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Comparison of the roles and responsibilities of positions within primary care across England

ID of request: 10741
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If you would like to request any articles or any further help, please contact: Marianne Lindfield at marianne.lindfield@sash.nhs.uk

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Date range used (5 years, 10 years): 2012
Limits used (gender, article/study type, etc.): England
Search terms and notes (full search strategy for database searches below): skills mix, primary care, patient liaison, medical assistant, HCS, Health Care Assistant, Receptionist, Administration, Administrator, Care navigator, care pathways, general practice nurse, health champion, UK, navigat*, Signpost, community, workforce, develop, impact, general practice.

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A. Synopses or Summaries

NHS England

West Wakefield reception care navigation (2016)

Available online at this link

57 receptionists in 6 practices across West Wakefield have been trained to work as care navigators for patients, as part the PMs GP Access Fund. The idea Receptionists have received training to enhance their ability to connect patients directly with the most appropriate source of help. When patients contact the practice, the receptionist identifies what their need is. They are then able to refer to information about services in the practice, other NHS providers and the wider care and support sector. Where appropriate, they direct the patient to these services. The system is also being offered through the practices websites. One receptionist describes it as "reception plus … it is trying to get the best for the person on the phone". It is seen as being most relevant for patients who initially think a GP will be the most appropriate person to meet their need, where better options may exist. Services to which patients may be signposted include: • Practice and specialist nurse appointments in the practice • Pharmacy First • Physio First • Acute ophthalmology services • 111 in order to access an emergency dentist • Mental health support including the local drugs and alcohol team, Big White Wall and others. • community support services for carers and older people

High impact case studies: Reducing pressure in general practice (2016)

Available online at this link

B. Institutional Publications

NHS Alliance

Making Time in General Practice. Case Study: Reducing the GP workload: the clinical personal assistant (2015)

Available online at this link

P40 Ten practices in Brighton and Hove are now deploying a new clinical personal assistant role to reduce the bureaucratic burden on GPs. It's an idea that has been backed by the RCGP, which in 2014, called for a medical assistant role, trained in 12 weeks to take on some of the GPs' administrative burden. This is very different to the physician assistant or physician associates who take on a clinical role.

NHS England

General Practice Five Year Forward View: Reducing pressure in general practice (2015)

Available online at this link

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The most common potentially avoidable consultations were amendable to action by the practice, often with the support of the clinical commissioning group (CCG). The biggest three categories were

where the patient would have been better served by being directed to someone else in the wider primary care team, either within the practice, in the pharmacy or a so-called 'wellbeing worker' (e.g. care navigator, peer coach, health trainer or befriender). Together, these three, which could be improved by more active signposting and new support services, accounted for 16 per cent of GP appointments. An additional 1 per cent were to inform a patient that their test result was normal and no further action was needed. A further 1 per cent of appointments would not have been necessary if continuity of care or a clear management plan had been established. The second most common issue lay within the control of hospitals. Demand created by hospitals accounted for a total of 4.5 per cent of appointments. The largest category, creating 2.5 per cent of appointment, comprised problems with outpatient booking (either a lapse in the outpatient booking process, such as failure to send a follow-up appointment, or a patient failing to attend an appointment, necessitating an entirely new GP referral). The other, creating 2 per cent, was the result of hospital staff instructing the patient to contact the GP for a prescription or other intervention which was part of their hospital care. Includes case studies.

The King's Fund

Supporting integration through new roles and working across boundaries (2016)

Gilburt H.

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Recent years have seen new roles emerge to support the delivery of integrated care. These roles aim to enable more holistic care, and facilitate continuity and co-ordination of care across organisational boundaries. Some of these new roles (such as care co-ordinators and case managers) have integration at their core, while others (such as extended support worker roles or personal assistants) build on established roles to facilitate integration. Our review of the evidence found few examples of truly innovative roles. The most notable examples are care navigators and community facilitators, enablers or link workers. These roles seek to enable individuals and, in some cases, professionals to access and navigate the range of support available from health, social care and the wider community. There is a lack of robust evidence on, and evaluation of, new roles. Most studies focus on the wider learning from programmes designed to integrate care, rather than the impact of individual roles. More evidence is needed on the key characteristics of new roles and their impact on outcomes if they are to be successfully replicated in other settings. There is also a need for more evidence about the cost-effectiveness of new roles. Key questions remain around the scale at which new roles need to be developed to demonstrate impact, be sustainable, and release cost savings elsewhere in the system. This is important given the investment needed to establish new roles.

C. Original Research

1. **1. Career planning for the non-clinical workforce – an opportunity to develop a sustainable workforce in primary care.**
   Tavabie Jacqueline A. Education for Primary Care 2017;28(2):94-101.

