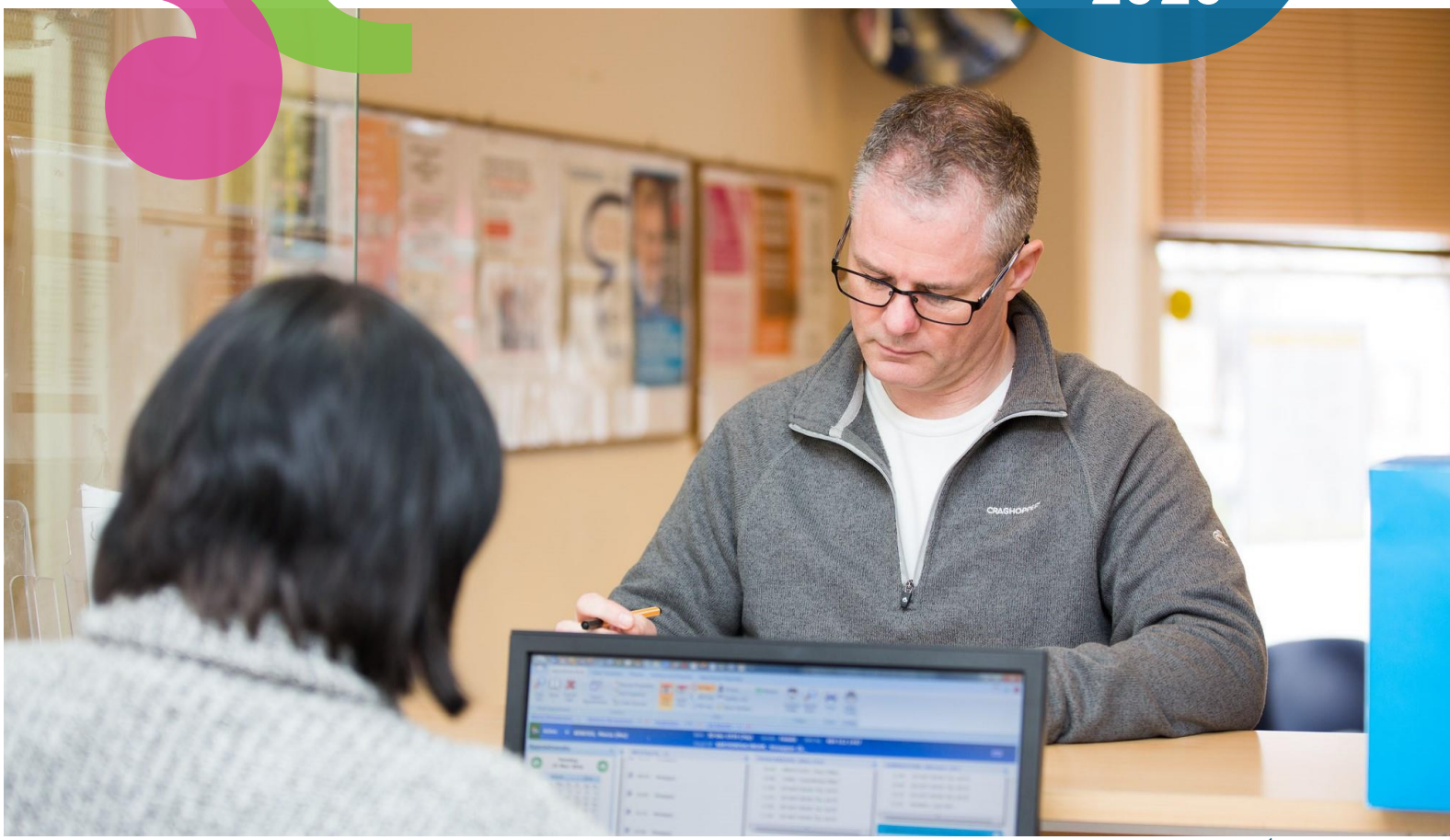
healthwatch Rutland

How people with long term or multiple conditions experience care in Rutland GP surgeries

June 2020



Contents

Summary

This report details the Healthwatch Rutland exploration of people's experiences of, and expectations for, General Practice (GP) care. We undertook this work as there have been many recent and ongoing changes to the way primary care, especially General Practice, is structured and delivered, including those outlined in the National Health Service Long Term Plan in 2019.

Semi-structured interviews were carried out with 30 respondents who were encouraged to talk freely about their experiences and hopes for GP care. Respondents were also asked for their opinions on social prescribing, which was being introduced in Rutland, and how they would help themselves or draw on community support to maintain their wellbeing.

The respondents' words were noted semi-verbatim and analysed for themes. The results are represented, largely using the respondents' own words, to provide rich detail to inform commissioners and providers of care in Rutland.

Key findings

- The main finding of this research is that everybody wanted to be treated and understood as a valued individual with needs and anxieties that are unique to them; there is no such thing as ‘one size fits all’.
- Most people spoke of their frustration with being unable to get an appointment with their doctor of choice either immediately or within a few days. In some cases, patients had to see another professional in order to be seen sooner. Nevertheless, they were satisfied when they felt they had been ‘listened to’, reassured and cared for effectively by someone with appropriate expertise.
- Those with poor vision experienced difficulties, sometimes exacerbated by poor lighting, in reading publications and information screens, operating check-in machines and finding entrances.
- There was universal agreement that reception and pharmacy areas do not afford sufficiently private spaces for confidential communication, causing embarrassment and loss of dignity.
- The reordering of repeat prescriptions and obtaining medications is problematic for some; with some complaining about having to remember to order in advance.
- The most immediate problem when referred to a hospital was the issue of transport. Secondary to this was the suspicions of poor communications between GPs and specialists. Several patients had felt the need to actively monitor and, sometimes, to intervene in the process to ensure everything went smoothly.
- Many people rely on family and social networks for support in managing their health and use the internet to access information about symptoms, conditions and possible treatments.
- Although some thought social prescribing is a good idea, they suggested it was not necessarily needed by them at this time as they were actively involved in community groups and were being well supported by partners, family members or their community. Those who explicitly supported the introduction of social prescribing often qualified this by saying the selection of the right person for the job was important and that he or she “should listen”.

Recommendations

1. Although we appreciate the logistical and organisational difficulties involved, people with long term conditions or multiple illnesses should be provided with continuity of care with the same preferred professional as often as possible.

2. There should be ongoing professional training, education and support to ensure that surgery staff can interact positively, professionally, and with empathy with all patients at all times.

3. Surgeries should organise their waiting and queuing areas so that patients can talk confidentially with receptionists and pharmacists without being overheard by other people.

4. Communications between surgeries and secondary care need to be accurate and timely.

5. Newly introduced social prescribing teams should be aware that they might encounter initial reluctance from some patients. Some respondents suggested that sensitivity and a willingness to listen might overcome this. Also, social prescribing teams should be aware that several respondents suggested that lack of transport and difficulty in access to suggested activities would mean that they could not attend.

Introduction

In 2019 Healthwatch Rutland volunteers indicated that their top priority for further investigation was the experiences of patients when they visit their General Practitioner (GP) surgery. This was at a time when Rutland surgeries were moving into a Primary Care Network and anticipating the introduction of a social prescribing team in the county. The National Health Service (NHS) Long Term Plan (2019) had also proposed many other changes for GP surgeries, including an expansion of multi-disciplinary teams and a greater emphasis on helping people with long term or multiple illnesses to manage their own wellbeing and to be cared for closer to home rather than in acute hospitals. This project was therefore designed not only to understand what is working well in Rutland surgeries and where there might be problems but also to share details of the forthcoming changes with Rutland people and seek understanding of what they might think about these reforms.

This report continues in three sections. In the first, NHS policy and difficulties experienced in general practice (GP) are set out. The Rutland general practice context is outlined, and newer professional roles in general practice are briefly described. In the second section, the research processes are explained. The third section contains the findings of the research which will provide commissioners and providers of general practice services with some insight into the hopes and expectations of people.

1. National and local policy for general practice

1.1. The difficulties experienced in general practice

It has been acknowledged for several years that the General Practice system has been under pressure in England. This pressure can be categorised as arising from either 'patients', 'system', or 'supply' (Baird, et al. 2016).

Pressures arising from 'patients' include illnesses associated with an ageing population and an increasing number of people living with one or more chronic illnesses. This results in more patients taking several different medications – all of which need monitoring. The Internet has enabled patients to be better informed about their health and resulted in them have greater expectations of possible treatment options.

'System' pressures arise from a rapid increase in the number of services and therapies that have been introduced into general practice, such as screenings or immunisations, requiring more GP active management. There has also been an increase in guidance and regulation, such as the Quality and Outcomes Frameworks and NICE guidelines, as well as frequent Public Health campaigns which encourage more people to visit their GP surgery.

