback whenever patients wish to contribute – something patient survey questionnaires can never match. One practice that contacted us during this consultation was planning to go a step further by introducing 'interactive feedback capsules' in the waiting area. Patients will use this to record feedback on a touch screen computer allowing staff easy data entry and live analysis of opinion on the various aspects of care and services offered.

To tie in with patient feedback gathered through the new English patient survey, the Department of Health has developed guidance for PCTs on how to support improvements in the accessibility and responsiveness of GP services (due to be published in July 2009 as part of the World Class Commissioning of Primary Care suite of documents), although the use of targets in this area have often led to greater problems delivering good access rather than improving it. The Department is also developing a Primary Care Service Framework for a Responsive Practice that will provide PCTs with options and improvement ideas that they can negotiate to commission from local practices using a local enhanced service (LES) contract.

> *'We always take the results of our patient survey seriously and some years ago this resulted in us installing a new telephone system, which has improved telephone access for the patients.'*

Handling complaints

Complaints about a GP practice can be made either to the PCO or to the practice itself. If a complaint comes directly to the practice there are a few things that may help to reach a quick solution.

- Arrange to meet with the complainant or discuss via the telephone the reasons for the complaint and what they would like to see happen as a result. You can then let them know from the outset whether or not their expectations are realistic. If the patient knows that their complaint is being taken seriously from the outset it will help to keep the process smooth. If you are able to resolve the issue to the complainant's satisfaction within one working day, then it will not be necessary to take the matter through the formal complaints procedure.
- Agree a plan of action, including when and how the complainant will hear back from you. Help with producing a plan is available in the Department of Health's advice sheets, which can be accessed from the Department of Health's website at **www.dh.gov.uk/en**

The GPC has produced an FAQ document on the complaints system, which can be accessed from the BMA's website at **www.bma.org.uk**

Practice opening

Patients, as well as politicians, are interested in practice opening hours and accessibility. Access to general practice has been one of the English Government's key political priorities over the last six years. A worthwhile approach is for a practice to listen to patients' views, decide whether they can be accommodated and how this could be done. If it has not been possible to change availability or opening times it is important the reasons for this are explained to patients.

In-hours accessibility

Practices should regularly review both accessibility for patients within contracted hours and the hours that the practice opens for appointments. Where possible it is preferable for practices to remain open throughout their contracted hours in line with most patients' expectations. However, individual practices do have very different circumstances and from a patient's perspective, a practice closed at some point in the day may be balanced by excellent access at other times. For example in small practices, limiting routine contact to telephone only for an hour at lunch time may be pragmatic, though larger practices could reasonably be expected to ensure that practice doors are open and the reception covered over the full course of the day. Most patients will expect, as a minimum, to be able to pick up repeat prescriptions from staff and book appointments.

Some surgeries close for half a day a week for historical reasons, but it is increasingly hard to defend this for any but the smallest practices. Contractually, it is up to doctors to determine how care is provided within hours but consideration should be given to the fact that half-day closure is usually unpopular with patients. Patients may feel as frustrated by having made a wasted trip, not being aware that the surgery was closed, as by the fact that they are unable to see a doctor, make an appointment or pick up a script. Where closure is unavoidable it is therefore important that patients are well-informed of the hours affected.

In larger practices it should be possible to rotate doctors' time to ensure that the surgery is always open in-hours. For smaller practices, branch practices and single-handed practitioners, solutions to half-day and lunch time closure may be much more difficult, particularly as employers must ensure their members of staff work within the constraints of the European Working Time Directive. However, even where very small practices cannot offer bookable appointments for a half day a week there may be scope to review the availability of reception staff or nurses so patients are not faced with a closed door and an answer phone message. While ending half-day closure may have cost implications for surgeries and require changes to staff contracts, doing so will probably allow more flexible working and the opportunity to develop new services.

The Royal College of General Practitioners (RCGP) has recently promoted a federated practice model which could present smaller practices with an opportunity to improve patient access by sharing workload and resources. This model enables practices to develop specific solutions to the identified access needs of their local population[2] and practices may wish to consider adopting this model in the future.

'A group of single-handed GPs all work in one health centre. They share employed staff including receptionists, and other expenses. Part of the sharing includes having a staff presence from 0800 to 1900. At times there will only be one receptionist, but at no time is the surgery shut and the GPs are available throughout the day for their own patients. On occasions when one GP is not available, the other GPs cover for them and keep a count of the visits they each do so that the covering work is evenly distributed. This reduces pressure on the staff as the work is spread more evenly and patients can get access to the surgery throughout the working day.'

The issue of half-day closure for historical reasons is totally different to closing for formal protected training or education time, often done at PCO level. Down-time for in-house training should also still be encouraged by both practices and PCOs. Local co-op arrangements may be able to cover while the surgery is closed to work on improving services. The importance of ongoing education and training should be explained to patients.

Some practices have gone well beyond basic access considerations in order to deliver excellent access solutions for their patients.

'As a dispensing practice we offer a delivery service to outreach areas each Wednesday the transport is provided by a locally run community project. The service is also available to patients if they need assistance to get to the surgery for appointments.'

Extended opening hours

General practice is highly adaptable and able to provide an excellent standard of extended services where properly resourced. Deciding whether to extend opening hours remains the prerogative of practices in consultation with their patients and is not a decision that can be taken by PCOs. Practices need to decide on an individual basis what type of service is needed by patients, as different populations will have different needs, and what is practicable within the given resources. Where practices are not in a position to extend their opening hours, or where they can only offer a reduced service outside normal hours, they may wish to explain the limitations of the current funding of extended hours arrangements to patients. In all cases, the times of the first and last appointments of the day should be clearly advertised in the practice leaflet and website and in England on the NHS Choices website.

Extended opening will not be discussed further here as it has been well covered in other GPC guidance available on the BMA's website at **www.bma.org.uk**

Appointments

Making appointments

Patients should be able to make appointments as conveniently as possible, either by telephone, in person, or, where possible and secure, online, depending on their preference. An effective method of reviewing the appointment system would be for practices to monitor the pattern of incoming calls to the surgery and to match receptionist availability and telephone lines to patient demand. Staff could be asked to focus on answering patients' calls during peak times and save other administrative tasks for a quieter part of the day. In larger surgeries, reception staffing may be able to be organised according to call patterns. To free-up administrative time and to save patients unnecessary inconvenience, practices may wish to consider longer repeat prescribing durations for regular medication. Electronic repeat script ordering can also help to free up administrative time.

