The Big GP Consultation

Summary Report for Session 5:

GPs in The Big Picture, Part II

(Primary/secondary care interface, greener practice, holistic medicine)

Session Date: Wednesday 20th April 2022
No. of Participants: 38

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This report represents the views of the participants in the consultation and not the authors themselves

The Big GP Consultation

Introduction

The Big GP Consultation is a platform for GP Trainees and Early Career GPs to collectively discuss their vision for the future of general practice, and how they can shape the future system that they will be working in. This programme consists of six sessions, each on a key theme relating to the future of general practice.

This programme is endorsed by Faculty of Medical Leadership and Management (FMLM). For more detail about the wider programme, please visit our website here.

Session 5 Findings

This report details the findings of **Session 5: GPs in The Big Picture, Part II (Primary / Secondary care interface, greener practice, holistic medicine)**. Both the report, and the infographic, collate insights gathered from a pre-session survey (n=18), a post-session survey (n=11), and the facilitated breakout room discussions, which 38 participants took part in. The respondents were split evenly between GP Trainees and fully qualified GPs.

The topics covered in the breakout rooms were as follows:

Breakout Room 1: How can general practice be greener and adapt to the climate crisis?

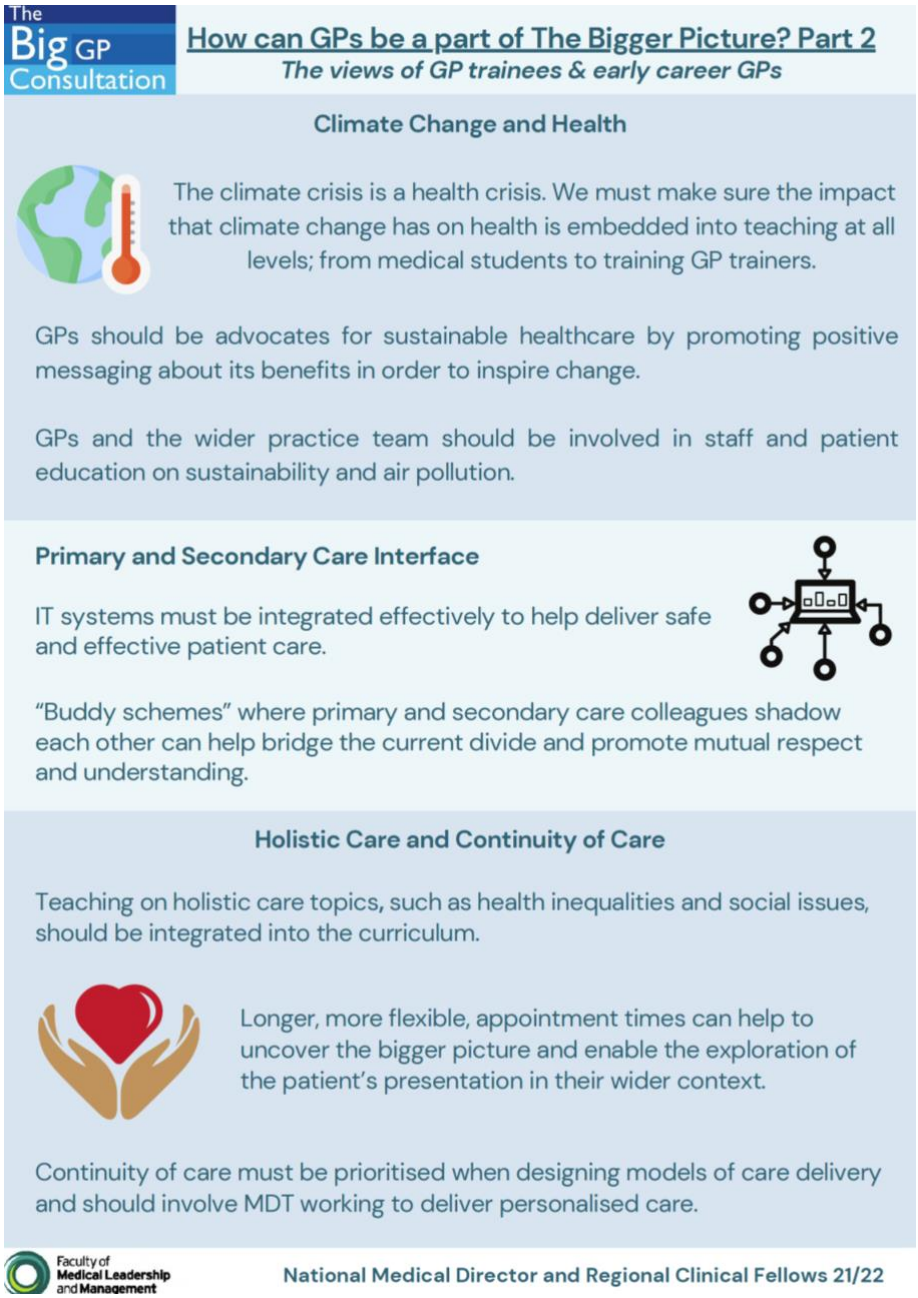
Breakout Room 2: How can we improve the interface between different NHS providers, such as between primary and secondary care?