'Supply' pressures refer to staff shortages. Many GPs are retiring early and GPs might also have more than one role and be involved in management or training and education, etc.

As a result, patients have been experiencing the following difficulties:

- Inability to get timely appointments.
- Lack of choice of which GP to consult.
- Experiencing poor staff attitudes.
- Lack of continuity of care.
- Insufficient information about illnesses, opening times, services, etc.
- Less support for self-management to keep well or to deal with illnesses.
- Short/rushed appointments.
- More difficult access due to surgery closures and mergers.

To address these issues, the NHS General Practice Forward View (2016) set out ambitious proposals for improvements in general practice over the following five years. These included an additional 5,000 GPs by 2020, more funding, reduced bureaucracy and new roles in surgeries. However, it still proved difficult to increase GP numbers and, by December 2019, there were 521 fewer full-time equivalent GPs than in 2016 although the number of other surgery personnel had increased (NHS Digital 2020).

In January 2019 the NHS Long Term Plan was launched. This included proposals to increase collaboration between health and social care services through the formation of Integrated Care Systems. There would be joined-up working between primary care,

acute hospital care and social care services, with a focus on more care closer to home, illness prevention, measures to avoid unnecessary acute hospital admissions, and the use of technology to increase productivity and improve patient experiences. Also, GP practices would collaborate in Primary Care Networks serving populations of 30,000 - 50,000 by July 2019 allowing surgeries to pool resources and expertise while simultaneously retaining their own patient lists.

Another feature of the NHS Long Term Plan (2019) was the promotion of more use of technology; including video technology for consultations. All GP surgeries were required to offer online consultations by April 2020 and video consultations by April 2021 'subject to available IT infrastructure' (NHS England 2019).

1.2. The structure of general practice in Rutland

The Rutland Primary Care Network serves a population of approximately 39,000 people across four general practices[1]:

Uppingham Surgery

11,411 patients

(Branches at Gretton and Barrowden)

(As at 1/5/2020 retrieved from: https://www.nhs.uk/Services/GP/Overview/DefaultView.aspx?id=36006)

Empingham Medical Centre

7,084 patients

(As at 1/5/2020 Retrieved from: https://www.nhs.uk/Services/GP/Staff/DefaultView.aspx?id=37994)

Market Overton and Somerby Surgeries

4,611 patients

(As at 1/5/2020 Retrieved from: https://www.nhs.uk/Services/GP/Staff/DefaultView.aspx?id=36712

Oakham Medical Practice

16,013 patients

(As at 1/5/2020 retrieved from https://www.nhs.uk/Services/gp/Overview/DefaultView.aspx?id=44185)

[1] Rutland health and social care services will belong to an Integrated Care System which incorporates the three local authorities and clinical commissioning groups of Leicester City, Leicestershire and Rutland. Some Rutland residents have opted to register with surgeries across county boundaries in Lincolnshire, Leicestershire and Northamptonshire. Also, Somerby surgery sits in Leicestershire but is allied with Market Overton.

1.3. New Roles in general practice

Rutland surgeries have already seen an expansion of their multi-disciplinary teams. The newer roles that patients will be encountering include:

- **Social Prescribers,** offering personalised support to people with one or more long term physical or mental conditions, those who are lonely, or those who have complex social needs which affect their wellbeing. Rutland's social prescriber started working in January 2020.
- **Clinical Pharmacists,** offering minor illness clinics, medication reviews for patients recently discharged from hospitals, and repeat prescription reviews. This role is due to be introduced during 2020.
- **First contact physiotherapists** who act as a first point of contact for people with suspected musculoskeletal conditions instead of GPs. This role is due to be rolled out during 2020.
- **Physician associates** who are medical healthcare professionals working under the supervision of doctors, carrying out physical examinations, diagnostic, and therapeutic procedures, and taking medical histories. They do not prescribe medicines or request scans. This role is due to be introduced from 2020.
- **Community paramedics** who are highly trained, generalist practitioners who can assess and diagnose patients' conditions. Some can prescribe medicines and duties include running clinics, the triage of minor illnesses and home visits. This role will be added in 2021/2022 but some are already working in surgeries and urgent care centres.

Other primary care professionals might include occupational therapists, dieticians, podiatrists and mental health counsellors.

2. Research method

'GP surgeries' was chosen by Healthwatch Rutland volunteers as the topic of healthcare that most needed further exploration in our county. The volunteers were then involved in each stage of the research set out in this section. Throughout, close attention was paid to established research ethics[2] in order to:

- Ensure respondents' wellbeing and safety and obtain their informed consent to take part.
- Inform respondents that they could withdraw from the project at any time.
- Assure respondents' anonymity and confidentiality.
- Ensure qualitative research rigour by agreeing standard questions and prompts for further detail and minimising researcher bias.
- To ensure that Healthwatch interviewers were Disclosure and Barring Service checked and had completed Safeguarding training. Face-to-face interviews would be carried out in pairs in order to maintain the safety and wellbeing of researchers and respondents.

2.1. Research design

A qualitative approach, looking at an in-depth interpretation of people's experiences, was selected. Qualitative research is very useful when establishing opinions and deeper and richer understanding of people's experiences. However, there are associated issues concerning participant mis-interpretation or mis-recall and researcher bias. To counter these issues as much as possible, widely accepted research practices were conducted/applied throughout this project.

The questions were deliberately designed to encourage respondents to talk widely and freely about their experiences, thus providing a rich picture of what they think about their surgeries. This approach acknowledges that everybody's 'take' on their experiences is different but equally valid. Common themes (codes), emerge from these accounts in addition to occasional unique themes which, in themselves, can inform more about experiences.

A list of open-ended questions was constructed for individual interviews with a slightly abbreviated version for focus groups[3]. These lists were for interviewer guidance only as respondents were encouraged to talk about what matters to them. A small pilot study was carried out and, as a result, the questions were slightly amended. In addition, all interviewers were requested to describe, to respondents, the new roles being introduced into general practice.

[2] See for example British Sociological Association Ethical guidelines: www.britsoc.co.uk/ethics

[3] The questions can be viewed in appendix 1 and 2

2.2. Participant recruitment

We advertised widely for people to come forward to tell us about their experiences, including making use of (but not exclusively): social media; the Healthwatch Rutland website; local networks and groups; personal recommendation and word of mouth; and the distribution of fliers. We were seeking a diverse group of people with short illnesses and long term conditions across all age ranges. In all, 25 women and 5 men, aged 22 - 85+ years, took part in the research, but it became noticeable that all those people volunteering to take part had long term or multiple conditions, and the majority were in the older age groups; thus determining the focus of this report on this specific patient group[4].

2.3. Interviews and Focus Groups

Although the majority of one-to-one interviews and one focus group were conducted before mid-March, the coronavirus (covid-19) pandemic measures meant that we had to curtail all face-to-face appointments. Pre-booked interviews were then carried out by telephone and further focus groups were abandoned. The participants' remarks were recorded semi-verbatim and transcribed. All Rutland surgeries, including Somerby were represented.

2.4. Analysis

The transcripts were scrutinised carefully and all common emerging themes were coded as per accepted qualitative research processes. A proportion of the transcripts were also coded by a second person to ensure consistency. No new codes were identified after about the 15th participant but interviewing continued to ensure no experiences or expectations were missed, and in the hope of attracting those with short term health problems and younger people. It was noticeable that the later interviews, conducted after the pandemic social lockdown began, included comments about the first examples of novel ways of accessing GP care. The analysis is presented in the next section.

[4] The demographic detail of the respondents can be viewed in appendix 3.

3. What people told us

In this section the different themes people spoke about are set out broadly to correspond with a patient's journey when using the GP system.

3.1. Understanding of the pressures on general practice

Many of the respondents showed their understanding of the pressures on GPs nationally, but expressed this in different ways.

> *I saw Dr X twice, he was excellent - gave me lots of time, listened and encouraged me to return if I felt the need. He was amazing I cannot recommend him enough. He gave me plenty of time (Empingham).*

Here, an expression of unqualified satisfaction with the respondent's GP makes no reference to time constraints or pressures for GPs.

These two respondents acknowledged that GPs are busy and, in the first extract, that it is not always necessary to see a doctor. The second extract shows an awareness of problems often reported in GP surgeries across England.

- *I only need to see the doctor when I need that level of expertise. It frees them up to give time to more urgent appointments if I see someone else when I don't need a doctor. (Empingham)*
- *When I listen to friends, I can't fault our GPs. It's not just the patients feeling difficulties, they [the GPs] are, too. (Market Overton)*

- *After 10 minutes the doctor says the time is up. He told me I should have made a double appointment but I didn't know that. I got up and walked out and I won't see him again. I would have been happy to make a double appointment if I had known this, but I didn't. (Empingham)*
- *The last time I went I thought I was getting my usual annual "MOT" which he had done in previous years. But, when I got there, he said, "You've only got 10 minutes" and that the nurse should do it. He can be very kind but also very terse and straight-talking. (Oakham)*

These are the words of two people who seem to have a poorer understanding of the appointment system. Also, they demonstrate some sense of 'their time' being cut short and a feeling of having been scolded for overstaying their welcome.