Previous Government access targets led to the development of systems where patients are sometimes asked to phone for same day appointments first thing in the morning. This results in a high demand and sometimes in patients ending up on hold or constantly redialling the practice until they can get through on the phone. Now that there are different access criteria, practices should review their systems to make improvements for patients and the practice.

> *'Conversation with a patient group in one practice found that patients felt frustrated trying to get through to the surgery by phone between 8.30 and 9.00 in the morning. In response, the practice started opening the call centre from 8am and put more staff on the telephones first thing in the morning. This had the effect of spreading the calls and avoiding such high peaks in demand.'*

Regardless of improvements made by practices, there are likely to be some peak times of demand for appointments. It may be helpful to highlight such times in the practice leaflet so patients can call at a quieter time at their convenience.

> *'We showed our PPG around the practice including the call room. This gave them a much better appreciation of how hard we try answering phones.'*

Practices should review appointment booking for all the clinics held at the surgery. An allied health professional at the practice may work independently from the main surgery but if this is not clear to patients, any disjointedness between appointment booking for GPs and allied clinics could appear unprofessional. Understandably, patients referred to a service located at their surgery expect a seamless service. If it is not possible to book all appointments through a central channel, reception staff should ensure they know how and when all appointments can be booked. The implementation of a new service should include information and training for reception staff.

Surgeries should consider the needs of a wide variety of patients when assessing their booking systems and specifically consider how to meet the needs of patients with disabilities. Research by the RNID[3] shows that almost a quarter of deaf people have missed at least one GP appointment owing to communication problems. Practices should consider allowing patients to make appointments using textphone, email, fax, a website or text messaging. These communication methods require prompt responses if they are to help patients.

Telephone systems

Modern telephone systems with adequate capacity to deal with peaks in patient calls can make a real difference to patients' perceptions of GP practices. Call systems as a minimum need to address the requirements of hearing-impaired patients. Having calls answered within a couple of rings, even with an automated menu of options, is preferable to receiving no answer or an engaged tone during busy periods. Directing callers using an automated menu may also help large reception teams to respond to calls more efficiently. Having said this, telephone systems should be appropriate for a practice's own patient population. In some cases an automated menu may be judged to be inappropriate for an elderly population. Age Concern and Help the Aged's response to the GPC consultation suggested that older people do not always like the additional functions of 084 numbers and would rather speak to another person directly than to use push-button options. Input from patients and PPGs would help practices tailor their systems to their patients' needs.

'We opted not to go down the route of a multiple choice menu as we have a large elderly population.'

'Our telephone system is always answered by a member of staff. We do not have an answer machine (except during out-of-hours) so patients can always reach a member of staff.'

Upgrading telephone systems does require investment but some practices and many other NHS bodies have found using advanced telephone systems allows them to respond better to patients' calls; though this sometimes incurs a slightly higher charge for patients. Although there has been public debate about the use of 084 numbers in general practice, their wide use throughout the NHS demonstrates that many organisations judge the marginal differences in call charges to be a reasonable price for more patient friendly call handling. Practices using these improved systems often see a significant improvement in patient satisfaction with the handling of calls. Advanced telephone systems are available without 084 numbers but at an increased cost to practices. One possibility may be for the PCO to help fund upgrading telephony without recourse to 084 numbers. Some practices that introduced 084 numbers to improve patient services are bound by long contracts and are unable to change easily to a different system. Where patients express dissatisfaction with the additional cost of phoning 084 numbers, practices should explain the benefits of replacing the previous system to help address these concerns.

Running late

It has been reported that patients have sometimes found even the first appointment of the day running 20 minutes behind time and later appointments running an hour late. This can cause great frustration. Patients should be given as long as they need in an appointment and waiting to see a doctor can reflect the complexity of previous patients' appointments. Although most patients are very understanding about the unpredictability of clinical need, patients should always be offered an apology by reception staff and an explanation when the surgery is running behind time when they book in for their appointment. Where running late is a common occurrence, practices should consider reviewing their appointment systems. Possible solutions include booking longer appointment times, adding catch-up slots or ensuring that meetings do not overrun. These measures can improve patients', and doctors', experience greatly. Reviewing the timing of surgeries may also help to prevent appointments running late. One practice found that opening the surgery doors well before the first appointments were due to begin helped appointments run to schedule.

Appointment types

There is currently very wide variation in practices' balance of appointment types with a few practices offering almost no appointments bookable in advance and others having an insufficient number of same-day appointments available. Both extremes cause problems for patients and practices (including funding issues) and would need to be reviewed. A regular audit of demand for appointments, preferably involving a PPG, allows practices to tailor appointment availability to patient demand. The Primary Care Foundation[4] recently found that reserving around a third of the total number of appointments available for same-day access is normally sufficient to meet patient demand, but it needs local review and flexibility. However, during peaks in demand, even the most organised practices can struggle to provide enough appointments to meet patients' expectations.

Patients should be able to:

- book appointments within a reasonable timeframe, recognising the urgency or otherwise of their condition
- have the option of booking an appointment with a named clinician if they are prepared to wait until that person becomes available
- be seen very quickly or get an appointment within a timescale appropriate to the level of urgency of the clinical situation.

> *'Following a brief period of patient consultation and using results from our patient questionnaire… same day appointments have been increased (advance availability reduced to accommodate this). 70 per cent of patients at our branch site and 60 per cent at the main site desired more same day availability.'*

> *'We changed our appointment system last year. We have always had an open surgery each morning in both of our surgeries but introduced same day appointments in the morning, if patients phoned the surgery during the first hour of opening. Patients were able then to either walk in and wait or phone ahead and gain an appointment on the morning of that day. We have always had afternoon booked appointments for up to six weeks in advance. We also allowed phone consultations more and made them available to patients as a regular option.*
>
> *We found that patients have welcomed the new arrangements. We recently scored well above the national benchmarks in access and patients have said many times the new system has made the waiting times to be seen far less and made the waiting room less crowded.'*

> *'We run our books six months in advance but have recently changed a quarter of the appointments to book on the day appointments. We have also introduced Nurse Practitioner appointments, phlebotomy appointments and patients on multiple disease registers now have the opportunity to attend an extended appointment to cover all conditions.'*

Booking the correct type of appointment can be a major difficulty for patients and a source of great confusion. Patients should be helped to understand how to get the most clinically appropriate and convenient appointment at the surgery in the future. Practices may be able to help patients appreciate the difference between urgent, chronic and ongoing problems through the use of good examples in practice information. Many practices give advice about this in their practice leaflets.