Breakout Room 3: How do we provide holistic care to our patients?

Breakout Room 4: How do we ensure continuity of care for our patients?

Key Themes

The key themes of the session are summarised in the infographic below.
A high-quality copy of the infographic is available to download from our website here.



Breakout Room 1: How can general practice be greener and adapt to the climate crisis?

Climate change and planetary health should be embedded into clinical teaching and practice, ensuring that all healthcare professionals are aware of the clinical importance of this topic, and have tools to make practice more sustainable. Wider advocacy on the climate crisis, such as information on air pollution for patients, is a vital part of the GP's role.

Participants in this group had a mixed exposure to, and awareness of, greener practice initiatives. Some felt that this was a prominent issue that was discussed frequently in their working lives. One participant felt particularly engaged and inspired regarding greener practice, having recently joined a local greener practice group. Others felt less familiar with green strategies, guidance, and initiatives, but felt sustainability was an important issue that was unfortunately not treated as a priority in their working lives.

Participants suggested several ideas for how primary care could be more sustainable:

1. Focusing on health promotion rather than treating disease, leading to fewer investigation and treatments needed.
2. Employing sustainability leads at practice and/or Primary Care Network (PCN) level who can advocate for greener practice and be the contact point for sharing good practice.
3. Strengthening the focus on social prescribing, including green and blue prescribing[1].
4. Encouraging green Quality Improvement (QI) initiatives, such as those that focus on low-carbon respiratory care, which improves patients' health alongside reducing the carbon footprint.
5. Promoting the business case around sustainability, ensuring that colleagues understand that sustainable healthcare improves health, the environment and often saves money.
6. Encouraging training programmes to consider where they are sending trainees in terms of travel distances.
7. Reducing over-prescribing and improving patient compliance to reduce medicines waste.
8. Reducing unnecessary home visits and offering more virtual/telephone appointments where appropriate.
9. Reducing the use of unnecessary personal protective equipment (PPE) and exploring and using an evidence base for which infection control measures are necessary.
10. Reducing the use of paper by moving to electronic systems and records.
11. Reducing the electronic carbon footprint with fewer emails where possible.

Participants discussed the importance of embedding sustainability curriculum changes into training. They felt that sustainability needs to be introduced as early as possible, such as at medical school. It was also suggested that the e-portfolio could have a "sustainability" domain which may prompt trainees to reflect on sustainability in more detail. It was reflected that many of the greener teaching sessions, learning initiatives and attempts to encourage teaching sessions on sustainability have often been trainee led, suggesting that the younger generation are both more understanding of these important issues, and driving these conversations forward. There was a consideration that perhaps it is harder for some trainers / educators to lead these conversations if they are less familiar with sustainability principles. It was felt that informed, hopeful, and inspiring speakers and educators are needed to engage colleagues and share the vision of greener practice.