This respondent acknowledged the lack of time but expressed concern that GPs seem to depend more on their computers rather than attending to the signs and symptoms their patients are expressing.

> *GPs don't have the time. They don't talk to you personally - they just look at their computer. (Market Overton)*

These extracts therefore show a continuum moving from 'very satisfied' with the primary care system on the one hand to 'very dissatisfied' on the other. They also provide the first example of the multitude of interpretations and judgements that people make about different relationships and interactions they come across when they visit their surgeries.

3.2. Making an appointment

The first encounter with a GP surgery for patients is when attempting to make an appointment. The respondents confirmed that 'getting an appointment' and delays in seeing a preferred GP are problematic in Rutland as in other parts of England. Most people showed a preference for telephoning the surgery for an appointment although one respondent stated, *"I book appointments online because it is easier and saves you from taking up a phone call slot"* (Oakham).

This strong preference for telephoning for an appointment, despite most of the respondents having computers and being able to use them, prompted a further examination of the transcripts. This revealed that most people, when they feel they need to consult a doctor, want to do so fairly quickly. A telephone call and a conversation with a receptionist appears to be widely understood as the most effective way of being allocated an earlier appointment as the following extract shows:

> *On same day appointments you don't have a choice. If you want to see your own GP you have to wait three or four weeks. Five of my appointments were 'on the day'. You can just phone up and they will fit you in. You can't ask for more really. They give you a time but I've never had to wait for long. Getting an appointment with a [named] doctor is the main problem for most people. (Empingham)*

Almost unanimously, the respondents understood that anyone needing to urgently speak to or be seen by a doctor or nurse can do so on the same day that they call the surgery. However, this does mean they might have to consult the first available professional rather than have 'continuity of care' with their regular or preferred doctor or nurse. Continuity of care was so important for some respondents that, when asked at the end of the interview if there was anything they wanted to add, they repeated that their prime concern is that they want to see the same surgery professional each time.

Eighteen respondents voluntarily introduced the importance to them of continuity of care with a preferred professional with whom they have built up a good relationship. In all there were 22 comments care about continuity of care: 16 reflected respondents' anxiety about lack of continuity, 3 comments expressed satisfaction of having received continuity of care and 3 comments were from people who did not think continuity of care was important. For example:

> *I think having a relationship with your doctor is important and being face to face matters. Seeing different people, you don't build up a relationship. Seeing others seems to lack the personal touch. The doctor knows us. He knows our set up. (Uppingham)*

Whereas the extract above demonstrates the perceived benefits of continuity of care, the extract below shows the disadvantages of seeing multiple professionals:

> *The only trouble is, you don't get to see your own GP and I can't remember the last time I saw him. You get palmed off to other doctors who don't know anything about you. I'd sooner see my own doctor but keep having to see other ones. My own doctor is a caring doctor. He's got time for you. Some doctors can't be bothered with you. (Oakham)*

Both of these extracts demonstrate that a doctor-patient relationship, built up over time, is important to patients. Being *"palmed off to other doctors"* can be understood by patients as being treated as a commodity rather than as real people with their own thoughts and anxieties.

The following extract from a respondent, aged 22, sheds different nuances on continuity of care and could be indicative of how the younger generations experience consultations with their GP:

> *If records are kept up to date with everything, then I'd be perfectly happy seeing different doctors. I often try to book a favourite doctor but, if unavailable, I have no issues seeing someone else if I need to see someone quite quickly. Recently I needed to see a doctor urgently for a mental health condition and had a good experience during the appointment. So, I have rebooked a follow-up appointment with that specific doctor because I felt listened to and trust him. I think it's important to see different doctors for different conditions because age and skills of the doctor can make a difference for conditions. I get on much better for mental health issues with younger doctors who I feel listen to me. Also, they have trained more recently and know more about newer illnesses and conditions. Older doctors are better at bedside manner and health issues that have been known about for a long time. (Oakham)*

It is impossible to generalise from just one extract, but this younger respondent has preferred GPs and, yet, seems to have greater flexibility and preparedness than the older respondents to talk readily with others. The respondent seems also to be able to more easily build a trusting rapport with GPs of a similar age but acknowledges the more comfortable and comforting expertise of older doctors. But younger doctors are also considered to be have more up to date knowledge and skills. This extract also alerts to the importance of 'being listened to' which prompted further examination of the transcripts.

I saw Dr X twice, he was excellent - gave me lots of time, listened and encouraged me to return if I felt the need. (Empingham)

They've got their laptops and things but they just won't listen. They just do not listen. Times have changed since the old days. (Empingham)

The two extracts above demonstrate how much patients appreciate a 'listening ear' from the professionals they encounter in general practice and how much patients' expectations, interpretations and experiences can differ - even between patients in the same practice. Whereas the first extract shows satisfaction, the repetition in the second extract, *"They just won't listen. They just do not listen"* and the comparison with earlier experiences demonstrates both a frustration with 21st century primary care and a nostalgic fondness for former times among older people with multiple health problems. Some of the GPs' pressures seem to, at times, be adversely reflected in the patient-doctor encounter. There is a conflict between the considerable pressures under which doctors are working and patients often wanting and needing more time and attention.

The respondents also spoke of their need for reassurance from their GP and their satisfaction when this need has been fulfilled:

> *I've seen four doctors, a nurse and a health care assistant. I've been once for myself and five times with the children over the last year or so. I've always felt very reassured when I've seen them. They know their stuff. (Somerby)*

However, the following extract points to the nuances and difficulties in the doctor-patient consultation which often seem more pronounced because the respondents also seem to compare the different professionals they meet:

> *I think she was efficient. She didn't try to reassure me when I said it was frightening, she just said, 'yes'. However, the other doctor I saw was too sympathetic and told me that my family should do more. (Oakham)*

On the one hand, these words above can be interpreted as receiving no reassurance or too much sympathy are equally disturbing for patients. On the other hand, the words *"too sympathetic"* could be understood as a polite criticism by the respondent of the GP for crossing an arbitrary 'line in the sand' and making an unwelcome criticism of family members. There seems to be personal boundaries set by patients that health care staff must take into account.

So, the respondents differ in their understanding of the primary care system with some appreciating the difficulties GPs face and others expressing frustration when they are unable to receive continuity of care. However, when there is some medical urgency, the respondents seem willing to see any doctor and express great satisfaction if that doctor listens to them and can offer reassurance. The very different judgements expressed, even about the same surgery, demonstrate patients' differing expectations and experiences of GP care.

3.3. What people said about the surgery environment

Although the respondents were not asked specifically about travel to the surgery, some of them volunteered information as follows:

- *For getting repeat prescriptions, their attitude is that I just live down the road and can get back but it's not easy as I don't drive. (Empingham)*
- *I'm pleased with Market Overton. I accept the difficulty in getting there. I zoom there on my electric bike in the summer. (Market Overton)*

Both of the respondents above are older and live in a village a few miles from their respective surgeries with no public transport to help them get there, and the first respondent is physically disabled.

Experiences of car parking at surgeries also prompted unsolicited comments relating to Oakham and Empingham practices:

Oakham

- *I like to walk down to the surgery if I can because I hate the car park.*
- *The carpark has a new surface now, so much improved. However, parking is a big problem and more parking space is required.*

Empingham

- *There's a tiny car park but people don't tend to use it. Car parking is an issue, one doctor's car was damaged. Car parking is horrendous. The doctors do acknowledge the problem.*
- *The car park is not big enough.*

The respondents' journey continued into the surgery environment and their descriptions are both vivid and informative:

Empingham

The premises are too small and dated with no room for expansion. The waiting room was decorated last year. They took out all the pictures. The big quilt hanging on the wall went. I like quilting so I was interested in it. It's clean, it's fresh and the chairs are quite comfortable. We have this awful screen the chairs are focused on. It gives out messages about the NHS - all based in Leicester. The building is just too small and there's not enough consulting rooms. They have difficulties in scheduling services there because there are not enough consulting rooms. I would say the surgery was built in the 70s.