Practices should do their best to respond to patient demand for appointments. However, all practices operate with finite resources. Practices should look at how their systems cope with the excess of demand for any kind of appointment over supply and then see if improved communication would help patients or whether reorganising appointment arrangements would improve matters. Cancelled appointments should be rescheduled. It helps if the practice, and especially the doctor or nurse, explain any reasons behind any delay in getting appointments when patients think they should be seen earlier. Having special arrangements for triage of urgent appointment requests, either by telephone with a GP or nurse has worked in some (often larger) practices. This may help to diminish the potential for possibly urgent problems to disrupt pre-booked appointments.

Patients who do not require urgent care value the convenience of advanced booking which may, for example, allow them to plan their working day or make travel arrangements around the appointment time. In an organised practice patients should not have to take up an urgent slot or be encouraged to call on the day for a non-urgent appointment in order to be seen when convenient for them. Difficulty accessing advance appointments has been highlighted as a particular problem for patients managing a long-term condition.

Appointment length

The 2007 GP Workload Survey found that the average length of surgery consultations with GP partners had increased from 8.4 minutes in 1992/3 to 11.7 minutes in 2006/07.[5] While the evidence is clear that the quality of consultations increases with length, as recognised by QOF, appointment length has to be balanced against the number of appointments available. From time to time patients would benefit from longer consultations with their GP than the standard appointment time. Offering variable appointment lengths can reduce the potential for overrunning surgeries and help with patient perceptions of time needed. Studies have shown patients are good at predicting the length of appointment they need, improving the experience for both patients and doctors. Simple guidance for patients displayed on notice boards, in the practice leaflet and on the website etc can help explain that longer appointments should be sought for multiple problems and joint injections. Longer appointments are often also needed for patients with learning disabilities, complex health or social needs, psychological problems or English as a foreign language. As care becomes more complex and general practices manage patients with multiple social and health needs, this may be an area which requires further funding consideration with Government.

Continuity of care

Continuity of care is the cornerstone of UK general practice. Continuity comes top in most independent surveys of what patients value about their surgery. Practices need to give thought to ways of promoting continuity with individual clinicians as much as possible. Possible methods for encouraging continuity of care may include doctors personally forward-booking, flexible time usage, 'personal lists', GPs job sharing or other mechanisms designed to ensure that, wherever possible if they wish, patients are seen by the same clinician. It is vitally important to communicate with patients so they understand the availability and benefits of pre-booked appointments. Members of staff of one practice that contacted us during the consultation ask patients to consider booking in advance for routine or non-urgent consultations with the explicit purpose of securing the benefits of long-term care by a specific doctor.

> *'Older people place a significant value on continuity of care – the ability to make appointments to see one trusted individual who knows and understands a patient's history.'*
> *Age Concern and Help the Aged*

It is helpful to remember that acute, on the day, booked patients may have less concern about continuity. Some practices allocate more pre-booked appointments to partners, allowing nurse practitioners and salaried doctors to concentrate on acute bookings but this is a matter for practices to decide for themselves, weighing the benefits of such a system against the need for all clinicians to build up their own 'patient lists'.

> *'We have two surgeries about one mile apart but we introduced the option for people from one surgery to visit the other surgery if they wish to 'see/follow' a doctor when they were working at the other surgery, to increase patient choice of who they saw.'*

Practices must strike the difficult balance between promoting the advantages of seeing a specific doctor (because of an established relationship or because that doctor has a particular interest in the patient's medical condition) while making patients aware that their doctors may work part-time and have a range of responsibilities which will sometimes prevent them from being able to see patients at short notice.

> *'Most of our feedback from patients indicates a high level of satisfaction with the range of services and quality of care. Their main dissatisfactions stem from the desire of most patients, particularly the elderly and children and young people [and their parents/carers] to see the partner doctors. There is little or no understanding from patients of part-time roles, or the importance of roles outside the practice, whether in medical politics, commissioning, medical education or governance.'*

Ensuring good record keeping within the practice team is vital for effective continuity of care. Sharing of important information and maintaining accurate records between practice staff and multidisciplinary teams helps to ensure this continuity continues within the extended practice team. The size of most surgeries ensures patients are often known within the team even if their own GP is not available that day. Many practices operate a system of buddying so patients and their results are known across the team, improving continuity of care.

Use of Information Technology (IT)

General practice has the highest level of computer use and IT literacy of any part of the NHS, and the UK's General Practice IT is amongst the best in the world. During the consultation period, the GPC received some very positive responses from practices which have harnessed IT to improve patient services.

Common IT-enabled services

A number of hardware and software packages which deliver tangible improvements to patient services are available to practices. Common IT-enabled services in general practice include:

- Touchscreen booking-in services allowing patients to book themselves in when they arrive at the surgery without waiting to see a receptionist. Practices that use these systems find that they can free up staff time and reduce the likelihood of patients having to queue at reception to book-in. The systems can also inform patients of any delays in appointment times. Such systems will need to be supported by identified alternative arrangements for those patients who cannot use them easily.