Many health and social care systems worldwide have been developing a variety of navigator and signposting roles to help patients negotiate care through increasingly complex systems and multiple provider agencies. This UK project aims to explore, through a combination of job description review and workshops of stakeholders, the common competencies and features of non-clinical roles. The information is collated to develop common job descriptions at four key levels. These form the basis for a career pathway supported by portfolio-based educational programmes, embracing Apprenticeship Training Programmes. The programmes have the potential to support recruitment and retention of an increasingly skilled workforce to move between traditional health and social care provider boundaries. This offers the opportunity to release clinicians from significant administrative workload and support patients in an integrated care system.

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2. **A qualitative study of collaboration in general practice: understanding the general practice nurse's role.**
McInnes Susan Journal of clinical nursing 2017;26(13-14):1960-1968.

AIMS AND OBJECTIVESTo explore the nature of collaboration between registered nurses and general practitioners in Australian general practice.BACKGROUNDThere is international recognition that collaboration between health professionals can improve care coordination, enhance health outcomes, optimise the work environment and reduce healthcare costs. However, effective collaboration requires a clear understanding of each team member's role.DESIGNA qualitative approach guided by Naturalistic Inquiry was used to elicit and interpret participant narratives.METHODSEight general practitioners and fourteen registered nurses working in general practice were purposefully recruited. Data were collected via individual, semi-structured face-to-face interviews during February to May 2015. Interviews were audio recorded and transcribed verbatim. Data were analysed using thematic analysis.RESULTSData revealed three overarching themes. This study presents the data for the overarching theme 'Understanding the general practice registered nurse's role'. Many general practitioner participants lacked clarity around the role and scope of practice of the registered nurse. At the same time, nursing participants often articulated their role as an assistant rather than as an independent health professional. This limited collaboration and the nurses' role within the team. Collaboration was enhanced when general practitioners actively sought an understanding of the registered nurses scope of practice.CONCLUSIONClarifying the nurses' role promotes collaboration and supports nurses to work to the full extent of their practice. This is important in terms of optimising the nurses' role within the team and reinforcing their professional identity.RELEVANCE TO CLINICAL PRACTICEIdentification of key issues around understanding the nurses' role may help inform strategies that improve collaboration and workplace relations.

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3. **Health Education England report on the general practice nurse.**
Duncan Debbie Nurse Prescribing 2017;15(6):274-275.

4. **Professional identity and the advanced nurse practitioner in primary care : a qualitative study**
Anderson 2017;:0.

Background: Health professional roles are being adapted in response to increased demand and declining medical workforces, both in England and internationally. This is exemplified by advanced nurse practitioners (ANP) in primary care. However, evidence suggests ANP practice may lack acceptability and understanding, leading to underutilisation. Professional identity (how colleagues are perceived by themselves and others) may influence how professionals work together to utilise such roles. Previous research has explored ANP professional identity during transition and in isolation from workplace cultures. Less is known about relationships between professional identity and established ANP practice within primary healthcare teams, or how ANP practice is affected by workplace cultures. Wider societal level influences have not been fully explored. This study aimed to explore the relationship between professional identity and ANP practice in a context where ANP practice was established. Methods: The study consisted of a qualitative cross-sectional study which explored professional identity of ANPs on a sample of general practice websites. Then the relationship between professional identity and ANP practice was explored, in-depth, in an ethnographic study of two general practices in England. Findings: ANPs lacked visibility on general practice websites. Both studies found ANPs were framed within a traditional nursing identity. This impacted on ANP practice and has implications for how professionals and the wider public understand ANP roles. Individual characteristics and interactional relationships were central to acceptance and utilisation of ANPs within the workplace, but were limited by broader societal level understanding of professional identities. ANPs negotiated their place within the workforce by utilising established understanding of professional identity. Intra-professional tensions were identified between ANPs and nursing. Conclusions: Professional identity is a useful framework within which to develop contextual understanding of ANP practice. Primary healthcare team members utilised shared understanding of professional identity to shape ANP roles, which both supported and inhibited ANP utilisation.

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5. **Providing sexual and reproductive healthcare in general practice: Historically, much of the work relating to women's health in general practice fell to female GPs. Now, it is more likely to be the general practice nurse who shoulders most of the workload relating to contraception and sexual health**
HUNT KATHERINE Practice Nurse 2017;47(5):20-25.

The article looks at essential elements of sexual and reproductive healthcare (SRH) that nurses can gain competence and confidence in. Topics include undertaking repeat contraceptive checks for women already taking oral or injectable contraception; assessing whether a woman is at risk of pregnancy; and undertaking a risk assessment to determine if a patient is at risk of a sexually transmitted infection.