Oakham

- *I've always been quite comfortable when I've been there. I've always thought it perfectly clean and tidy.*
- *It's okay, in lots of ways it's quite efficient. It is not stunning but not shabby. They send us to one of three waiting areas.*
- *It's fine to me. I'm happy to sit there. I find it ok to walk into. They could do with some comfortable seats. They are a bit hard to sit on.*

Market Overton

- *It is very pleasant, efficient, friendly, and accessible. I can call or go in whenever I need to. I like the size of the place - makes it intimate.*
- *It's very nice, comfortable, welcoming. I feel secure there. It has changed over the years.*
- *It's very pleasant. I can talk confidentially with the doctor in his treatment room. Surgery opening times are the crunch.*

Somerby

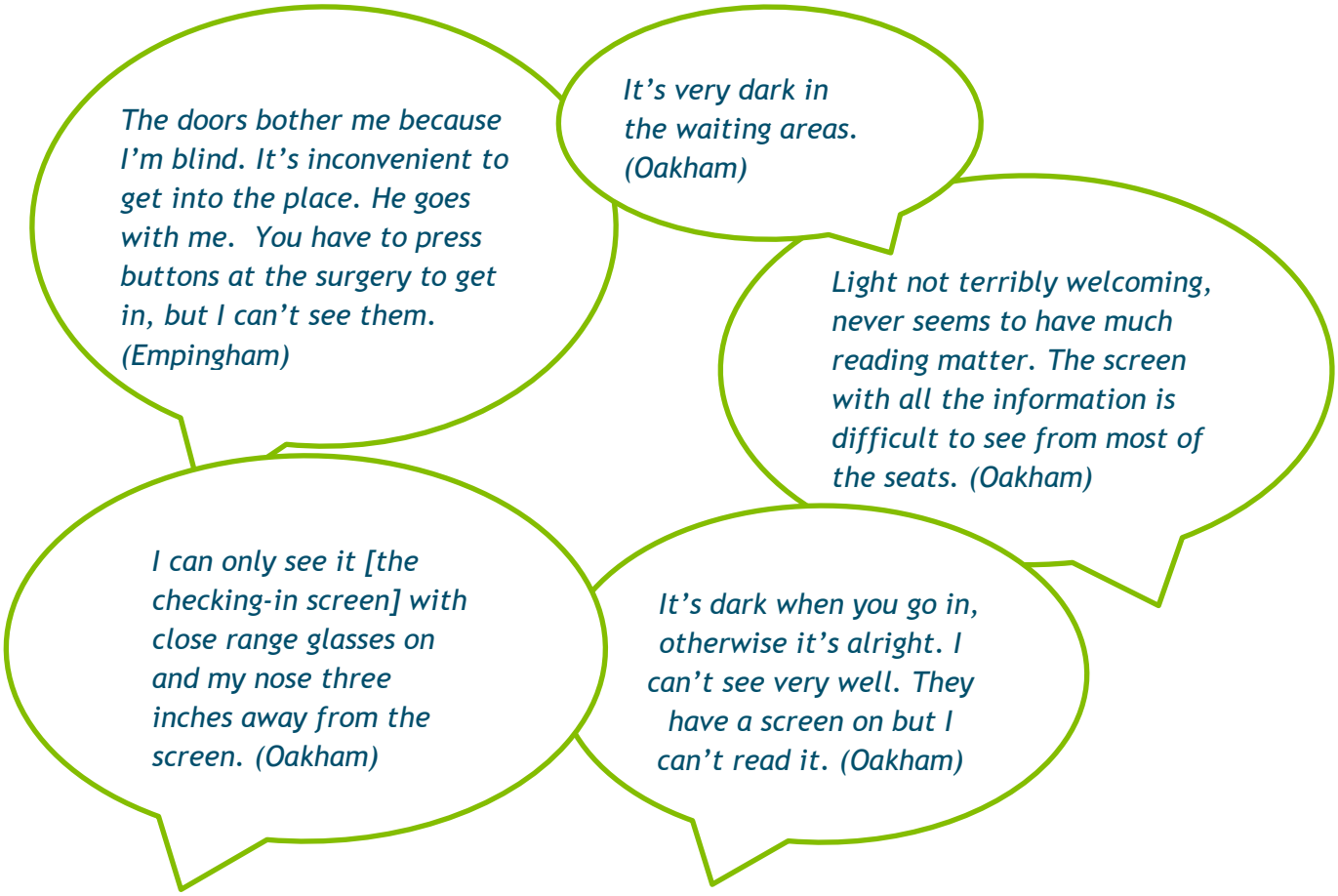
- *Somerby is also clean and lovely.*
- *It's very modern,*
- *It was built in the 70s/80s, I guess. It's very clean and pleasant but not ultra-modern. I do criticize that there's no proper call system. The nurse shouts your name from down the corridor and it's not very easy to hear.*

Uppingham

- *The waiting room has chairs facing a screen. Now [during the pandemic] the chairs are further apart and stretch down the corridor. The surgery is very clean.*
- *When you get to the surgery you go through automatic doors. You sign in on a little gadget with your name, etc. Then you go through another door to the waiting room where there are chairs. Your name comes up on a screen when the doctor is ready to see you and you go to the consulting room. Its comfortable and very clean.*

Therefore, most people are satisfied with the general environment in their surgeries and there was unanimous praise for the cleanliness of all practices. But there were two significant issues which cause concern. First, there were problems encountered by those with visual difficulties. One person with severe visual impairment described their

challenges at Empingham and five Oakham patients mentioned their problems with poor lighting:



The second issue was that of the lack of confidentiality at the reception desk and in the surgery pharmacies – areas which had been flagged in previous Healthwatch Rutland research.[5] All respondents were specifically asked the questions, 'Are there suitable arrangements to speak confidentially to staff?' followed by the question, 'How does that make you feel?'. There was a unanimous response that, in these areas, confidential conversations were not being achieved in any of the surgeries as one person describes:

> *The only thing I would say, when you're talking to the receptionist and you've got something you would rather be discreet about, it's difficult. Just once or twice I've felt uncomfortable. When I've been sitting there, I've heard what other people are saying. When I've been up there, you know that other people around you can hear what you're saying. [Prompt] No, I've not been given an opportunity to talk more privately – I had something internal but I had to talk to a young man [about an intimate problem]. Most of the time I'm not bothered but that time it was embarrassing. You have to stand in a line and, in a way, you're kept back from right up to the desk by a barrier. They've moved that now. (Oakham)*

[5] What would you Do? HWR engagement report on NHS Long Term Plan Sept 2019

Although we understand that surgeries will offer a confidential space to avoid such discomfort, respondents repeatedly told us they had not been offered this facility. Similarly, if they tried to avoid discussing their health problem, respondents encountered resistance from the receptionists.

> *The waiting room is open to the reception area and you can hear what the conversations are. It could be more discreet. I have seen someone taken into the pharmacy, which goes off to the side, for a private chat, but not me. (Somerby)*

> *I've said I will discuss things with the doctor as it's private but they say they want to make sure they direct me to the right person. (Oakham)*

These feelings were echoed by many of the respondents and show how lack of confidentiality undermines patient dignity and causes discomfort and, sometimes, great embarrassment.

3.4. Interacting with surgery personnel.

As patients are going to be seeing an increasingly diverse surgery team, this section looks at the respondents' opinions and experiences of seeing different members of surgery staff.

3.4.1. Thoughts about seeing people from different occupations

Responses to the question, 'What do you think about being seen by different professionals for different aspects of healthcare?' demonstrated many different opinions which are first set out by the key words the respondents used and then followed by a more in-depth interpretive analysis:

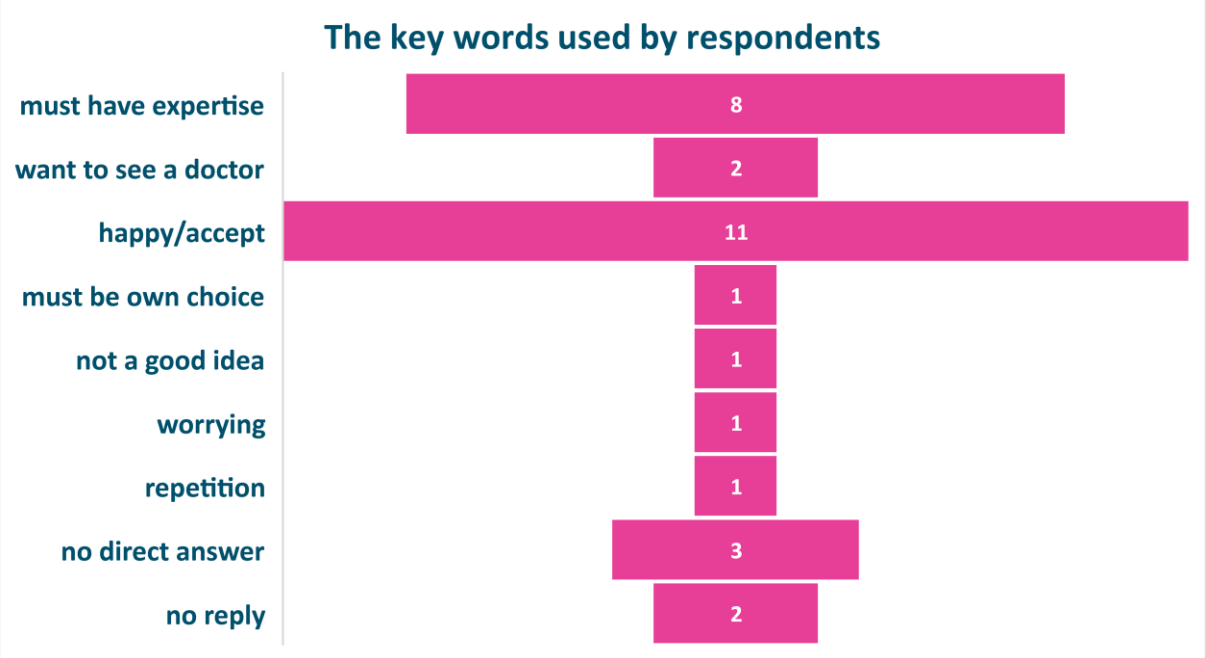


Table 1. The key words used by respondents when asked, 'What do you think about being seen by different professionals for different aspects of healthcare?