> *'Overall we are a very technologically advanced practice and ALL our patients benefit from that. For example, those patients that cannot or do not wish to use touch-screen check-in benefit from not having to queue behind other people who would be happy to use the touchscreen.'*

> *'Touchscreens can mean that the only person to person contact in the surgery is with your GP. There could be an emphasis on training reception staff to be more of a presence and not see the touchscreen as a replacement for themselves… it is possible the patient's relationship with the practice can lose out and they can lose sight of the practice as a team rather than just a building with GPs.'*

- Web-based appointment booking, and cancellation, which allows patients to book appointments when the practice is closed or when telephone lines are busy. The English Government's NHS Choices website in England will allow GPs to offer this facility if their software is compatible. Many accredited GP computer systems can offer the same facility.
- Web-based repeat prescription ordering. Some practice system products now allow patients with passwords to order their repeat prescription online or even view a summary of their patient record. Release 2 of the NHS Electronic Prescription Service (EPS) in England will allow patients to nominate their pharmacy so that GPs can send their prescription electronically for dispensing, making the process faster and more convenient.
- Practice websites offering information about the practice, links to health information and sometimes also (by using EMIS Access for example) links to web-based appointment booking, repeat prescription ordering etc.
- Printed appointment reminder slips.
- Text message appointment reminders for patients encouraging them to cancel if they cannot keep the appointment, so reducing DNAs and maximising the availability of appointments for other patients. This service appears to be popular with patients. Text message appointment reminders may be particularly useful for communicating with patients with hearing impairments.
- LED waiting room displays linked to the appointments screen calling patients to the consulting room.
- Information screens providing both general health information and information about the practice.

NHS Connecting for Health works with suppliers, GPs and PCTs to improve IT systems and services, which support practices in the delivery of patient care. Practices in England can secure central funding for clinical software systems through GP Systems of Choice (GPSoC). This funding is released following agreement between practices and PCTs. Over 6,000 practices are already receiving services under the GPSoC arrangements. Practices have a choice of IT systems from GPSoC suppliers, alongside choices offered by their Local Service Provider. More information on GPSoC and the IT systems available in England can be found on the Connecting for Health website:

www.connectingforhealth.nhs.uk/

Similar arrangements apply in the other three nations.

The English Government's own health agenda is heavily linked to the use of technology. For example, High Quality Care For All – NHS Next Stage Review Final Report committed to introducing HealthSpace online from 2009 enabling more patients to see and suggest corrections to a summary of their care records, to receive personalised information about staying healthy and to upload the results of health checks.

IT for better administration

Technology can reduce the workload of practice staff. IT systems can, for instance, automatically manage mail-merges for referrals, patient invitations and standard form completion.

> *'We use Macro Express to automate every-day IT tasks and extend the functionality of the clinical system (EMIS PCS). For example, when scanning hospital letters macro express pops up with pre-defined clinic lists which can be selected for easy data-entry (rather than hand typing entries and remembering to add appropriate Read Codes).'*

In some cases larger practices make extensive use of an intranet for staff information and management. Possible intranet content includes a practice calendar, referral forms, appraisal information, articles of interest, internet links, patient information leaflets, guidelines, practice policies and protocols and internal and external telephone directories. One practice told us that their intranet had improved staff communication across the board and helped to reduce paper waste.

IT within the consulting room

IT is widely employed within the consulting room. Almost all practices use IT to support clinical service delivery. Clinical systems allow coding, document management and faster access to information from hospitals. GPs also make extensive use of external sources of online medical information to improve diagnosis and effective condition management. All clinical systems monitor prescribing, minimising the risk of interactions and avoiding accidental prescribing of medication a patient is allergic to.

Many practices have become 'paperlite' in recent years, ending the traditional reliance of paper notes. Even outside the surgery, GPs can use hand held computers when on home visits, giving them access to patient records. This sort of technology use normally comes at a direct cost to the GPs involved, rather than to the NHS. However, many practices have still invested for their patients' benefit.

IT systems can often be linked with clinical tools. Test results from GP ordered blood tests are downloaded directly into the patient record in almost every practice. ECG and Spirometry results for example can be linked directly to the patient record with the right software. Pathology, radiology and other results can often also be accessed from the practice.

> *'We have an excellent on-line system where we can see the result of all investigations online (regardless of whether they have been requested by GPs or the hospital), can see if a patient is an inpatient (and if so, on which ward) and can also see all correspondence (including internal to the hospital, and between the hospital and other bodies).'*

> *'We have written in-house software that automatically sends diabetic patients their latest HbA1c lab results prior to their interim review appointment and we are expecting to extend that to sending cholesterol and HbA1c prior to their annual care planning appointment. We will evaluate and possibly extend that system further to other chronic disease areas.'*

Choose and Book in many places allows direct booking of hospital appointments. However, it remains controversial in some areas owing to issues with speed, reliability and functionality and is therefore far from unanimously supported by the profession or patients. Clinicians' recent experiences of Choose and Book can be found at *Choose and Book: Learning lessons from local experience* on the BMA's website **www.bma.org.uk**

Barriers to better use of technology in general practice

Not everyone has positive experiences of IT in a practice setting and some practices are wary of introducing specific technology-aided changes. Practices that do introduce technological improvements normally include partners or managers with an interest in IT, not least because migration to a new IT system can be a time-intensive process that requires a business case under GPSoC and involvement of the PCT. Unfortunately, not all PCTs support GPSoC. Some have a preference for one particular IT system over the others, often for reasons for management convenience. A local preference for a single system may also be a manifestation of pressure from SHAs or service providers.

Some practices chose not to introduce IT-based changes for practical reasons or because of concerns about the implications of certain initiatives for patient consent and confidentiality. In addition, moving from one administrative system to another does involve resources, including releasing staff for training, managerial support for developing a business plan and project management and a degree of clinical risk. Some of these barriers can be reduced if practices with more experience help relative novices or if PCTs support change management in the area.

Some patients are also uncomfortable with IT use. The elderly, sight impaired and those with learning disabilities for example, may struggle to use the technology on offer. Only 30 per cent of people aged 65 and over have ever used the internet[6] so the heaviest users of general practice will often not have online access. Online tools cannot therefore be a total replacement for more traditional systems.

> *'Any moves to increase opportunities to make online bookings should ensure that those without internet access are not disadvantaged and are still able to access the same range of appointments.'*
> *Age Concern and Help the Aged*

Having said this, modern technology can offer these same patients benefits if used well. Text messaging may help communication with deaf patients and sending automated reminders to patients may help patients with early dementia or learning disabilities. Use of technology by even part of the practice population also frees staff to devote more time to those patients with difficulties with IT. When thinking about IT solutions, it is incumbent on GPs to consider the make up of their practice and what is suitable locally.

