Involvement of lay visitors in general practice assessment visits

DENIS DURNO

SUMMARY. Six practice assessment visits which jointly involved lay and medical visitors were arranged by the patient liaison group of the Royal College of General Practitioners. These visits were inspired by the 'What sort of doctor' report published by the RCGP in 1985. A subgroup of the patient liaison group adapted the assessment grid from the report to take account of involving lay visitors with doctors on practice visits. The visits were educationally valuable to the lay visitors, and also prompted some practical changes in the practices. This experiment might have further application in the development of fellowship by assessment or even in the process of reaccreditation of general practitioners.

Keywords: peer review; interpractice visits; patient participation; quality in general practice.

Introduction

THE Royal College of General Practitioners established a patient liaison group in 1983, with the aim of encouraging the medical and lay members of the group to find ways of giving patients a more effective voice in the development of health care services in general practice. At present the group comprises five general practitioners and seven lay members. The general practitioner vice chairman and at least one other general practitioner member must be members of RCGP's council. The group has a close working relationship with the chairmen of the divisions of the RCGP and has access to minutes and agenda, which enables the group to respond to items where a patient's views could be helpful. The lay members are appointed following direct approaches to the major organizations representing patients in the United Kingdom, such as the National Association for Patient Participation. The patient liaison group is currently looking at quality of care initiatives and exploring the role of the patient in medical audit.

In 1987 the patient liaison group established a subgroup to explore the possibility of jointly involving lay visitors and doctors in practice assessment visits. This initiative was inspired by the patient liaison group's consideration of the 'What sort of doctor?' report, published by the RCGP in 1985.[1] This report was a milestone in the development of general practice, and has formed the basis from which many regions approve training practices. The report encouraged a voluntary, non-adversarial approach to peer review and the visits by a team of general practitioner colleagues took place under ordinary working conditions and attempted to focus on the doctor's effectiveness and efficiency.

The patient liaison group was not aware of any study in general practice which involved lay visitors spending a whole day in a selected practice. The group's interest was in the concept of the visit being an experience of mutual learning.[1] There was considerable enthusiasm among the whole group to be involved in a series of practice visits. It was hoped that such a study would confirm the educational benefit of visits to both the visitors (lay and medical) and to the practice itself. Questions were also raised about what further development might take place. For example, was there a role for lay visitors in the work of fellowship by assessment or even in the proposed development of reaccreditation of general practitioners?[2]

D Durno, MD, FRCGP, general practitioner, Portlethen, Aberdeen and former vice chairman of RCGP patient liaison group.
Submitted: 8 March 1991; accepted: 7 November 1991.

Practice visits

The subgroup reviewed the assessment grid for practice visits from appendix 4 of the 'What sort of doctor?' report[1] in some detail. It was agreed that the areas of performance in the sections practice profile, observation of premises, equipment and organization, discussion with members of the health care team, records, and interview with doctors required to be expanded. Only the areas of performance in the section 'videotaped consultations' as a source of information did not need to be expanded. The following are examples of the new areas of practice performance that were introduced: role of the patient in audit, for example, does a practice protocol for the care of asthmatic patients take account of the patient's views in setting a standard; facilities for patients to talk to their doctor on the telephone; evidence of patient satisfaction; quality of sound proofing of consulting rooms; staff training; briefing of staff handling patients with specific difficulties, such as hearing problems or language difficulties; and access to records by primary health care team members. Two additional sections were included: interview with patients and access for disabled people. The latter used the following checklist: Is the surgery accessible for disabled people in wheelchairs and those with walking difficulties, that is does it have wide entrance doors? Is there level access to reception and surgery? If there are steps, how many are there? Is there a ramp? Is there a handrail by the steps? Is the lavatory large enough to take someone in a wheelchair or using a walking frame or crutches?

The subgroup then encouraged members of the patient liaison group to arrange a visit to an interested practice in their own area. Six practice visits were completed during 1988. The six practices visited were located in north east Scotland (two practices), inner London (one), the Midlands (two) and the north west of England (one). The Scottish practices were semi-rural and the English practices urban. The practices varied in size from 3000 to 12 000 patients. The largest practice had six partners, the smallest was a husband and wife team. At the time of the study all but one of the practices had a practice manager. Five practices were in adapted buildings and one was in a health centre.

