INTRODUCTION

When the National Health Service (NHS) was first formed in the UK in 1948 most GPs continued to work, as they had before the NHS, in small single doctor practices, often from their own homes, providing 24-hour care for their registered patients. Whilst practices have gradually become larger and GPs tend to work in groups of varying sizes, most consultations have continued to take place “in the surgery”. But GPs have also always seen patients in a range of other settings as well as their own surgeries. These have included patients’ own homes, residential homes, nursing homes, cottage hospitals and a variety of clinics e.g. family planning, hospital outpatients or accident and emergency departments.

Over the decades NHS primary care has evolved from essentially a cottage industry into a complex web of different organisational models, with a wide variety of locations, workforce arrangements and funding streams. Telephone consulting, both in and out of hours, has also become a mainstream element of general practice, and on-line consulting is now available as an option for some, though not all, patients who wish to consult a GP.

Successive administrations have tried to tackle the twin challenges of increasing demand and limited resources through introducing different forms of community-based care. Some have endured and some faded, resulting in a complex array of primary care services in different parts of the country. Although this sounds (and feels!) chaotic, the constant experimentation has resulted in a system that has adapted to the varying needs of different communities in a process that might be described as organisational natural selection. Some services prioritise ease of access (e.g. walk-in centres), and some attend to needs of specific groups of patients (for example community services for frail elderly patients with complex needs).
NEED TO KNOW
DIFFERENT GP SETTINGS

Here are just some examples of various settings where patients may consult with GPs in the NHS:

- **Surgeries at a doctor's residence** - usually long-established single-handed or 2 doctor practices. Still found mainly in some rural areas but becoming rare, especially in cities.

- **"Lock-up" surgeries** - small “shop front” premises owned or rented by 1-2 doctors usually in inner cities. Premises only open during surgery hours. Such surgeries have been gradually phased out and are now rarely seen.

- **Adapted premises** - residential buildings in suburban area (e.g. family houses), often owned by one or more of the doctors and converted for use as practice premises for multi-doctor practice. Open “in-hours” only.

- **Purpose built group practice premises** - usually built for and owned or leased by a medium to larger group practice (4-8 GPs) with adequate accommodation for employed and attached ancillary staff.

- **Health Centres** - usually large purpose-built premises, provided by the NHS with surgery suites for GPs (6-12 or more) who may be practising in groups, pairs or occasionally single-handed within the Health Centre. Health Centres may also include other community-based NHS staff and/or clinics.

- **Community Health Clinics** - serving a geographical catchment area - usually a base for NHS employed staff eg community nurses, midwives, health visitors, school dental and medical services, speech therapy, audiometry, chiropody and other local services, ante-natal clinics, baby clinics, family planning, well woman clinics.

- **Polyclinics** - Forerunners of ‘super surgeries’, this was the first attempt in the early 2000s to extend the range of services offered by some general practices in an attempt to move care out of relatively expensive hospitals to more cost-effective primary care settings.

- **Hubs** - are a relatively new way of managing workload across a number of practices and their respective patient lists, enabling practices to work together particularly in order to organise the delivery of same-day appointments. The aim is that patients, when needed, can be seen urgently without placing additional and potentially unsafe pressure on over-stretched practices.
• **Urgent Treatment Centres** - Urgent Care/Treatment centres exist in some areas as an option for people to attend if they feel they have an urgent (but not life threatening) medical problem. These units may be located in hospitals or in the community and may have a variety of names eg walk-in centres, urgent care centres, minor injury units. The current trend is to rename them all as Urgent Treatment Centres. They are usually GP-led and open for at least 12 hours a day every day of the week (including bank holidays). They are equipped to diagnose and treat many of the most common ailments people go to A&E for. Patients may be referred to an urgent treatment centre by NHS 111 or can just walk in during opening hours.

• **Emergency (A&E) Departments** - Some hospital emergency departments now employ GPs to see patients presenting with urgent problems. Whilst there is evidence that GPs working in A&E see patients faster, use fewer investigations and admit them less often, there is concern that every GP working in A&E is one fewer to work in local practices, many of which may reduce capacity where these patients would more appropriately be managed.

• **NHS 111** - A free-to-call non-emergency medical helpline operating in England, Scotland and parts of Wales. The 111-phone service has since 2014 replaced NHS Direct. The service is available 24 hours a day, every day of the year and is intended for 'urgent but not life-threatening' health issues. It complements the long-established 999 emergency telephone number for more serious matters, although 111 operators in England are able to dispatch ambulances when appropriate. When a patient calls 111, a health advisor will assess the caller’s symptoms using a clinical tool called ‘NHS Pathways’. At the end of the assessment the caller will be directed to the service deemed most appropriate for their symptoms or, if appropriate, will be given self-management advice. For callers whose symptoms indicate the need for a referral to a GP outside of their normal GP surgery opening hours, their call will result in a referral to their local out of hours GP service to be seen at an out of hours centre or visited at home if necessary. The out of hours period is from 1830 to 0800 on weekdays and all day at weekends and on bank holidays.

