POLICY From the other side of the GP's desk: a patient perspective on the Fuller report

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ABSTRACT

As the recommendations of the Fuller Review are implemented and the new system of integrated care boards becomes established, it has never been more important to involve the voices of patients and communities as we shape the future of general practice. Here, a patient offers a perspective on how we can harness multiple viewpoints and apply the principles of human-centred design to bring solutions to the challenges of access and prevention that are grounded in local communities.

KEYWORDS: Fuller Report

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Introduction

The Fuller Review[1] (Box 1) of the future of general practice came at a time of declining public satisfaction with some aspects of general practice, alongside low morale within the profession. It also came at a time of yet another reorganisation in the English NHS, with moves away from clinical commissioning groups (with GPs on their governing bodies) to larger, integrated commissioning boards (ICBs) with responsibility for commissioning primary care. These ICBs are also charged with ensuring the restoration of NHS services after the pandemic, their transformation and integration with social care, the reduction in inequalities and unwarranted variation. The list goes on.

Despite the recommendations and the support of all the chief executives designate of the integrated care boards, there still seem to be high levels of dissatisfaction among patients and low morale amongst professionals. Although the voice of local residents is expected to be used by ICBs, there is variation in the ways in which this is being undertaken. So how then do we address some of the factors which led to Fuller being asked to undertake her review?

Over a year on from her report and looking ahead, we urgently need a meaningful conversation with patients about the future of general practice. This needs to be at national, system, place and practice level, with proper resourcing and support.

Within all of Fuller's recommendations, there is a clear need to co-design solutions. This needs to be done in a way that takes into account the huge diversity in communities at the levels of system, place and practice. This diversity will also be present amongst commissioners and providers of services, many of whom will not have experienced the challenges (and joys) of co-design.

Box 1. What are Fuller's main recommendations?[1]

- Streamlining access to care and advice for people who get ill but only use health services infrequently, providing them with much more choice about how they access care and ensuring care is always available in their community when they need it.
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs.
- Helping people to stay well for longer as part of a more ambitious and joined up approach to prevention.

Do patients really understand general practice?

First, we need a conversation with the public about how general practice works. All GPs are NHS employees, aren't they? All practices operate in the same way, don't they? The backlash against general practice during lockdown needs to be acknowledged, to allow all parties to begin to re-set their relationship. This is not to condone the aggression and violence which took place against staff in general practice, but it is important in understanding and re-framing concerns. Co-design cannot begin in earnest without trust.

If we want to engage with our communities, to co-design a service for the future, then we need to share knowledge about how general practice is funded and what its relationship with the NHS is. What is an integrated care board? Local people do not need to know about clause 9.4 of the national contract.[2] But if GPs and the NHS are not sharing this understanding, then our communities will assume they are hiding something. Being open and honest about possibilities and constraints is critical. The balance of power remains tilted towards professionals. The move to introduce new professionals into general practice has largely been done without explaining these new roles. Nurse practitioners have increasingly gained currency, especially around long-term conditions such as diabetes. But do patients understand what a physician associate does? How are they trained? What is their scope of practice? Are there risks? Local systems need to take the time to explain who forms part of the wider general practice team – how they can benefit patients, but also the limits and controls around their

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practice. They need to use patient stories to do so. Without doing this, patients will continue to rely on the general practitioner, despite there being qualified alternatives. This will apply to the integrated neighbourhood team as well.

Involving patients

We also need to consider how best to resource and support co-design. Co-design does not just happen. Co-design does not happen in line with the timescales expected by the NHS. This also needs leadership, but does co-design feature in any development for GPs or primary care network leads? Does the governance of ICBs really capture the voice of local residents? With the reduction in running cost allowances for ICBs, will there be capacity there to deliver co-design in primary care, let alone in mental health or falls services?