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6. **Stroke survivors: the long road to recovery.**
GREGORY MEL Practice Nurse 2017;47(7):29-32.

The article explores the role of general practice nurse (GPN) in providing a useful source of information, advice and support to stroke survivors in Great Britain. It mentions sexual dysfunction as a common problem for stroke survivors and GPN need to encourage stroke survivor with communication problems to increase their participation in social activities. It also mentions muscle weakness can result in difficulty speaking and swallowing.

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7. **Using community education provider networks to develop general practice nursing.**
Walsh Nicki Primary Health Care 2017;27(4):26-29.

Changing health and social needs and a rapidly ageing population in the UK (Office for National Statistics 2011) mean providers' responses must be dynamic, flexible, sustainable and focused on the delivery of safe, effective care. Longer lifespans mean that illnesses last longer, with conditions such as diabetes, respiratory disease and arthritis having a greater likelihood of co-morbidities (NHS England 2015a). This has significant consequences for services across all areas of health and social care. General practice is well placed to respond to pressures and provide healthcare to those with long- or short-term conditions, in part due to its registered list of patients. The general practice nurse is pivotal to this, but demographics and years of underinvestment in the workforce are likely to see a deficit in the number of skilled workers needed to support this. Therefore, investment in pre-registration nursing programmes is needed to create a highly skilled, effective, sustainable workforce. This article highlights the work of one community education provider network in establishing nursing student placements in general practice.

8. **GP receptionists should 'deal more sensitively' with patients, research reveals.**
Anon. Primary Health Care 2016;26(9):7-7.

The article discusses findings of research published in the British Journal of General Practice and in the Journal of Public Health which shows that patients prefer not to talk to clinic receptionists about their health issues when making an appointment to see a General Practitioner (GP).

9. **Having to discuss symptoms with receptionists puts 40% of patients off GP visits.**
Millett David GP: General Practitioner 2016;:10-10.

The article presents information on the survey published in the Journal of Public Health on patients that are put off going to their general practitioner (GP) in Great Britain. Topics

include the patients' unwillingness to discuss their symptoms with reception staff, the General Practice Forward View of the National Health Service (NHS), and the need to search for ways to prevent patients to postpone appointments that may delay the diagnosis of serious ailments.

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10. **How we reduced appointments by a third for socially isolated over-75s.**
Malpass Jo 2016;:91.

The article discusses the impact of Prime 75+ project conducted by the consultancy service Prime GP and was authorized by NHS South Warwickshire CCG in December 2014 to patients over 75 year and older that are socially isolated and weak. Topics include the activities organized by co-ordinators who helped the patients, the assessment in which they identify fifth of the population was lonely, and decline in the population of patient's appointment in March 2015.

11. **Medical Assistant-Based Care Management for High-Risk Patients in Small Primary Care Practices: A Cluster Randomized Clinical Trial.**
Freund Tobias Annals of internal medicine 2016;164(5):323-330.

Patients with multiple chronic conditions are at high risk for potentially avoidable hospitalizations, which may be reduced by care coordination and self-management support. Medical assistants are an increasingly available resource for patient care in primary care practices.To determine whether protocol-based care management delivered by medical assistants improves care in patients at high risk for future hospitalization in primary care. Two-year cluster randomized clinical trial. (Current Controlled Trials: ISRCTN56104508).115 primary care practices in Germany. 2076 patients with type 2 diabetes, chronic obstructive pulmonary disease, or chronic heart failure and a likelihood of hospitalization in the upper quartile of the population, as predicted by an analysis of insurance data.Protocol-based care management, including structured assessment, action planning, and monitoring delivered by medical assistants, compared with usual care. All-cause hospitalizations at 12 months (primary outcome) and quality-of-life scores (12-Item Short Form Health Survey [SF-12] and EuroQol instrument [EQ-5D]).Included patients had an average of 4 co-occurring chronic conditions. All-cause hospitalizations did not differ between groups at 12 months (risk ratio [RR], 1.01 [95% CI, 0.87 to 1.18]) and 24 months (RR, 0.98 [CI, 0.85 to 1.12]). Quality of life (differences, 1.16 [CI, 0.24 to 2.08] on SF-12 physical component and 1.68 [CI, 0.60 to 2.77] on SF-12 mental component) and general health (difference on EQ-5D, 0.03 [CI, 0.00 to 0.05]) improved significantly at 24 months. Intervention costs totaled $10 per patient per month. Small number of primary care practices and low intensity of intervention.This low-intensity intervention did not reduce all-cause hospitalizations but showed positive effects on quality of life at reasonable costs in high-risk multimorbid patients. AOK Baden-Württemberg and AOK Bundesverband.