> *'A local practice abolished its telephone repeat script line, and this has caused problems for a considerable number of elderly patients in this very rural area where post-boxes are few and far between, and not all feel comfortable with computers; and don't own them. This leads to confidentiality issues when they find themselves asking other family members or friends to email prescription requests for them.'*

> *'I have not offered online booking as the majority of my patients are from a deprived area and/or elderly with low access to the internet. These innovations could increase healthy inequalities in such practices.'*

Consultations

The ethos of good levels of 'customer service' should continue from the reception through the waiting room into the consulting room. General practice training has always had a focus on the skills needed in the consultation. The computer, although now essential to the consultation, can act as a distraction from the patient and lead to the perception that the doctor's attention is not fully on the patient. Interruptions to the consultation by other staff or telephone calls are often unavoidable, but should be minimised if at all possible and apologies should be offered to the patient where this occurs. Many patients find consultations stressful. Apart from good communication skills the positioning of furniture and general ambience of the consultation room can help patients feel more at ease.

The importance of good communications skills for clinicians is well documented and cannot be overemphasised. Patients value their appointment with their GP highly and this should be reflected in the quality of the consultation.

Telephone and email consultations

Some practices now use telephone consultations in addition to face to face appointments. This can be an effective way to respond to demand for, and assess the need to provide, same day face-to-face appointments and often provides a time saving alternative for both clinician and patient. If a clinical examination is not necessary, this option may prove particularly convenient for working patients who can consult their surgery from their workplace during office hours. Pre-bookable telephone appointments will help to improve patients' perception of accessibility and are likely to reflect well in access questionnaires. [The convenience of telephone consultations for some patients may be complemented by local pharmacies' home delivery services for prescriptions, ensuring an easier method of obtaining medication.]

Not all doctors however are comfortable with telephone consultations. It may therefore be appropriate to use doctors with particular skills in this area, or to ask a duty doctor to rotate the role. Some surgeries employ a dedicated triage nurse. Regardless of the arrangements for telephone consultations, patients should normally be able to leave a message for the GP who knows them and have a reasonable expectation that their message will be passed on and a reply returned to them in a reasonable timescale.

> *'We do offer a service whereby patients can speak to a GP – basically they ring and make a request and we ask the GP to ring back at the end of surgery. This is helpful as it does sometimes negate the need for a visit to the surgery or a home visit.'*

Telephone consultations do have some drawbacks. Some practices using them have experienced problems with patients' expectations of what can be achieved without face-to-face contact, however this seems to be only an occasional problem. Studies show around only 50 per cent of telephone consultations result in a face-to-face consultation and this should be taken into account when considering triage appointments.

> *'The problem with phone consultations is the expectation that you can do all things without the patient coming to the surgery. They are then quite reluctant to come to the surgery to be seen if a doctor feels they need to, or to have investigations etc done.'*

> *'... if they need to be seen, most patients in my experience are happy to come to the surgery.'*

Telephone consultations have clinical governance implications that practices should be aware of. The RCGP has published a book for doctors on the principles of telephone consulting which is a useful reference tool in this area.

Email consultations potentially have far greater drawbacks. At this time GPC still advises against email consultations for reasons of data protection, security and confidentiality, although it is perfectly reasonable to consider using email to patients for general communication. If not using them, practices might wish to explain why email consultations are not currently used in their practice leaflet and on their website. Practical problems have been experienced by some practices using email consultations.

> *'We do not make any time provision for email consultations, which simply pile up through the day and are answered in the evening. Only two partners use this facility.'*

> *'... [with telephone consultations] you still have a "live" interaction with the patient, can be reassured the patient's questions have been answered and that there is a clear outcome, whether that be advice, a certificate, a prescription or the need for a face to face consultation. The same cannot be said of email. It must take longer. If not live, how do you ask questions? When will they be answered? There could be an endless to and fro of emails from just one patient and they could easily be lost or missed then could become a medico-legal nightmare. The patient can keep coming back and back and back. It must be more difficult to assess whether the patient has had a satisfactory consultation with a good outcome.'*

> *'Secure electronic communication can be useful with carefully selected patients but it is important the patient realises the limitations beforehand. A big benefit for both GP and patient is the communication can be conducted at a convenient time. Emails do take longer though, as it is important to avoid ambiguity, and at this stage there is no scheduled time in the day, unlike telephone consultations, which can be "booked".'*

Premises, facilities and waiting rooms

For many GPs inadequate premises and lack of premises funding is a major constraint on their ability to improve the patient experience. A considerable injection of resources is still needed to remedy some premises problems but others can be solved.

The waiting room and reception give patients their first impression of the surgery. Waiting rooms as well as consulting rooms should always be clean, tidy and comfortable. Ideally there should be enough seating with chairs that are easy to get out of for elderly or disabled patients. The provision of clean and easily cleanable toys and a range of magazines in good condition can make a big difference to patients' experience, particularly when appointments are unavoidably delayed. Many patients will spend more time in the waiting room than with a GP or nurse. Waiting rooms are heavily used and are inevitably subject to considerable wear and tear. Staff should get into a habit of checking for torn posters, litter, peeling paint, broken furniture and dirty toys etc. PPGs can play an important role in improving waiting rooms. In one practice that contacted us during the consultation period, the patients group had requested drinks machines in the waiting room and then raised funds to install water coolers for patients' use.

Some surgeries chose to play music or use televisions to show programmes on health and health promotion topics over satellite channels. Surgeries should ensure they have the appropriate PRS broadcasting licence for television, radio or music used in the waiting room.

Waiting rooms are often a key source of information for patients and their carers. Notice boards should be neat and up to date and used to help inform patients. As well as producing their own information, practices normally provide resources from other organisations, perhaps covering specific clinical issues. This can be very useful for patients but, because practices can become inundated with various leaflets and posters over time, frequent review by staff is necessary if patients are to be able to pick up information relevant to their circumstances. The use of television screens in waiting rooms for displaying patient information is covered below under patient information provision. Practices using screens for patient call and health messages will need to consider whether these should include commercial content. Where screens are used in waiting rooms the font and colour of text needs to be legible for patients, including those with visual or reading disabilities.