During COVID-19 lockdowns, practices were told that they could de-prioritise patient participation groups, a contractual obligation. What has happened since the easing of the COVID-19 restrictions? Are practices embracing the chance to re-engage with their patients? Or is this being subsumed within patient participation groups at primary care network or neighbourhood level? Real engagement takes time and resource, neither of which are always recognised by the NHS, where rapid results are demanded. The balance of power rests with the GP and the practice. Patients need to be supported to gain the confidence to act as equal partners, to challenge in a constructive way, to understand the jargon that professionals use. Any initiatives to address this need to be sensitive to local cultures and communities. Moves to increase shared decision-making – where patients want it – is a small step to redressing this imbalance. If you are a carer, your time needs to be valued. The NHS needs to recognise the costs of providing and sourcing support for your loved one, be it a child or an adult. Some sections of the patient population feel a mistrust of ‘authority’ – think of the Gypsy/Roma/Traveller community, or those from minority ethnic groups who saw a disproportionate impact of COVID-19. At the same time, practice staff may need help to have meaningful conversations with patients. How can they all embrace curiosity and not see feedback as critical? How easy is it to ‘de-medicalise’ a conversation?

Whose role is it to involve patients?

Patient engagement in general practice is a contractual requirement (clause 5.2 of the national contract[2]), albeit wrapped in terms like ‘reasonable efforts’. The patient participation group’s (PPG) recommendations for improving the services they receive must be jointly agreed with the contractor, who ought to take ‘reasonable’ steps to implement them. Many primary care networks are now setting up patient participation groups (PPGs). These should not be seen as an opportunity to opt out of patient engagement at practice level. Working at scale to co-design phlebotomy services or seasonal vaccination campaigns across a group of practices is positive. Other issues are more localised to individual surgeries – the need for a pram shelter – and need that very local input. Commissioners need to support practices to reinvigorate their PPGs, recognising that the skills required at practice level can also be used at PCN level. Where practices are reluctant to do so, ICBs should use their performance management mechanisms to ensure that patients are given a voice and that it is heard.

ICBs have a majority of professionals on their boards, with two to three non-executive members. These members are appointed to bring leadership and challenge, but although they should demonstrate a connection with the area covered by the ICB, they are not viewed as patient or public representatives. ICBs are also part of integrated care partnerships (ICPs), a broader alliance of NHS, local authority, voluntary sector and Healthwatch, among others. ICPs oversee the development of an integrated care strategy. The strength of this broad coalition is that partner organisations bring better-developed mechanisms and experience in talking to, and working with, local residents.

Working in Partnership with People and Communities[3] sets out the statutory basis for NHS organisations – integrated care boards and provider organisations - to involve local people in the planning and delivery of care. Both ICBs and providers have a legal duty to involve the public under the NHS Act 2006, as amended by the Health and Care Act 2022. Other pieces of legislation, such as the Equality Act 2010, also support the drive for greater responsiveness to local needs. The requirements relate to all aspects of healthcare, from primary care services to specialised physical or mental healthcare. This means that there are no specific activities expected at primary care level. There is also a balance to be struck between engagement at a system level, at place and at network levels. There needs to be a collective and transparent agreement about what takes place at what level.

Human-centred design

A number of the strands in the Fuller report must be addressed with real dialogue with patients and their carers. The estates issues need not just GPs and other professionals to think about where services are delivered, but also how they feel to both the patient, the carer and the caregiver. This is where human-centred design comes in to play (Box 2).[4] This moves beyond just asking patients and carers to asking patients and carers *and* the staff who use the premises at the same time, and towards thinking in much broader terms. Does the layout also work for the driver delivering stationery?

Prototyping is not always feasible when considering new buildings, but virtual reality solutions may have a role in allowing users to ‘fly’ through a design.

New premises need to be health-promoting. The idea of ‘designing out crime’ has been with us for a long time. ‘Active design’ is also gaining more attention. Integrated care systems are a welcome opportunity to bring patients together with the NHS and local planning authorities, alongside other partners. We need to think about how buildings for primary care support wellbeing[5] as well as creating a sense of place, where local people feel welcome and more inclined to work with primary care and others in managing their own health.