The visits involved seven doctors and 11 lay visitors — four of the visits involved one doctor and two lay visitors, one involved two doctors and two lay visitors and one involved two doctors and one lay visitor (one doctor took part in two visits). Three of the doctors and four of the lay visitors were members of the patient liaison group. The remaining lay visitors were either members of patient participation groups or had a working knowledge of the health service. The remaining four doctors were known locally to the lay visitors, were willing to participate and were also acceptable to the practice to be visited. The patient liaison group was represented on all visits.

The six volunteer practices provided the visitors with a prac-

tice profile and timetable for the visit. The visiting team then held a briefing meeting to review the profile, highlighting any areas of special interest for questioning, and agreeing responsibility for each part of the visit, for example who would lead the discussion with the doctors or comment on the video session.

The visiting teams spent the first hour of the day in the reception area. Three main aspects were observed and recorded, these were the number of telephone calls received, the number of patients dealt with at the reception desk, while a third visitor looked at a 'mock up' record which showed how records were set out and in particular how repeat prescriptions were handled. Time was also spent with the receptionists discussing their role in the practice. The visitors met representatives of the doctors, health visitors, district and practice nurses, and the practice manager. Approximately 30 minutes was set aside for each group throughout the day to explore and discuss their roles within the practice. The visitors also interviewed patients who had agreed to meet them after the patients' consultation and before they left the practice.

Approximately one year after the initial visit a follow-up questionnaire was sent to the six doctors who had agreed that their practice should be visited. The purpose of the questionnaire was to assess how the practice had reacted to the visit.

Outcome of visits

The lay visitors were impressed with the way in which the volume of work in the reception area was dealt with in all the practices and how courteous the reception staff were to patients. In one practice the lay visitors were especially impressed with the way three receptionists dealt with 58 telephone calls and 52 patients at reception in the first hour of the day.

Four of the six practices visited were approved training practices and were therefore accustomed to external assessment. The visitors had no difficulty in identifying the designated leader in all of the practices. The value of videotaped consultations obviously created a division of opinion among the doctors in one training practice. In one practice the visitors heard the receptionists describe some tensions and problems regarding their rota. In another, the practice nurses experienced difficulties in coping with the demands for travel immunizations.

The interviews with patients consulting on the day of the visit were productive. Three broad issues emerged during these interviews: how appreciative patients were of the generally high quality of service offered by both medical and non-medical staff; the willingness of patients to take time to share their experiences with the visitors; and the patients' openness in describing unsatisfactory experiences in a non-judgemental way.

In four of the practices, written consent was obtained from patients to allow consultations to be videotaped and viewed by members of the visiting team. Viewing these videos allowed the visitors to confirm impressions of the doctor's style of practice. One surprise was an invitation by a patient to a lay visitor to sit in as an observer while the patient consulted her doctor.

All members of the subgroup were aware of the needs of disabled people, but one visiting lay member, herself a paraplegic, was especially aware of their needs. Sadly all six visits showed how poorly equipped general practice was to meet these special needs.

The six visits were completed in the period immediately before the introduction of the new contract for general practitioners. It was surprising, therefore, that no practice had introduced an up to date practice leaflet. Four of the practices held regular meetings. In the other two it was not clear how forward planning decisions were made (one of these practices was a training practice). Reviews of the 'mock up' records showed that regular medication could be easily identified in three of the practices. In two practices there was a need to improve the quality and number of records summarized (again one was a training practice). There were inadequate library facilities in two practices and once again a training practice was involved. It should be noted that it was not always the same training practice which had these problems.

The results of the follow-up questionnaire indicated that many changes had come about as a result of pressure from contractual requirements, but each practice valued the report produced by the visiting team. Examples of change which had clearly been influenced by the visits included: the introduction of regular practice meetings; an extra telephone line for repeat prescriptions; upgrading the practice library to training standards; more meetings of the patient participation group; and the involvement of the patient participation group in the production of a new practice leaflet. One practice commented that the lay visitors took their responsibilities more seriously than the visiting doctors.

One practice had arranged a follow-up meeting with the visitors to discuss the content of the visiting team's report. This discussion focused on the interpretation of observations concerning relationships and the authority structure within the practice.

Whole day visits to a practice, with or without lay visitors, can be expected to uncover sensitive areas. In this study, issues were encountered which the visiting teams felt were of such a sensitive and confidential nature that they should be excluded from their report to the practice. This possibility should be anticipated by visiting teams. The visiting team and representatives of the practice should meet before the visit to discuss how such issues might be handled in the final report. In offering feedback to a practice, it would seem only courteous to highlight the positive features of the practice in the report, but for progress and change to occur, ways should be sought to allow discussion and debate of areas which are of a sensitive or personal nature.