More technological waiting room diversions include machines patients can use to measure their body mass index and blood pressure producing print outs for the patient and for the practice to record. The layout of a waiting room and reception area can make a big difference to patients. It is always worth considering the non-verbal messages given by GPs and staff. Does the reception desk look inviting and open with staff ready to greet patients? Wherever possible, practices should endeavour to provide privacy to patients at reception so they are able to discuss their details with staff in private. It is seldom appropriate for reception staff to ask about patients' problems and it can be acutely embarrassing for patients if they are asked to indicate what an appointment is for where other patients can hear.

Improving access for patients with disabilities

All practices need to comply with the Disability Discrimination Act (DDA) insofar as costs and necessary changes are reasonable. Where this is not possible, the reasons should be clearly recorded. PCOs should be looked to for support in making appropriate adjustments and reminded firmly of their shared responsibilities under the DDA. Financial support from PCOs may make a huge difference to the work that can be reasonably undertaken to improve access for patients.

Age Concern and Help the Aged suggested that practices consider the following:

- proximity to a bus route or engagement with local transport providers to enable a range of transport options
- nearby parking with designated spaces for disabled patients
- availability of a phone in the surgery so that patients can call a taxi when they are ready to leave
- doors which are easy to open and wide enough for wheelchair access
- ramps in place of steps
- if there is an entryphone, ensure instructions are clearly marked, and there are alternative arrangements for people with physical impairments
- plenty of seating in the waiting area
- accessible toilet which is clearly signed with a wash basin and bin.

Practices should ensure that they are as user-friendly as possible for patients with additional needs. Patients that are deaf or hard of hearing (one in seven of the general population by some estimates) may benefit from:

- induction loops, well maintained, switched on and supported by appropriate staff training
- translation support during consultations, such as Sign-Translate for BSL-users
- systems that offer a range of options for appointment booking.

> *'Sign-Translate is a web based communication programme for deaf people available to all GPs, currently free of charge in England. The programme translates over 300 medical questions into BSL by means of short video clips. It also allows online access to BSL interpreters via webcam. It is not intended to replace interpreters but can be useful when a deaf patient needs to see a doctor quickly and a face-to-face interpreter is not available.'*
>
> *RNID*

Patients with English as a foreign language (including those with British Sign Language as their primary language) may need:

- easy-to-follow written material in plain English
- appropriate communication support during appointments, such as Language Line for pre-booked appointments.

Patient information provision

Practices should use existing resources to their full potential to advertise services. Practice leaflets and websites as well as waiting room notice boards should be up to date, accurate and clearly presented. An attractive leaflet and website gives a good impression of the practice and can include a wealth of useful information. Practice leaflets should be routinely given to new patients and should also be available at reception. Practices can add important practice information to prescriptions or use text messaging to distribute information to patients.

The GMC's *Good Medical Practice (2006)* provides clear guidance on patient information provision:

- If you publish information about your medical services, you must make sure the information is factual and verifiable.
- You must not make unjustifiable claims about the quality or outcomes of your services in any information you provide to patients. It must not offer guarantees of cures, nor exploit patient's vulnerability or lack of medical knowledge.
- You must not put pressure on people to use a service, for example by arousing ill-founded fears for their future health.

The RCGP and GPC document *Good Medical Practice for General Practitioners (2008)* adds:

- 'Providing information to patients is an important and positive part of practice. Patients want to know what services are provided in the practice, which ones can only be used on your recommendation, and which ones they can access directly. They need to know about arrangements for out-of-hours care and when they will next be able to talk to a member of the practice team. This applies to written information (e.g. your practice leaflet), to your website and to any recorded telephone information.
- The information in your practice literature or website needs to be accurate and factual, and should avoid making comparisons with others. It should be reviewed regularly and kept up to date. Your responsibilities are to provide information for your own patients and to those thinking about registering with your practice. You should not go out and canvass or entice patients to join your practice.'

Information given to patients in practice leaflets and/or a practice website should cover:

- all key contact information
- details of practice staff and ancillary team
- opening hours and accessibility. This should explain any difference between contracted hours (08.00-18.30) and appointment times
- appointment types and times, including information on the way a practice offers urgent access in-hours and any consequent limitations on choice of clinician
- appointment booking arrangements and how to book a home visit. If they have one, this may include an explanation of a practices' appointment triage system or home visit policy
- how to order a repeat prescription, with an indication of how long such a process might take
- whether patients are responsible for contacting the practice for test results and what will happen if unexpected or worrying results are received
- how the practice uses personal information (and links to the Freedom Of Information Act scheme)
- details of the complaints procedure
- advice on management of common, minor conditions and links to important website/telephone numbers including out of hours
- the help available to patients with visual or hearing impairments or learning disabilities and the arrangements for wheelchair access.

Beyond these vital pieces of information there is huge scope for practices to add information relevant to their own patients. An obvious addition to practice websites would be downloadable practice newsletters and, where the necessary software is in place, links to web-based appointment booking and repeat prescription ordering. One surgery that contacted us during our consultation had been asked by its patient group to share more background information with patients about the running of the practice. As a result it had introduced basic statistical information in its newsletters and waiting room about the number of calls received daily and how many appointments were unattended. Notice boards in waiting rooms routinely hold information on current health issues, patient surveys etc but this type of information is also displayed by some practices on websites. Practices should think about how they communicate information to existing patients rather than relying on providing practice leaflets to new registrants.

> *'Our practice website was created initially to allow patients access to the service offered by the practice, but it is now much more functional and it includes appointment booking and cancellation services, repeat prescriptions, health and travel information. The website also has a feedback link for patients to email us with suggestions for improvement of the website, and services offered. This has been really useful in developing a patient friendly website that is structured to allow easy access to information and services. There has been a huge interest in the website since its onset. Our patient forum sees it as an extremely useful development. Suggestions are being offered on a weekly basis by patients to improve the website.'*

Practices may wish to consider a television or electronic notice board in waiting rooms for patient information on clinical issues or patient services. Several companies offer health promotion programmes via waiting room screens.