There are opportunities to promote sustainability in healthcare through QI and audit projects with medical students, postgraduate trainees, and trainers, who all need evidence of QI and leadership projects. We should be hopeful in our communication.

In terms of the role of GPs in wider advocacy around climate change, it was felt that patient health education is a vital part of a GP's role. A good example of this is the GP giving patients information on reducing their exposure to air pollution. Furthermore, as trusted pillars of the community, we may be able to champion the importance of planetary health in ways that our communities will listen to. Participants felt that GPs should use our positive reputation and community trust to build patient and community confidence in the importance of the climate change agenda.

Participants noted how important it is to be hopeful in these challenging times, as colleagues and patients respond better to hope rather than fear.

[1] Green social prescribing links people to nature-based interventions and activities, and blue social prescribing links people to activities on or around bodies of water. More information can be found here.

Breakout Room 2: How can we improve the interface between different NHS providers, such as between primary and secondary care?

Artificial barriers between providers must be removed to improve patient care. Barriers are caused by different IT systems, a lack of mutual understanding, and poor communication between providers. There are many examples of how we can remove these unhelpful barriers. We should seek out exemplars and promote the fact that "we're all on the same team, and here for the same reason" – to deliver high quality patient care.

Participants discussed the challenges of providing effective transfers of care between different organisations, alongside examples of where this currently works well and how it may be improved in the future. Participants highlighted how important it is for these interfaces to work well, recognising that it essential for the delivery of safe and effective patient care.

A key challenge to effective transfers of care was miscommunication. One commonly referenced example was that of discharge summaries. Participants felt that these were often incomplete and did not paint an accurate picture of what had happened to a patient during an admission or at an out-patient appointment. Participants noted that despite the discharge summary being "one of the most important documents for patient care", it was often completed by the most junior member of the team, or by someone that was not particularly familiar with the patient's care. Participants also highlighted issues with the timeliness of receiving this information, with patients frequently contacting the practice to discuss these documents prior to the practice receiving them. When combined, these issues were felt to have a detrimental impact on patient care, and in some cases, impact upon the safety of care delivered.

Fundamentally, the systems must be integrated effectively in order to deliver safe and effective patient care. Primary and secondary care 'buddy' shadowing schemes can help to improve mutual understanding.

When discussing how this may be improved, one participant shared the example of a "Buddy Scheme". This is a scheme whereby hospital doctors and GPs spend time 'in each other's shoes' to experience their working life. This scheme was hailed as a success through improving both mutual understanding and the quality of discharge summaries. Consequently, it is now being expanded. This is one initiative that Training Hubs may wish to explore further. However, participants recognised that the time required to do this would be a barrier. Alongside this, participants felt that more senior clinical input into the discharge summary would be a feasible way to bring about tangible improvement in patient care.

Another example of a commonly experienced communication challenge was when referring a patient into a specialty, or seeking specialist advice, by telephone. There is often difficulty in getting hold of the right person, with the GP often on hold or needing to call back if the speciality doctor is busy or unobtainable. The Buddy Scheme outlined above may bring about improvements here through improving understanding of each other's working lives. One participant-suggested solution was a dedicated referral taker or liaison doctor who was solely responsible for supporting GPs with admissions and advice and guidance. They gave an example of where this worked well in practice. However, it was recognised that this might be challenging to implement due to workforce constraints.

There was also discussion around whether all secondary care doctors should experience GP working as part of their training, in a hope that this would enlighten them to the challenges faced by GPs. This is already reciprocated as all GP Trainees spend time in hospital settings. This may also tackle some of the challenges participants faced around having referrals rejected for unclear reasons. While this would likely improve understanding and collaboration, it is again challenging to achieve in practice.