Discussion

One of the aims of the patient liaison group, which is echoed in the government's white paper *Working for patients*,[3] is that of giving the patient a more effective voice in the development of health care services in general practice. Fitzpatrick has recently highlighted the importance of patient satisfaction as an outcome measure and of taking patient views into account in assessing levels of care.[4]

Many patients are unaware of the many and varied activities that make up the job of a general practitioner. Even those patients who are members of patient participation groups may not understand some of the complexities of general practice. Developing and refining a role for lay practice visitors may be one method of achieving this understanding.

No one can challenge the intuitive response of the lay visitors that the experience was stimulating and educational. However, it is certainly legitimate to ask whether their presence in a team contributed anything special or unique. Examples of issues raised by three of the visiting teams, which might suggest a special role for lay visitors were: Is it appropriate for a doctor on call not to carry a bleep and therefore to depend on receptionists leaving messages at patients' homes? How does the practice respond to the observation that there is no clear process in the practice for decision making? Is it reasonable for patients to say that if they make a last minute appointment they always find themselves consulting the trainee?

There are approximately 130 patient participation groups in the UK giving support to general practice. The experience of the subgroup suggests that these groups could benefit

from arranging a formal visit to their own practice, using the methodology described here. Such activity could be a positive step towards a fuller understanding of general practice and a strengthening of the doctor–patient relationship. It would be an expression of the openness of British general practice for this to be achieved.

If the current attempt to interest faculties in establishing faculty patient liaison groups is to succeed, then a clear vision of their role would be necessary. One task for such a faculty group might be to assist with the development of lay visits to practices. The lay visitors in this project were all associated with the RCGP patient liaison group or a patient participation group, or had a working knowledge of the health service. In future the faculty could become involved not only in the planning of visits, but also with the selection and training of lay visitors.

It is also appropriate to consider the balance of control of practice visits between the RCGP and lay visitors. While this should be seen as an initiative led by the RCGP, such an initiative should not stifle or suppress the lay involvement.

For the past nine years the RCGP has supported its patient liaison group and encouraged it to find ways of giving patients a more effective voice in the development of general practice. This experiment is an example of this support, but it does involve some risk, in that the commitment of time and effort may be more rewarding for the lay visitors than for the doctors who are involved. Should the College support further work in this field, then it should control some aspects of lay visiting. In particular lay visitors should not be expected to make judgements about clinical competence or have access to clinical records, and clearly all aspects of the visit should be considered in the strictest confidence.

Currently, the north west England faculty and the north east England faculty have patient liasion groups. If more faculties develop patient liaison groups, then the door is open to a possible lay input to the process of fellowship of the RCGP by assessment, and there is a willingness on the part of the fellowship by assessment working party to consider lay involvement (Baker RH, personal communication). It is also possible that there could be a role for lay visitors in the proposed development of reaccreditation of general practitioners.[2]

To date, principals, trainers and trainees and more recently practice managers have been involved in practice visits.[5] The educational value of such visits is not in question, particularly as they are the chosen method of trainer selection in some regions. The patient liaison group is of the opinion that, if the initiative of involving lay people in practice visits is taken up by the RCGP, working through the faculties in close collaboration with local patient participation groups, then it could prove to be a useful educational development for general practice.

References

1. Royal College of General Practitioners. *What sort of doctor? Assessing quality of care in general practice. Report from general practice 23.* London: RCGP, 1985.
2. Schuppler P. Reaccreditation of GPs [letter]. *Br J Gen Pract* 1992; **42:** 40-41.
3. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555).* London: HMSO, 1989.
4. Fitzpatrick R. Surveys of patient satisfaction: 1 — important general considerations. *BMJ* 1991; **302:** 387-389.
5. Schofield TPC, Hasler JC. Approval of trainers and training practices in the Oxford region. *BMJ* 1984; **288:** 612-614.

Acknowledgements

I would like to thank Mrs Doreen Bugler, chairperson of the patient liaison group, for her support in carrying out the work and in assisting with the preparation of this paper.

Address for correspondence

Dr D Durno, Portlethen Group Practice, Health Centre, Bruntland Road, Portlethen, Aberdeen AB1 4QL.