> *'A large plasma screen in the waiting room displays video and still images of the various resources and services offered at the practice, for example: healthy eating and smoking cessation, 'know your staff' introducing staff members and doctors to patients and featuring video clips of staff members and a video tutorial on how to use the check-in service. This service has attracted some very positive comments from our patients who want more.'*

Practices should carefully consider the tone of all messages given to patients. Posters in waiting rooms sometimes include notices such as 'One appointment, one problem' and 'this month patients have missed *x* appointments'. These project powerful messages but are very negative. The same message may achieve more if delivered in a positive way, for example 'this month this practice has offered patients *x number* of appointments. We are grateful to our patients for keeping these appointments' or 'if you wish to discuss several problems with your doctor please let reception know at the time of booking your appointment'.

> *'I personally find it very frustrating and condescending to sit waiting 45 minutes for a pre-booked appointment to read several notices around the building telling me that if I am 10 minutes late for my appointment I won't be seen by the doctor. Such messages create a 'practice versus the patients' atmosphere.'*

The GPC's consultation elicited some good examples of communication with patients. For example:
- a quarterly newsletter available in the waiting room, on the website and sent out in a condensed version with recall and invitation letters
- a waiting room information loop – a series of self-containing topical slides lasting 10 minutes in total, changed monthly, displayed in the waiting room to tie in with the waiting room displays
- photo boards in the waiting room showing names and faces of staff members
- interactive patient self education models on the inappropriate use of A&E services, directed towards frequent attendees to help them understand and use primary and secondary care services appropriately.

One practice's patient participation group told us:

> *'Through a team of volunteers we ensure that every patient of the practice receives a hand delivered copy [of the practice's newsletter]. We are trying to encourage patients to provide the practice with their email address not only to save on printing but also so that the practice has a means of quick communication with their patients if an emergency arises.'*

Information for patients should be produced in an easily accessible way. Help the Aged and Age Concern suggests:
- information printed on standard-weight paper so that older people can easily hold and turn the pages
- printed information in text size of at least font 12, so it can be read comfortably by older people without spectacles
- text broken up into small chunks, using bullet points and illustrations
- the offer of alternative formats for the visually impaired – large-print versions or information on tape.

Practice charters

Some practices are developing 'contracts' or 'charters' setting out reasonable expectations for patients, staff and doctors. Many practices are developing mission statements to outline their ethos of care and improve the partnership between patients and staff. As well as setting out an expectation for mutual respect and politeness, a practice charter could include an undertaking by the surgery to:
- whenever possible try to run surgeries to time, inform patients if surgeries are running late and automatically rebook appointments, where patients wish, if surgeries are running significantly behind schedule
- inform patients about and maintain urgent access standards in line with access guidance
- treat patients politely and with respect.

In return, practices could expect patients to:
- adhere to the NHS policy of zero tolerance of abusive behaviour to NHS staff
- keep appointments. Practices might even consider imposing restrictions on forward booking for those few patients who repeatedly fail to cancel in good time, although other sanctions are unlikely to be appropriate
- inform the practice if they cannot attend appointments.

Violence – Practices are reminded that the DES on violent and disruptive patients remains in force and must be provided by PCOs. Practices should not have to accept violence or abuse from patients. Zero tolerance is an entirely acceptable position.

Staff training

Ongoing training and development of all practice staff should be as well established as continuing professional development for GPs. All non-clinical staff should have an annual appraisal including identification of training needs. In addition, practices should hold regular team meetings for the entire team including, where appropriate, attached staff.

> *'Non clinical staff are trained on a one-to-one basis on induction, and each department has a weekly meeting for communication and training.'*

It is particularly important that staff receive ongoing training where practices are introducing changes to the practice's services.

> *'Any changes are supported by the necessary discussion, communication and training. We have four TIPS sessions per year (Training to Improve Patient Services). Everyone at the Practice meets for an afternoon, the first two hours cover relevant issues/information for all staff and then we divide into two groups – clinical and non-clinical. We can also utilize the time when clinicians attend PBC TIPS (four afternoons of four hours) to carry out group training within the surgery for non-clinical staff.'*

Customer care training on equality and disability issues should probably be provided at a PCO level as recommended recently by the Welsh Assembly's guidance in the disability access DES.

Reception staff

Reception staff members are normally the face of the surgery and they play a huge part in shaping a patient's opinion of a practice. Friendly, helpful, understanding and well-organised reception staff can make a huge difference to patients. Really good staff can help outweigh intractable problems with premises, ease frustrations with delayed appointments and help build the relationship between patients, practices and GPs. Unfortunately patients sometimes report difficulty with this relationship and see reception staff as a barrier to seeing a doctor leading to tension on both sides.

In all sectors staff benefit from periodic training and reflection on their working habits. Receptionists are already routinely trained in skills specific to their role within a surgery, such as knowing when a patient could see a nurse instead of a doctor. GPs should ensure that staff know when it is appropriate to ask patients what type of appointment they need and when the reason for patients visiting their GP is confidential. It is not always appropriate to ask patients why they wish to see a GP but well-trained staff should be able to determine patients' needs well enough to ensure that the majority have the right type and length of appointment booked for them. Often a simple enquiry by the receptionist may help to solve the patient's request without further delay.

> *'Staff are offered a broad range of training geared to their specific roles – there is no protected time for this however. We do have a bi-monthly opportunity to arrange in-house training as this is when the GP Network training takes place. Last month for example we organised an in-house Child Protection update for admin and nursing staff. Other sessions have covered complaints, health and safety, etc.'*

Reception staff may benefit from generic customer service training. Training in telephone manner, interpersonal skills including body language and conflict diffusion all have the potential to improve patient experiences. This will improve staff working conditions, as well as the patient experience. Reception staff could consider wearing name badges and introducing themselves on the telephone so patients know who they are speaking to. They should be encouraged to exercise patience with people who cannot hear well or who need things to be explained more than once.