Participants were passionate about harnessing technology to solve some of the communication challenges. Participants spoke favourably about a single IT system that spans primary and secondary care, and even recognised it would be worth "taking a step backwards before we can move forward", by moving initially to simpler IT systems that could be shared across organisations. This system must be one that "works in practice" – is easy to use and can load information quickly. Interoperability would also help significantly with reducing unnecessary duplication, which was highlighted as a particular problem at the interface between out-of-hours GP and the Emergency Department in one area, despite the fact the services were co-located. It was noted that many of the current challenges arise due to the competitive nature of current IT systems, and moving towards a single, shared, and fully integrated system would remove this barrier. Information governance and data sharing were also seen as a big barrier towards integrating in this way.

There was a clear recognition that no matter where we work in the NHS, "we're all on the same team, and here for the same reason" – to deliver high quality patient care. The move towards Integrated Care Systems was seen as a positive in this sense, through enshrining our duty to collaborate between organisations. There was optimism that this could be a key enabler for both improving mutual understanding between clinicians, while also ironing out some of the more technical challenges around IT system interoperability and data sharing.

Breakout Room 3: How do we provide holistic care to our patients?

Holistic care is the golden thread in providing effective patient care. However, this is poorly defined, taught and supported. The system needs to look at how it can support healthcare professionals to deliver effective holistic care.

Participants felt that for GPs, providing holistic care for our patients is essential. However, the current pressures mean that our ability to do this is limited. Longer, and more flexible appointment times are needed for healthcare professionals to uncover the bigger picture and think about other factors affecting patients, including the psychosocial aspects.

Participants found that holistic care is the golden thread of meeting the needs of the population beyond the surface clinical level. The system, as it currently stands, is very target- and number-driven, and we are missing the person at the heart of this, and their continuity of care. We need to define what holistic care is in the 21st century. Participants felt it was vital that trainees fully understand the concept, which needs to be balanced with what is feasible to achieve when managing the patient within our current constraints.

It is vital that all trainees truly understand what holistic care means. The RCGP should review the training curriculum to ensure the key objectives of holistic care are included.

The RCGP curriculum capabilities was felt to be very broad in terms of holistic care. It covers safeguarding and systems under the 'holistic care' subheading but does not specifically cover topics such as health inequalities, and social issues such housing quality and deprivation. Participants felt these should be included in the core curriculum, and that the RCGP should undertake a mapping process to identify and clarify the key objectives of holistic care, and what we need to know.

It was felt that social prescribing is an important tool but may be used as a 'dumping ground' for more complex patients that are hard to find solutions for in standard appointments. Participants felt that it is vital that GPs understand when to signpost, and what the roles and boundaries of the GP are, to prevent patients from being bounced between services. It is important to have information available to GP practices on which services are available internally and externally, encompassing face-to-face and remote options.

Participants felt that patient expectations and patient responsibility will be key to helping provide holistic care, which is vital to providing preventative medicine. Participants also suggested that integrating with the social care system more widely was key to achieving success in this area.

Breakout Room 4: How do we ensure continuity of care for our patients?

Continuity of care is an important aspect of primary care; it is however increasingly hard to deliver with a diminished workforce and increased patient demand. There are examples of how systems can adapt and still promote continuity of care. We should seek out exemplars, and support pilot schemes, in order to improve our models of practice.

Participants agreed that continuity of care was important to both patients and GPs alike. It is one of the cornerstones of General Practice, as seeing the same patients helps to establish trusting relationships, resulting in improved outcomes for patients and greater satisfaction for GPs.

That said, participants felt that healthcare professionals and patients have differing perspectives on what continuity of care means. That differing definition could lead to strain on the doctor-patient relationship and instil unrealistic expectations from the public.

Patients and healthcare professionals have differing definitions of what continuity of care is. This can lead to a strain on the doctor-patient relationship, while fuelling society's unrealistic expectations of what they should receive from primary care.