Three people, rather than give an opinion, detailed past experiences of seeing other professionals and two people taking part in interviews with more than one person, did not reply. We have selected some extracts from the transcripts in order to provide a fuller understanding of the respondents' opinions in their own voices:

What's the good in having other people? I make bloody sure when I see my GP. I make a list. The GP says it's not possible to do everything in 10 minutes but we did. The medical profession is not all-embracing as it used to be. It's awful now. The way nurses are trained is ridiculous. All they want is a degree. As soon as they brought managers in it was the beginning of the end. (Market Overton)

This respondent's frustration with the present system is apparent. Past negative experiences of changes to the 'system' appear to be creating scepticism about any future change.

As Table 1 demonstrates, acceptance of seeing different professionals was qualified by some who expressed their wish to have a choice or to feel certain that the person they were seeing had suitable qualifications and experience.

- *I am very happy to see different professionals as long as they are trained, including pharmacists. For example, I was very happy to see a Nurse Practitioner when I had a urinary tract infection. Spoke on phone twice to GP and nurse for flu jab. It was fine. (Empingham)*
- *I don't mind as long as it is my choice. (Market Overton)*
- *Doesn't bother me so long as they know what they're doing. (Oakham)*

- *It's slightly worrying. When things get contracted out and more people get involved, it gets less efficient. (Market Overton)*
- *Young mothers and old people want to feel safe. I watch people. They [the staff] respond to the patients and that's very important. The doctors say they have a good team. I think that's what people feel. It's like a pyramid. You've got the doctors at the top and the core workers at the bottom. The core workers must be right and be stable so the doctors can work well. (Market Overton)*

There were also comments that focus on the organisational efficiency of the surgeries.

In some cases, past experience has helped people to realise how new professional roles might be of benefit to GP practices.

Makes a lot of sense. GP's, bless them, can't have expertise in everything – they need to be able to refer. For example, for back pain, most people go to the GP and he can't do anything. He would just prescribe painkillers when a local physio would help more. I got called back after my routine blood test by a doctor to say that my cholesterol was high and needed to be brought down. I was told I was pre-diabetic. He sent a prescription for statins - I demurred – I didn't want to take statins. I called and asked for dietary advice. They had no-one to give me that advice at the surgery so a new dietician role for the surgeries would have been useful. (Somerby)

3.4.2 Encountering practice receptionists

Receptionists are often the first people with whom people speak and, again, the respondents' opinions and interpretations of their experiences differed:

Traditionally receptionists have been thought of as the gatekeeper for doctors and, for some, this still prevails. Here the respondent expresses concerns.

> *I am happy to see the appropriate practitioner. However, I am worried that the receptionist might not always in every case be able to decide on the appropriate practitioner. (Empingham)*

> *When I ring up for an appointment and speak to the receptionist it works well. You don't have to wait long for an appointment. You ring in the morning and give a brief outline of the problem [to the receptionist]. (Uppingham)*

But this Uppingham patient seems satisfied and accepts that the receptionist is the gatekeeper for surgery services.

This Uppingham respondent finds a lack of empathy when trying to access their surgery services.

> *I talked to the receptionists when my husband was ill. They don't relate to you positively. I get the feeling that the receptionists, I can't explain it really, it's like they're doing a job. They don't ask the questions in a personal way. It's a bit like ringing NHS111. They didn't seem to understand what you're asking them to do.*

> *Some receptionists are discreet and some not so good and speak very loudly. The approach of some of them is of giving a favour and they are like schoolteachers. But some are very good indeed. (Oakham)*

Several respondents observed that some receptionists in the same surgery were more friendly than others.

Despite an acknowledged improvement in receptionists' customer facing skills, they still are gate keepers with power to cause distress.

> *The receptionists used to be blunt but they are better now but I have overheard patients getting upset. (Oakham)*

> *I have to say I'm not comfortable telling them openly, for example, about mental health issues. When I did say that, the receptionist put "menstrual" on the record and not "mental". The Doctor was then very confused when I went in to see him. Reception staff are incredibly impersonal and that's quite off-putting. (Oakham)*

This respondent told us of an incident where the receptionist got it wrong!

And this respondent told us of receptionists getting it right!

> *I think the receptionists are really good, I really do. I've got upset sometimes and put the phone down but they've sent me an email with an appointment. They were lovely. The receptionists always tell you if the doctors are running late. They are all so good which is why they [the surgery] are oversubscribed. (Empingham)*

3.4.3. Consulting the GP

The respondents also talked about their interactions with GPs with positive comments about the care received at all Rutland surgeries:

Oakham

The doctor I saw, the last one, was really brilliant, she was brilliant. I think they listen to you. You can't fault them much really. I went to see another doctor she was brilliant.

Empingham

I never feel rushed seeing my GP and I think that Dr X is amazing and has a wicked sense of humour. When, 18 months ago, I had a mole I couldn't get to see Dr X, so I saw another Doctor and he was a bit brusque and I felt as if I was wasting his time but, overall, he was fine.

Market Overton

Some say our GP is forthright but I get on with him very well. When I had a stroke my GP was brilliant. He sent me to Leicester Royal Infirmary straight away.

Uppingham

My own GP is always available to see if he's not on holiday. During my husband's illness my own GP was very supportive. If my own GP was not available, I saw other doctors but they were supportive too.

Therefore, patients appear to appreciate swift treatment and rapid referral to a specialist when needed. However, as the following extracts demonstrate, some respondents felt they had not received the care or treatment they needed:

- *In the case of one doctor, it was because he had difficulty understanding my long term condition – either not understanding it or not believing it. I was denied any further consultation or testing until I kicked up a fuss. After finally getting a referral and consultation I was referred back to the GP for birth control as a means of managing my condition. The GP didn't think this was necessary, even with consultant's letter. I kept pushing that Doctor and got resolution eventually but you shouldn't have to push that hard. (Oakham)*
- *I said about my knees – another sarcastic comment. [They say] it's because I'm too fat... My knee wants doing desperately but they're not interested. I've asked about it but they just say 'pah!'. (Empingham)*
- *I also had gall bladder pain. They wouldn't see me at the surgery and told me to walk home which I couldn't do. I went to Rutland Memorial Hospital and was given morphine and told I would be put in for a scan. But nothing happened so I phoned the radiographer and I was told I was not on the list. (Oakham)*

Again, there were preferences for continuity of care:

- *I have x problems so I need to see my own GP to make sure I see somebody who knows the complete picture.*
- *I only like to see the one doctor cos she knows me.*
- *I do like to have the same doctor each time. You get to know him and if you like him you get to trust him…. It's really good to have the same doctor.*

But 3 respondents said they were happy to see different doctors:

I'm happy to see different doctors. If they have an air of confidence with their knowledge that gives me confidence

3.4.4. Seeing the nurse

The role of nurses was mostly accepted in the surgeries and respondents talked freely about them. Most respondents were able to distinguish between nursing assistants and registered nurses; some of the latter being nurse practitioners who are able to diagnose and prescribe. However one respondent told us, *"The nurses are always good although I'm not sure what 'type' they are"*. The opinions about nurses seem to depend on the respondents' perception of their skill, judgement and a trusting relationship built up over time as two contrasting extracts below demonstrate:

- *I saw the Nurse Practitioner twice and felt she was excellent, the correct level for my need and able to prescribe what was necessary. The Nurse practitioner gave me treatment that worked and reviewed the treatment to check it had worked.*
- *I would prefer to hear from the doctor and not from the nurse. It didn't help that she seemed to have to look things up. I don't feel she showed confidence. In herself she was timid and didn't have the air of confidence that the doctor has.*

Interestingly, the respondents also often spoke about community or specialist nurses and seemed to associate them with the services provided by their surgeries:

- *The nurses and the physio that came here [to my home] were absolutely brilliant. I was amazed when they made me a walking stick in hospital. The after-care - I can't speak highly enough about it. They were incredible. One of the days I stayed in bed. The nurses had been. Then the doorbell rang. It was one of the nurses. I told her the nurses had been and she said she had come to give me a hug as she felt I needed it.*
- *My specialist at Leicester General Hospital passed me on to a nurse who comes to see me once a year. I thought this sounded a good idea but I'm not really impressed with her, not so good really.*

3.4.5. Calling the emergency services

Although not specifically asked about emergency services, several respondents talked about their experiences of being treated by paramedics who had been called by a GP or NHS111:

- *We got the doctor to come round. He came at 3pm and by 3.30pm we were waiting for an ambulance to take me to Peterborough. A paramedic came because I had stomach pains which could have been appendicitis. Except I had my appendix out years ago. He was a foreign fellow who spoke good English. He gave me Gaviscon – that sorted it. He wasn't allowed to prescribe anything. He came to the house. I was happy with them.*
- *The first time I had the problem, the ambulance men came and I said that I could ring the surgery in the emergency time. The ambulance man rang up to speak to the doctor to tell me what tablets I could take.*
- *It was a 111 doctor who referred me to hospital. He took care. I was so ill. To be honest I didn't really realise. I had no choice. When the ambulance men came, they took me to Leicester Royal. I know a lot of people do go to Peterborough. That day they just took me off.*

The extracts above, while appearing to not be relevant to GP practices, do demonstrate how NHS 111, GPs and ambulance crews are working in an integrated way to avoid unnecessary pressures on Accident and Emergency departments (A&E) and acute hospital beds. Ambulance crews are now empowered to treat more patients at home and, when necessary, call for medical advice. Nevertheless, they can, and do, take patients experiencing medical emergencies and accidents to A&E.

3.4.6. Patient power

Many of the extracts have shown that people feel they have a right to stand up against what they feel are inappropriate or inadequate responses to their problems. Noting this we looked for examples of more direct challenges than the extracts in this report have so far revealed:

- *I saw the practice manager and office manager about a situation with my husband. They were responsive, not evasive. I was there for about 1.5 hours. I was taken seriously and they investigated the problem with one of the GP's. They have continued to be ok and I was satisfied with that. (Empingham)*
- *When my husband was very, very ill we had a prescription for morphine when he needed it. I stood in that surgery and fought with that receptionist. She said we had had some in the last fortnight and couldn't have any more. But I said it was for taking when needed. (Uppingham)*
- *I saw the new consultant twice but I wasn't impressed. He didn't seem to know much about my condition. I now see a new consultant at [another hospital]. The good thing about this new consultant is that she still works with my first consultant so there is some continuity. I decided after two appointments that I was not going to go back to the LRI. I looked on-line and found three consultants who deal with my complaint. I wrote to all three and asked if they would see me either privately or on the NHS. I didn't get a reply from two but the one in [the other hospital] said she would treat me on the NHS. She was marvellous. I go to her annually. (Uppingham)*

In a few cases, respondents reported extreme frustration with their interactions with NHS services, and felt not only ignored but '*bullied*' (see below). For example, one respondent with ongoing and complex medical issues has expressed a complete loss of confidence in NHS primary and secondary care services in Rutland and other parts of the country.

> *I feel bullied. They say it's all in the mind. I'm no longer 'squashable'. They've met their match. I take my [cleaning] lady with me so they can't bully me anymore. I've abided by all their rules but I've just had enough. This lot wonder why I am so nasty about them but I think they are beginning to realise. They're good at telling you that you know your own body but they don't take it on board. I used to be very weak. I just have a fear of them. (Empingham)*

Similarly, another couple reported feeling the need for family '*back-up*' to ensure satisfactory care:

> *My daughter rang up the surgery and complained bitterly and they've always been helpful since then. Some people I feel sorry for if they don't have that back up. When you feel so rotten all you want to do is weep.*
>
> *We always speak [our] mind, you know. Some people get put on and I don't like that. That time I went to Peterborough Hospital I rang X [neighbour] up and asked him to come and fetch me home. It's not the NHS to blame, its bureaucracy. Some can't fight it but we can.*

3.5. After the GP appointment

Patients with long term conditions often find their journey does not end with one consultation. Often there are medications, ongoing reviews and hospital appointments to attend. Again, we did not specifically ask about medications but did ask about the referral process.

3.5.1 Prescriptions and medication

Most people with long term conditions take regular and, often, multiple medications in order to maintain their wellbeing. Somerby, Market Overton, Empingham and Uppingham surgeries have dispensaries within the surgery premises. Oakham surgery has an adjacent Boots pharmacy. There are other dispensing pharmacies in the Oakham and Uppingham town centres; some of which will deliver medications to residents in outlying villages at no extra cost. Several respondents volunteered details about the problems they associated with getting both the repeat prescription and their prescribed medicines. Remembering to re-order repeat prescriptions is a problem mentioned by several respondents:

> *The waiting time [for repeat prescriptions] is three days - you can't vary it. You can forget to reorder. I can order them on-line but others can't. There are people who just can't do it. The pharmacist is always very busy. There's just one person and there's always a queue there. They need another pharmacist. (Empingham)*

The extract below is from the interview of a respondent residing in a different village from the surgery. Apart from the surgery pharmacy, the nearest facility for obtaining medications is in Oakham. But the respondent does not drive and, so, dependent on a delivery service and problems are described as follows:

> *I find a problem with the pharmacist. They never bring your prescription on time. I wanted Ventolin [an inhaler for respiratory conditions]. I had run out. I had to ring up the surgery for more. The surgery said I had just had one and the pharmacist would not send me one. I had to ring the surgery who had to ring the pharmacist to get one out to me. They will come one week and then come out two weeks later. You've got to watch the [expiry] date. Once I didn't get tablets until 7 o'clock at night when they should have been out straight away. Delivery is the problem. The surgery gets the prescriptions out. One time you're waiting ages and then you get two lots quickly. (Oakham)*

Others, however, expressed satisfaction with the service:

- *My prescriptions are delivered every week. When they go away, they deliver every two weeks. The surgery brings them. (Empingham)*
- *I have a dosette box once a month and I'm happy with the service. (Oakham)*

3.5.2. Being referred to an acute hospital

Respondents spoke of being referred to hospitals in Peterborough, Cambridge, Leicester, Nottingham, Stamford and Oakham and described their transport difficulties in accessing these hospitals:

> *I got a volunteer driver to get there. I don't drive to the Leicester hospitals. I don't know where to go. I went to the General – the easiest to get to from here. The bus services are deteriorating. People now can't get to towns or hospitals or dentist. But lots of people can't drive, like those with Parkinson's or dementia. You can often get there but you can't get back.*

Such transport difficulties have previously been identified by Healthwatch Rutland to healthcare commissioners and providers and the Local Authority.[6] However, one respondent drew attention to the difficulties encountered by others wishing to visit patients:

> *The main problem was distance from Oakham to Addenbrookes for my wife to visit regularly – it was difficult as a non-driver and she relied on family members for transport. (Oakham)*

Most respondents reported that they were also not offered a choice of which hospital they preferred to attend and their experiences of the referral processes differed considerably with some having a good experience:

> *Referrals have been pretty good and I have no problem with the referral system they have. I was referred to a Nottingham based consultant which resulted in a hip replacement. The consultant holds clinics at the Oakham surgery and I saw him once before the op and twice afterwards at the clinic. (Oakham)*

But others identified sufficient issues with communication between GP surgeries and specialists for them to feel a need to monitor progress closely or to intervene when necessary:

- *Eventually I was referred to a specialist in Peterborough. He asked me if I'd had a scan and I said, 'Yes, my gall bladder was full of stones'. The specialist did not have the scan. I went to [query this at] Oakham Medical Practice and they said that the scan had been sent to Leicester and I had been referred to Peterborough. If I hadn't known what was on the scan it would have been a waste of the specialist's time. (Oakham)*
- *It was over three weeks and I hadn't got an appointment so I telephoned. It can take up to four weeks for the GP referral but the private referral was over three weeks. It shows the pressure GPs are under. I phoned them up and asked the date of the GP letter and they said it had only just come in. (Empingham)*

3.6. Self-help and community support

The NHS Long Term Plan (2019) directs that more care should take place in the community rather than in secondary (acute) hospitals. The respondents were therefore invited to talk about their experiences and opinions of trying to manage their own health and drawing on their community for support.