Box 2. Seven tenets of human-centred design[4]

- Get past your own great idea
- Don’t be restricted by your own knowledge
- Spend time with real people in real environments
- Identify other users
- Follow your users lead and needs
- Think about the whole journey of the product
- Prototype and test your idea

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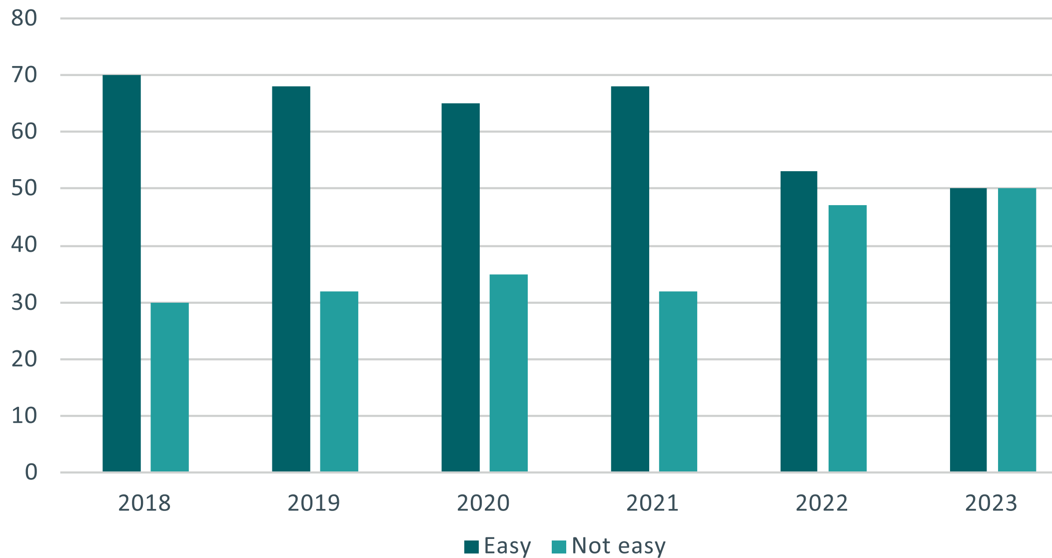

Fig 1. Results from the 2023 GP Patient Survey:[6] percentage of patients reporting that it is 'easy' or 'not easy' to get through to their GP practice on the phone. Weighted data. Patients who answered 'haven't tried' are not included.

Access – one size does not fit all

Human-centred design also comes in to play with access. The results of the 2023 GP Patient Survey[6] show a fall in the numbers of those rating their overall experience of making an appointment from 69% 'good' to 54%, with ease of access by phone having fallen from 70% to 50% 'easy'.

With the Recovery Plan,[7] practices are to address the 8am scramble for appointments, with improved telephony and other digital solutions such as the NHS App. Although the 2023 GP Patient Survey showed the decline in satisfaction with the process of making an appointment, from 69% 'good' in 2018 to 54% in 2023 (Fig 1), the percentage of patients saying their needs had been met in their last appointment had only dropped four percentage points in the same period from 95% to 91%. This suggests that once a patient has navigated the appointment system, their outcome is positive. Simplifying access, though, needs to be balanced by increased capacity within general practice. Otherwise we risk an improvement in one element of the patient experience at the detriment of another.

Over recent years, people have become more demanding of services. If you can buy a paperback at any time of the day, why can't you access your GP as flexibly? Banking, possibly the only other service requiring high levels of confidence and confidentiality, moved most of its transactions online over the last few years with little outrage, until the banks on the high street started to close, removing choice. But really, when did you last see your bank manager? Has it affected your income or savings? The NHS needs to work with patients to understand the concerns of patients about online services and how their data may be stored and accessed. Media coverage of data breaches in many sectors does not instil confidence and highlights the need to give assurances.