> *'We have a monthly training session where all staff attend for three hours this covers compulsory staff training and ongoing training, sometimes speakers are invited to attend. All staff are trained to a level 2 NVQ for customer service and all our dispensary staff must obtain a buttercups dispensing course to work at the practice.'*

> *'Practice staff attend protected learning sessions one day each month. This allows us to accommodate mandatory training but is also useful in shaping how we deliver our services to patients. The whole practice often meets to discuss how best a new service could be provided or monitor existing processes. We also discuss questionnaire results at Practice Meetings which can help determine whether change is required. Our senior reception team meet monthly to specifically discuss the appointments system, repeat prescription provision etc to address difficulties or take on board suggestions made by patients in reception.'*

> *'We have trained our reception staff to try to respond to all patients' requests positively. If a patient requests a same-day appointment, they are the more likely to be told "yes certainly, I have one available at 3.30 or ten to four if you prefer" than to hear "not until this afternoon I'm afraid". Patients requesting a home visit are told "yes, I'll put you through to the duty doctors" and the need for a home visit is then assessed by a doctor who may suggest a standard appointment instead. This sort of positive response relaxes patients, makes them feel welcome and creates a good impression of the practice. The surgery has found this type of response is well received by patients.'*

It is very important that practice staff members are trained to respond to patients with additional needs. For example, the RNID advises that:

> *'It is important that staff are trained in deaf awareness. Guidelines for all staff when talking to deaf people include making sure they have the person's attention before they start speaking and facing them, speaking clearly and keeping their voice at a normal level and using plain language. It is also important to find a suitable place to talk, with good lighting and away from noise and distractions.'*

Practice managers

Practice managers have a pivotal role in promoting and improving customer care and should be encouraged to regularly liaise and network both within the surgery and at external meetings. There are many active practice manager networks already in existence across the UK, usually organised on a geographical basis and meeting regularly to enable networking and the sharing of ideas and help practice managers stay in touch with PCTs, LMCs and other practice manager networks. With the support of the Department of Health, a number of professional organisations representing practice managers in England have now come together to form a national network called Primary Care Managers.

Benefits to practices of being involved in a practice managers' network include:

- advance alert of forthcoming issues, allowing the practice to be prepared for change
- opportunities to influence local proposals and policies before they are finalised
- an increased profile for the practice allowing earlier identification of strengths and weaknesses and a better opportunity to make improvements before being prompted by the PCO.

Barriers to making changes

In our consultation document, we asked practices to tell us about the barriers they experience in responding to patient expectations. Some of the most common perceived barriers are outlined here.

Difficulties in taking on new patients

Many practices currently wish to open their lists but are unable to do so because of practice premises restrictions or concerns about the implications of increasing patient numbers for existing patients. The way practices are currently funded still does not always provide the incentive or support many practices need to grow their lists safely. It is perfectly reasonable for practices not to take on patients to whom they are unable to offer services without depriving their current registered population. Practices must however be consistent in their approach when declining to register patients. It is not acceptable to decline applications to join a practice on the basis of demographic characteristics. A practice policy to ensure this would offer protection to practices as well as transparent and fair reasons to all patients unable to register. Ideally there should be no restrictions on new registrations within the practice area, unless agreed with the PCO. If practices are struggling to take on new patients, it may be worth discussing solutions with the LMC and PCO to see if there is any scope for developing local solutions.

> *'We have formally closed our list due to patient demand for registration. We cannot afford to take on new doctors due to the MPIG / normalization issue. We took on 500 patients last March 2008, and our global sum fell by £2,000 per month!'*

Temporary residents

Providing consultations to temporary residents is part of the GMS contract and practices are expected to comply with this, though it is an area of the contract which probably needs revision as it causes high, unrecognised, workload in some areas. Practices must ensure the medical records of temporary residents are forwarded on appropriately, though PCOs have a clear responsibility in this respect as well. Failure to do so can damage continuity of care and potentially raise patient safety issues. Without accurate data it will be difficult to ensure increased funding in the future

Migrant populations, language difficulties and high population turnover

Practices which have a large proportion of patients who do not speak English confidently often experience particular difficulties in service delivery. These language problems can be compounded by high population turnover (new patients tend to consult more in the first year, increasing workload) and by the very different expectations of primary care sometimes found among patients from other countries. Some practices see large numbers of patients who do not understand the NHS or general practice system and who have diverse health beliefs and experiences of healthcare. Migrant populations sometimes also approach practices with untreated problems having lacked good access to healthcare in the past.

> *'My practice is in an inner city area, with a very diverse population. Our patients are from all walks of life, including the very deprived, as well as many university students. Patients are from all over the world and there are a large number of migrants – 60 per cent of our new patients who are not students were born overseas. Patient turnover is high. Literacy in English (whether as a first or second language) is poor in non-students.'*

Language problems will usually result in a need for a large number of long appointments, sometimes with formal interpreters. Outside the consulting room, communication with patients who do not speak fluent English can also be more challenging. Arranging appointments or even calling them in for follow-up can be subject to communication difficulties. In such practices establishing an active PPG will pose its own challenges, but it may be an excellent way to help tackle others.

Premises

Lack of premises investment in the UK means many practices can only aspire to many of the innovative service improvements made in other surgeries. While for example some waiting room improvements can be straightforward, others are cramped and uncomfortable by virtue of the fact that the building is basically unfit for purpose. Premises constraints can also impair practices' ability to extend services.

> *'Whilst we would like to be able to offer more appointments we are limited by two factors. Firstly we do not have the financial capacity and secondly our main site does not hold enough consulting space to allow expansion. These factors may change once we settle into our new practice.'*

Lack of support from other health bodies

Real development of patient services often involves the support of local primary care organisations and other parts of the health service. Where this support is not forthcoming or where these other bodies are also constrained by tight resources, it can prove difficult to respond to patients' aspirations.

> *'We are encouraged to develop services which meet local needs: our Practice Based Commissioning Cluster has been trying for over a year to secure services at our local District General Hospital by involving GPs in running services there. Political battles between Hospital Trusts and PCT have used this as a tool to consolidate their own positions, placing patient services far below Trust finances in the list of priorities.'*

1 The National Association for Patient Participation (2007) *Survey of patient participation in general practice (2005-2007).*

2 Royal College of General Practitioners (2007) *The future direction of general practice: A roadmap.*

3 RNID (2004) A simple cure.

4 Primary Care Foundation (2009).

5 The Information Centre (2007) *GP workload survey.*

6 ONS (2008) *Internet access 2008 households and individuals.*

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