The respondents reported many methods of finding information about self-managing their illnesses:

- *I do sometimes use Google. I think googling can be scary. I will use NHS sites for advice.*
- *I would ask family members who have good knowledge and are good researchers.*
- *I have a nursing background so know some things.*
- *I'd ask our daughter. She does the computer.*
- *I went to Boots.*

Family, friends, community and illness-specific support groups were all named as sources of support:

- *I was taken ill and both our daughters were away. Word got around and a lady turned up with a roast dinner for my husband. The pub does a Sunday dinner if they know someone is on their own. They get their driver to take it round - free of charge. People along here look out for you and check on each other.*
- *Because of my long term condition, I joined a [specialist] group so I would contact them.*

However, some respondents also highlighted possible problems for people getting the necessary support, care and companionship:

- *The council sent somebody to help with the garden. He came twice and then didn't come again. They suggested I had somebody to sit with me when he [my partner] goes out but that would have meant a complete stranger. I can't sit with somebody I don't know for 8 hours.*
- *I think, from being an Age UK volunteer, that people don't know what's available. There's lots of help out there but people don't know about it.*

3.7. Social prescribing

Rutland's first social prescribing link worker took up post in January 2020. Social prescribing was described to all 30 respondents and they were invited to give their opinions about the concept. Social prescribing is defined by the King's Fund (2017) as:

> Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services [….]
>
> It also aims to support individuals to take greater control of their own health.
>
> Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports [….] Those who could benefit from social prescribing schemes include people with mild or long-term mental health problems, vulnerable groups, people who are socially isolated, and those who frequently attend either primary or secondary health care.

All of the participants were invited to give their opinion about social prescribing and these differed widely as the table below demonstrates:

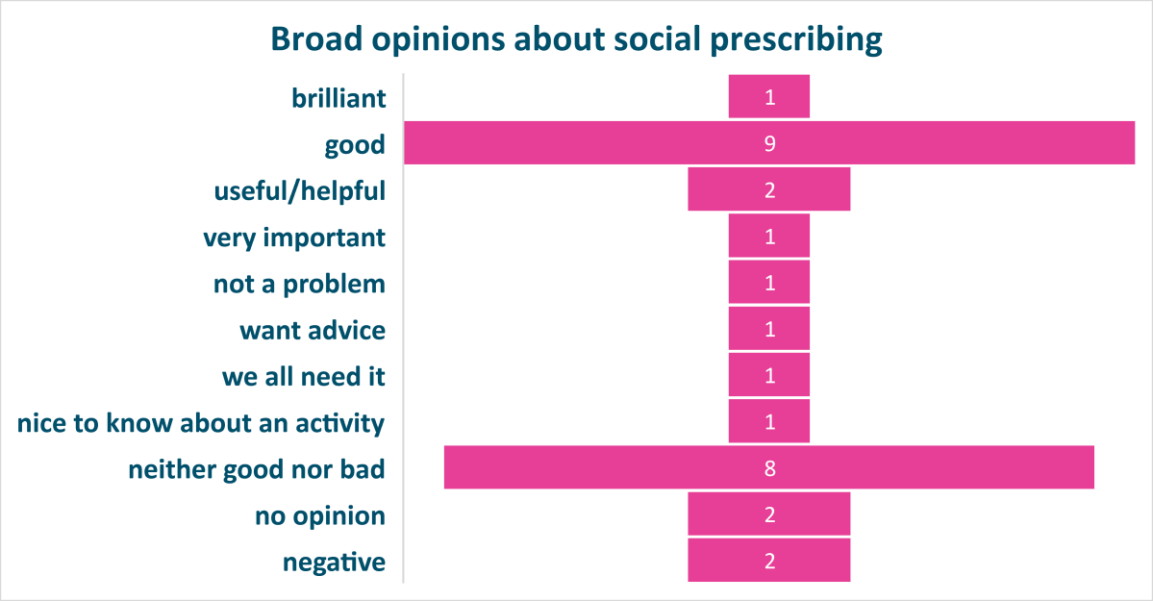


Table 2. The broad opinions about social prescribing

However, individual comments provide a more detailed understanding of how social prescribing might be more effective in Rutland.

One problem identified by several respondents was that of access to activities in a rural area where the local public transport infrastructure is infrequent.

The bus services are deteriorating. People now can't get to towns or hospitals or dentists. You can get there [from Empingham to Oakham], but you can't get back. The town 113 bus goes at 9.30 , 10.30, 11.30, 1.30 and 2.30 and then stops. Groups are diminished as people can't get home and can't afford a taxi.

The problem is that I might not be able to get to the things they suggest. I do drive a bit but not very far. I'm not very confident driving now.

Access to activities was also understood to be constrained by physical disabilities. One disabled person is unable to use public transport and, as they told us, *"It's £20 for a return taxi to Oakham and I just can't do it."* A second person with physical disabilities said:

> *How to get there to the activities [is the problem]. But it would be nice to know how and where to go swimming. You can't just walk into a swimming session with a walking stick.*

A further issue was that, although people thought social prescribing is a good idea they did not think it was appropriate for them. Some of the reasons for this were because people felt they were '*alright as I am*' or because partners were helping each other and managing with friends or family at hand to support them if needed.

> *It might be useful for somebody but not for us. While we are compos mentis, our family backs us up. We're alright.*

> *It might be a good idea but I'm quite happy with what I do.*

A further theme emerging from the data demonstrated a concern that social prescribing link workers should be '*the right person for the job*':

> *As long as the social prescribers know what they're doing and take time to listen*

> *The social prescriber would need to be personable and not tell people what to do.*

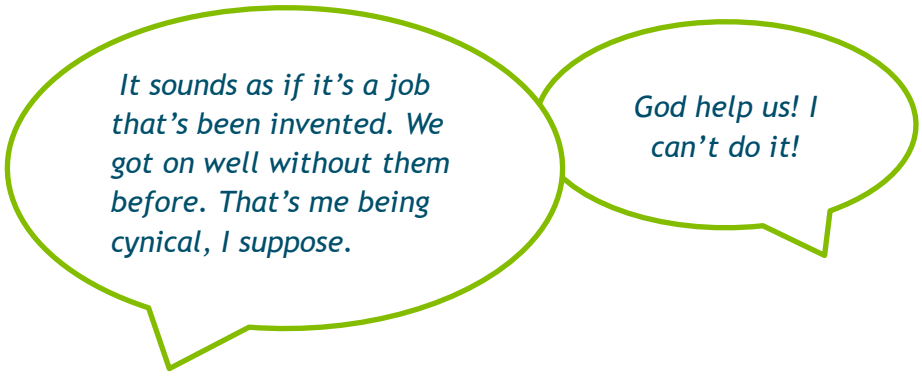
There were also wide-ranging comments about the illnesses or issues people were experiencing:

- *I do think social prescribing is good if people have mental health or are lonely or bereaved or have a new chronic condition, better than medication like antidepressants.*
- *I think local bereavement counselling/support group that wasn't attached to a church would be useful.*

- *It would be good to be educated on some support groups – I'd like to be in a support group for one specific condition but have no knowledge of any suitable ones.*
- *Social prescribing is very important and, I think, especially for people living with dementia.*

One respondent who lives alone told us that, despite being very active with community activities, feelings of loneliness can be overwhelming on returning home to an empty flat.

Finally, there were two people who did not think social prescribing would be a good idea but their feedback is nevertheless important for the Rutland Integrated Social Empowerment (RISE) team that is delivering the service:



Just as people have different interpretations about their experiences in GP surgeries, it seems they have different expectations of the newly introduced social prescribing service

3.8. Using the telephone

The respondents' frequent mention of the use of telephones was an unexpected theme from the interviews. Eighteen respondents (60%) mentioned the use of the telephone at some point in their interviews and most talked about how their problems were resolved satisfactorily without needing to go to the surgery. A decision was therefore made to explore this use of telephones in greater depth, with some respondents seeming to prefer communicating symptoms over the phone and, perhaps, avoiding embarrassing conversations in the receptions area. Others preferred a face-to-face approach:

- *When you phone for a same day appointment and explain your symptoms, they put you in with the appropriate person. I don't mind saying my symptoms over the phone. You can just phone up and they will fit you in. (Empingham)*
- *I phoned the GP and he asked me to go and see him. The GP would send us to an in-house physio. I spoke to the physio on the phone who sent out a sheet of paper with exercises to do. So, we paid to see a physio privately.*

Although most of the respondents were happy to communicate by telephone, one respondent talked about her own experience and this warns about potential risks:

> *The reason I don't like the over the phone thing, and I felt really awful at the time - a friend came for coffee. She's an ex-nurse. She took my blood pressure and temperature. She said she should phone the surgery. With my permission, she phoned the surgery and told them I was poorly. They asked her to come back to me the following morning and take my temperature and blood pressure again. That night I shook all over. I felt so ill. My friend came back and phoned the doctor and I ended up eight days in hospital with a kidney infection. That was a phone call. They couldn't even send a doctor from the surgery. They sent me a 111 doctor. I'm sure that if they had seen me the previous day, this would not have happened. I don't trust this phone call thing at all. (Oakham)*

It should be noted that most of the data gathering took place before measures for tackling the Covid-19 pandemic were introduced and the use of telephone triage and video conferencing was not so common in surgeries at that point.