• **Digital First Primary Care** - The NHS England Long Term Plan\(^1\) promotes primary care moving towards a digital first approach, where patients can easily access the advice, support and treatment they need using digital and online tools. Probably the best know example at present is ‘Babylon GP at Hand’. This is an NHS general practice in North West London which has implemented a “digital first” service through the use of a mobile app which is provided by Babylon Health. The practice also provides in-person services should patients require them at sites in and outside of its local catchment area. Many other GP practices are now offering online access to services, including the option to have an on-line consultation. This development has generated much interest and debate, Research is underway to explore the benefits and risks of digital first primary care.
• **GPs with Extended roles (GPwERs)** - A GPwER is a GP who undertakes, in addition to their core general practice, a role that is beyond the scope of standard GP training and requires further training and experience. Extended roles are not necessarily only clinical. They may also for example be teaching, research or management related. However, in the context of clinical extended roles the general idea is that patients from the same or local practices may be referred to a GPwER in order to provide specialist advice that does not necessarily need the full panoply of hospital. GPwER specialties and organisational arrangements vary in different areas but more common examples might be in the fields of dermatology, rheumatology, ENT, minor surgery.

The list above is not exhaustive. For a detailed exploration of innovative models of general practice see the 2018 King's Fund report by Beccy Baird et al.²

**IS THIS EXPANSION OF GP SETTINGS A GOOD THING?**

Whilst increased health care availability in the community must surely be a good thing, caution has been expressed in some quarters. There may be a risk that something will be lost as doctors and patients are reallocated to these new services, especially those focused on immediate access. The traditional model of general practice involves GPs getting to know their patients' medical history, personal, social and family background, coordinating their care and developing a trusting relationship over time (see the section on continuity). If general practice becomes too fragmented this accumulated knowledge and continuity of care may be lost. Prioritising access at the expense of other core attributes of general practice such as continuity, coordination and person-centred holistic care may have unintended consequences. This could impact on decisions as to when medical treatment is needed, and less ability to manage uncertainty safely outside of hospitals.

These arguments are explored further in Rebecca Rosen’s 2018 Report for the Nuffield Trust “Divided we fall: getting the best out of general practice” which goes on to consider what GPs and national NHS bodies can do to get the best of both traditional and innovative models of general practice.³

Rosen summarises her report with the following key points:

• Policies designed to segment general practice often emphasise faster access to quick, transactional, 'see and treat' encounters. The rapid growth of these services is pulling GPs away from the expert 'medical generalist' role of general practice that is a defining characteristic of list-based primary care.
Medical generalism involves using deep contextual knowledge of patients and their family and social situation to understand and interpret symptoms and problems. It enables GPs to hold clinical risk in the community without onward referral to other services. For around a quarter of patients, it can help to ‘de-medicalise’ problems for which medicine may be unable to find an answer.

Health systems like the NHS, which feature strong primary care with GP-registered lists and a gatekeeper function, generally have better health outcomes at lower cost. Evidence suggests that GPs contribute to this by requesting fewer tests and procedures and, where there is continuity with a lead GP, they refer to hospitals less. These approaches are characteristic of the medical generalist role.

At a time when staff and money are in short supply, it is essential to clarify what we want from general practice and the role we want it to play in the wider NHS. There are opportunity costs associated with the current emphasis on timely and convenient access because fewer resources are left to deliver medical generalist and multi-disciplinary care.

Focusing too much attention on using technology to improve access may exacerbate supply-induced demand and distract us from thinking more broadly about where technology adds value (for example in long-term conditions surveillance or risk factor monitoring) and where it adds extra layers of work with limited benefit to patients.

It is important to distinguish patients who will achieve good outcomes from the transactional encounters of access services from those who will benefit from medical generalist or multi-disciplinary care and research is needed to work out how to do this. Software that analyses clinical data and patterns of service use can help to identify who falls into which category in order to steer them to the type of clinical encounter that will deliver the greatest overall value.

Traditional general practice has not always delivered good medical generalist care, especially with growing numbers of part-time doctors. Working with nurses and other professionals to provide ‘team-based continuity’ could provide an answer, and medical training should change to teach aspiring GPs how to do this.

Comparisons are needed of the overall outcomes and costs of care for specific conditions for people treated in different forms of segmented primary care.

Future models of general practice should aim to offer enhanced access and medical generalist care, within a single integrated organisation and supported by systems to steer patients seamlessly between different forms of clinical encounter according to need.
ACTIVE LEARNING

✓ Ask doctors, nurses and receptionists where else their patients sometimes go to see a GP locally. Do they feel these alternative sources of advice are generally helpful? Do they think there are any disadvantages?

✓ If a patient tells you they have consulted about a problem elsewhere (out of hours doctor or AE department), ask them why they chose to seek advice in that way, how it worked for them and why they have now come back to their usual GP practice.

✓ Take an hour out to read over three two key documents referenced below. Both are readily available online.

✓ If you get the chance, try and visit another local GP service near your placement practice eg a HUB or Urgent Treatment Centre.

FURTHER LEARNING


The following resources have been developed in conjunction with SAPC Heads of GP Teaching. If you have any queries or questions regarding the resources on offer, please contact Prof. Joe Rosenthal or Prof. Alex Harding, Co-Chairs of SAPC’s Heads of GP Teaching Group.