Patients want their doctors to know their full history prior to seeing them, and they assume that healthcare professionals have the time to understand what has happened independently of the patient both in secondary care and within the community. The increasing diversity of services and complexity of patient pathways means that the once ever all-encompassing role that GPs could play to ensure continuity of care is increasingly being eroded; by the complex system landscape, and by the workload pressures that the profession finds itself in.

Participants agreed that whilst continuity of care was important, it was increasingly difficult to deliver, and some solutions were proposed. One participant talked about the wider use of Additional Roles Reimbursement Scheme (ARRS) team members with a feedback loop through to a GP who takes on the role of accountable senior decision maker when needed, much like the model in secondary care with consultants and their wider teams. This allows allied health professionals to deliver care, whilst the GP is kept abreast of progress, and can provide both clinical oversight and continuity of care to those that need it.

Another suggestion was forming mini-GP teams within a practice, made up of 2-3 GPs, nurses, and a physiotherapist, for example. This would enable GPs and ARRS staff to work flexibly in their clinical role, while also enabling patients to have a familiar team that they can receive care from, who thereby provide *team-based* continuity of care.

Participants also noted that *access to general practice* and *continuity of care* are different issues in the delivery of care and are not mutually exclusive. There has been an explosion of methods through which patients can access medication requests, tasks, and as a means of booking routine appointments. Some argued that this puts the onus on the patient to choose continuity of care by selecting the clinician they book in with. Others argued that it doesn't change the variation in popularity of some clinicians over others, resulting in an inability to see patients in a timely manner and thus forcing patients to see any clinician rather than their named GP.

Some participants noted that the pandemic resulted in some access issues at particular times over the last two years. These systematic resource constraints led to a degradation in continuity of care as the demand and capacity mismatch was so great that continuity of care had to be deprioritised to ensure that patients could be seen within a safe time interval.

A key point was that in order to make continuity of care possible, access to primary care had to be suitable, workforce constraints needed to be rectified, and working in smaller teams in an MDT fashion, covering the working week, would need to be considered.

High Impact Actions

The box below suggests areas of exploration which colleagues identified as being important in this session.

- Ensure the links between climate change and health, and sustainable healthcare practices, are taught at all levels, from medical school, to GP training, through to GP trainers.
- GPs should use their trusted voice to advocate for climate change and health issues and educate the public, for example, on reducing contributions to and avoiding exposure to air pollution.
- Mutual understanding of primary and secondary care pressures can be improved by “buddy schemes” involving shadowing of other healthcare workers.
- A single, shared and fully integrated IT system would remove barriers between primary and secondary care.
- Teaching on specific holistic care topics, such as health inequalities and social issues, should be integrated into the core curriculum.
- Continuity of care must be prioritised when designing models of care delivery.

Next Steps

The Big GP Consultation programme has gathered a great deal of insight from our participants about the challenges that we currently face in general practice, as well an many ideas on how to overcome them.

The next phase of this work will therefore focus on how to use this insight gained to help to shape a positive and bright future for general practice. There are three broad ways through which The Big GP Consultation Team plan to do this:

1. **Sharing findings widely**. We are currently writing our Big GP Consultation Final Report, which brings together the findings from all five sessions. This will form the centrepiece of our plan for sharing our findings more widely.

2. **Using the findings to influence change**. We have now had a number of conversations with local, regional, and national organisations in which we have shared the ideas generated during this process. These ideas have been very well received. We plan to continue these conversations, in order support the organisations to implement the ideas our participants have put forward.

3. **Supporting others to influence change**. We *all* have a part to play in shaping the future of general practice. The Big GP Consultation Team is passionate about using the findings from these consultations, as well as the learning from our influencing work to date, to support others with bringing about change in their own area. We will be producing resources that will support our colleagues to bring about tangible, positive change in their area of work.

To keep up to date with our progress on the above, as well as joining us on the journey for positive change, please our website here, and our Twitter page here.