Understanding your communities

During lockdown, the use of the NHS App increased significantly and for understandable reasons. Yet its use is not universal. Patients registered with practices in the most deprived areas have lower uptakes rates.[8] Registration rates are higher where the practice list has a higher proportion of white patients, and among 15–34-year-olds.

In considering access, the NHS needs to recognise and act on the differing needs of some of the most vulnerable in our communities. Verity & Tzortziou-Brown[9] describe some of the difficulties faced by groups such as those experiencing homelessness, migrants, sex workers and Gypsy/Roma/Traveller communities. Digital exclusion is a key theme, but concerns about language barriers and attitudes towards certain groups also feature. It is estimated that 7.1m adults in the UK read at or below the level of an average 9-year-old, with more than 4 in 10 adults struggling to understand health content written for the public.[10] The NHS also needs to recognise the financial cost for many of digital access.

Fuller and her ICS CEO colleagues all reference the role of primary care in addressing the four aims of integrated care systems, which include reducing health inequalities. Taking time to work with 'inclusion health groups' must be high on their agenda if they are committed to this. Getting it right for these groups will reap benefits for the whole community.

Prevention

As well as the Fuller recommendation of helping people to stay well for longer, two of the quadruple aims of integrated care boards support the prevention agenda:

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience and access.

The Hewitt Review of integrated care systems[11] acknowledged the importance of prevention and called for an increase in expenditure on prevention by the NHS. Of course, GPs and their teams are well-placed to give advice and promote healthy living. The development of health coaching and social prescribing roles in primary care is an important move in response to the

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understanding that only 20% of wellbeing is related to clinical care, the other 80% being related to broader issues such as housing, air quality or income.[12]

This means that a number of organisations can and should contribute to the development and dissemination of advice and guidance for residents. These are precisely the partners joined in to the integrated care partnerships and place-based partnerships, not least local authorities, with their breadth of responsibilities. National organisations such as the Office for Health Improvement and Disparities (OHID) are also vital in providing consistent, evidence-based resources. However, the challenge is to place any such initiatives in the context of local populations. One size will not fit all. Here again, local systems need to work with their communities to co-create approaches which reflect their diversity – the use of different languages and media, or culturally-sensitive interventions. Residents will be less interested in whether they come from OHID, and more about whether dietary advice is grounded in their community's shopping and cooking habits.

Turning data into intelligence

Fuller rightly emphasises the need for data to underpin the way primary care operates. Yet for it to become 'actionable', primary care needs to triangulate activity and spend with the lived experience of those to whom the data relates. The data tell us that we have high levels of obesity, so let's give people vouchers to use at their local leisure centre! I worked with a GP in Essex who took the time to talk to his patients and devised a scheme for patients needing to increase their levels of physical activity. They worked with a personal trainer from a local gym in the safe space of a church hall. No expensive trainers. No lycra. No fit people parading their slim waists and bulging muscles. Consider access to the ingredients of a healthy diet. How close are shops? Which items are most affordable, given the cost-of-living crisis? Only by having this dialogue can the NHS deliver some of the changes needed to promote health. The use of community connectors[13] as part of NHS England's Core20Plus5 approach to reducing inequalities brings lived experience in front of decision-makers. In this way, a deeper understanding of local issues can surface, leading to interventions which will work because they have been co-designed.

Conclusion

Working with communities will be fundamental to the implementation of Fuller's recommendations. This will require time and investment. It will require a move from a centralised, one-size-fits-all approach to a plurality of approaches. This may not always sit comfortably with systems covering many hundreds of thousands of residents. A new general practice must be grounded in local communities, drawing on what works best and the strengths of those communities. There will be a need to support all participants to work positively together, leaving preconceptions of power outside the room. Recognising that clinicians and patients are all human and embracing different viewpoints will bring a richness to co-design. ■

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