4. Conclusions

Letting people talk freely about what is significant for them has proven highly valuable as unexpected themes emerged from the data. These themes include the problems of obtaining repeat prescriptions, difficulties for the visually impaired and the reliance of both patients and surgery staff on telephones – even in the pre-Covid-19 era.

This project was designed to capture a picture of the experiences of all age groups with short term health problems and long term conditions. However we realised that those who volunteered to speak to us were more frequent users of health services, i.e. older people and those with long term and/or multiple conditions. They then became the focus of the project.

The opportunity to talk freely sometimes meant that we heard about experiences which have not been included in this report. These omissions were not due to any lack of importance in what respondents told us but in the interest of maintaining the focus on

primary care. For example, a few respondents told us about their poor experiences of care as inpatients in the city hospitals and this is something that will need investigating in more depth outside of this project.

Many respondents spoke very positively about their surgery experiences; especially if they felt they had been 'listened to', reassured and given prompt and effective care. Equally, many comments have been constructive and highlight easily solved problems. For example, improved lighting in reception areas and the use of a bigger font on public screens would improve the patient experience in small, but significant ways.

However, Healthwatch Rutland was particularly concerned to hear that a lack of confidentiality in surgery waiting areas and difficulty with transport remain a big problem for Rutland residents despite these issues being highlighted in previous reports.

Writing in June 2020, during a social 'lockdown' due to the Covid-19 pandemic, many of our ways of living have changed; including how GP care is accessed. There are now suggestions that what has worked well within the NHS during the lockdown might be carried forward into a 'new normal'. Hopefully, the respondents' voices in this report will be relevant to shaping this future 'new normal' in primary care services in Rutland.

5. Response from Clinical Director, Rutland Health Primary Care Network

"Thank you to all those who gave their time to produce this insightful report, which will help Rutland Primary Care Network to develop its practices.

Since the publication of the Five Year Forward View and NHS Long term plan, general practice has been undergoing transformation which has been greatly accelerated by the Covid pandemic. An ambition of the NHS long term plan is for a "digital front door", and for patients to be empowered to take care of their own health.

The NHS long term plan addresses increased demand by diversification of the primary care workforce, and there are many different types of skilled clinicians that now make up the primary care workforce.

In response to the Covid pandemic, general practice across the country has been asked to change to a total triage model. This has led to greatly improved access and shorter waiting times.

The role of patient services teams has changed from simple reception to complex care navigation, so that patients can be signposted to the most appropriate

professional for their needs, and especially since Covid, the majority of contacts will increasingly be online, by telephone and video consultations.

Whilst maintaining the relationship and continuity based clinical care that improves clinical outcomes is one of Rutland Health PCN's key values, patients could regard their care as being delivered by a multidisciplinary team led by a GP, rather than by an individual.

We are working much more closely with our partners in social and community care, and this means that patients' needs can be addressed in a personalised, holistic way recognising that many of the factors that result in poor health and well-being are not medical. In Rutland we have developed a team, known as RISE (Rutland Integrated Social Empowerment. This is social prescribing, which has proved invaluable in supporting people during the lockdown.

Dr Hilary Fox FRGP

Clinical Director, Rutland Health Primary Care Network

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Appendices

Appendix 1 – Question guide for individual interviews

1. With which GP surgery are you registered?
2. Can you describe your GP surgery environment?
   Prompt: Are there suitable arrangements to speak confidentially to staff? (How does that make you feel?) Is it clean and comfortable?
3. How often have you used the surgery in the last year?
4. Which surgery staff dealt with you and how did you feel after speaking with them?
5. What do you think about being seen by different professionals for different aspects of healthcare?
6. Have you been referred onwards to hospital or other clinics by your GP and can you describe your experience?
   Further Q: Were you offered a choice of location or consultant?
7. How would you obtain information about self-help to maintain your health and wellbeing? (Do you have examples of this?)
   Further Q: In what ways do you think social prescribers or your community can help you manage your wellbeing?
8. Would you recommend your surgery to family and friends?
   Further Qs: Why? Would anyone you know be interested in being interviewed?
9. Is there anything else you would like to tell us?

Prompts to encourage more in-depth replies could include:

1. Can you say a bit more about this?
2. Can you describe this a bit more?
3. How did that make you feel?
4. Do you have examples of this?

Appendix 2 – Question guide for focus groups

1. With which GP or Doctor's surgery are you registered?
2. Can you describe the environment at your GP surgery?

   Further Qs:

   a. Are there suitable arrangements to speak confidentially to staff? (How does that make you feel?)

   b. Is it clean and comfortable?
3. Which surgery staff dealt with you and how did you feel after speaking with them?
4. How do you feel about being seen by different professionals for different aspects of healthcare?
5. How would you obtain information about self-help to maintain your health and wellbeing? (Do you have examples of this?)

   Further Q: In what ways do you think social prescribers or your community can help you manage your wellbeing?
6. Is there anything else you would like to tell us? (Do any of you have friends or family who might want to tell us about their experience?)

   Supplementary if required:
7. Have you been referred onwards to hospital or other clinics by your GP?

   a. (were you offered a choice of location or consultant?)

   b. (how was the experience?)
8. Would you recommend your surgery to family and friends?
9. Additional Prompts to encourage more in-depth replies can include:

   Can you say a bit more about this?

   Can you describe this a bit more?

   How did that make you feel?

   Do you have examples of this?

Appendix 3 - Respondent demographics

Transcript number	Age	Gender	Surgery	Times visited in last year
1	65	F	Empingham	3
2	80+	M	Oakham	Handful of times
3 Focus group (1)	65+	F	Oakham	
Focus group (2)	65+	F	Mkt Overton	
Focus group (3)	65+	F	Empingham	
Focus group (4)	65+	F	Empingham	
Focus group (5)	65+	F	Empingham	
Focus group (6)	65+	F	Empingham	
4 (husband)	75+	M	Mkt Overton	3 monthly
4 (Wife)	75+	F	Mkt Overton	fortnightly
5	60	F	Empingham	4
6	85	F	Oakham	6
7	65-74	F	Oakham	4-5 times
8	85 +	M	Oakham	'They keep bothering me'
9	65-74	F	Empingham	12
10	75+	M	Empingham	2 x month
10	75+	F	Empingham	monthly
11	75+	F	Oakham	3
12	65-74	F	Oakham	GP x3, blood test regularly
13	65-74	F	Empingham	4
14	65-74	F	Oakham	1-2
15	23	F	Oakham	4
16	51	M	Somerby	A lot
17	42	F	Somerby	x1 for self, x5 for children
18	75+	F	Somerby	A lot
19	22	F	Oakham	10
20	70-75	F	Mkt Overton	3
21	85+	F	Uppingham	Every 5 weeks
22	66	F	Uppingham	3-4 times
23	85+	F	Uppingham	2
Totals		25 F, 5 M		

About Healthwatch Rutland

Healthwatch Rutland is the local independent consumer champion for health and social care. We are part of a national network of local Healthwatch organisations. Our central role is to be a voice for local people to influence better health and wellbeing and improve the quality of services to meet people's needs. This involves us visiting local services and talking to people about their views and experiences. We share our reports with the NHS and social care, and the Care Quality Commission (CQC) (the inspector and regulator for health and social care), with recommendations for improvement, where required.

Our rights and responsibilities include:

- We have the power to monitor (known as "Enter and View") health and social care services (with one or two exceptions). Our primary purpose is to find out what patients, service users, carers and the wider public think of health and social care.
- We report our findings of local views and experiences to health and social care decision makers and make the case for improved services where we find there is a need for improvement.
- We strive to be a strong and powerful voice for local people, to influence how services are planned, organised and delivered.
- We aim to be an effective voice rooted in the community. To be that voice, we find out what local people think about health and social care. We research patient, user and carer opinions using lots of different ways of finding out views and experiences. We do this to give local people a voice. We provide information and advice about health and social care services.
- Where we do not feel the views and voices of Healthwatch Rutland and the people who we strive to speak on behalf of, are being heard, we have the option to escalate our concerns and report our evidence to national organisations including Healthwatch England, NHS England and the Care Quality Commission.

Healthwatch Rutland

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We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

Part of Connected Together Community Interest Company Registered in England and Wales. Company No. 8496240

About Connected Together CIC

Connected Together Community Interest Company (CIC) is the legal entity and governing body for Healthwatch Rutland.

The remit of the Connected Together CIC includes:

- Contract compliance
- Legal requirements
- Financial and risk management
- Sustainability and growth
- Agreeing strategy and operations
- Agreeing policies and procedures

Connected Together CIC is a social enterprise and a partnership between the University of Northampton and Voluntary Impact Northamptonshire. It aims to be first for community engagement across the county of Northamptonshire and beyond.

Connected Together
First for Community Engagement