12. **Medical Assistants as Flow Managers in Primary Care: Challenges and Recommendations.**
Gray Caroline P. 2016;61(3):181-191. .

As healthcare organizations look for ways to reduce costs and improve quality, many rely increasingly on allied healthcare professionals and, in particular, medical assistants (MAs) to supplement the work of physicians and other health professionals. MAs usually work in primary care, where they often play important roles on healthcare teams. Drawing on an empirical study of a large, multispecialty delivery system engaged in reconfiguration of primary care, we found that using MAs as flow managers required overcoming several challenges. These included entrenched social and occupational hierarchies between physicians and MAs, a lack of adequate training and mentorship, and difficulty attracting and retaining talented MAs. We offer several recommendations for healthcare organizations interested in using MAs as flow managers in their practices.

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13. **New Roles for Medical Assistants in Innovative Primary Care Practices.**
Chapman Susan A. Health services research 2016;:-.

To identify and describe new roles for medical assistants (MAs) in innovative care models that improve care while providing training and career advancement opportunities for MAs. Primary data collected at 15 case study sites; 173 key informant interviews and de-identified secondary data on staffing, wages, patient satisfaction, and health outcomes. Researchers used snowball sampling and screening calls to identify 15 organizations using MAs in new roles. Conducted site visits from 2010 to 2012 and updated information in 2014. Thematic analysis explored key topics: factors driving MA role innovation, role description, training required, and wage gains. Categorized outcome data in patient and staff satisfaction, quality of care, and efficiency. New MA roles included health coach, medical scribe, dual role translator, health navigator, panel manager, cross-trained flexible role, and supervisor. Implementation of new roles required extensive training. MA incentives and enhanced compensation varied by role type. New MA roles are part of a larger attempt to reform workflow and relieve primary care providers. Despite some evidence of success, spread has been limited. Key challenges to adoption included leadership and provider resistance to change, cost of additional MA training, and lack of reimbursement for nonbillable services.

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14. **Nurse practitioners' perceptions of their role and value in UK general practice**
Hall 2016;:0.

This research explores the role and value of nurse practitioners to UK general practice from the perspective of nurses working in these advanced roles. Nursing has had a presence in general practice for decades, but it is only over the last twenty years that it has extended into a traditional medical domain of care and treatment. Research has understandably focused on the ability of nurses to substitute for doctors and there has been relatively little investigation of what nursing at an advanced level contributes. The study is located within a

qualitative interpretive paradigm utilising a Social Constructionist (SC) approach which recognises that knowledge is not based solely on objective observations of the world, but is generated between individuals in the course of their everyday life. The theoretical perspective grounded in this epistemological paradigm is symbolic interactionism (SI). This emphasises the construction of the social world and meaning through the use of symbols, particularly language. Thematic Analysis (TA) is utilised deliberately as a research strategy guiding sampling, data generation, collection and analysis. A purposive sample of ten nurse practitioners was selected. Semi-structured interviews were conducted, digitally recorded, transcribed and the data analysed using Braun and Clarke's model. Four broad themes were identified from the narratives; the enactment and development of the nurse practitioner role, its value to the organisation and function of general practice, the impact of nurse consultation upon the patient experience and finally, how the role has integrated into the primary health care team. The findings demonstrate that rather than one generic nurse practitioner role in general practice there are multiple constructs, driven at macro level by political necessity, negotiated at micro level by the needs of individual general practices and framed within a professional vacuum of non-regulation. This has not been fully explained before. The research provides a clear and original understanding of what nurse practitioners can contribute to general practice through the diversification of their roles, not as substitute but as part of a diverse, fluid team working collaboratively to address the needs of the general practice population.

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15. **Protocol for using mixed methods and process improvement methodologies to explore primary care receptionist work.**
Litchfield Ian BMJ open 2016;6(11):e013240-.

INTRODUCTION The need to cope with an increasingly ageing and multimorbid population has seen a shift towards preventive health and effective management of chronic disease. This places general practice at the forefront of health service provision with an increased demand that impacts on all members of the practice team. As these pressures grow, systems become more complex and tasks delegated across a broader range of staff groups. These include receptionists who play an essential role in the successful functioning of the surgery and are a major influence on patient satisfaction. However, they do so without formal recognition of the clinical implications of their work or with any requirements for training and qualifications. METHODS AND ANALYSIS Our work consists of three phases. The first will survey receptionists using the validated Work Design Questionnaire to help us understand more precisely the parameters of their role; the second involves the use of iterative focus groups to help define the systems and processes within which they work. The third and final phase will produce recommendations to increase the efficiency and safety of the key practice processes involving receptionists and identify the areas and where receptionists require targeted support. In doing so, we aim to increase job satisfaction of receptionists, improve practice efficiency and produce better outcomes for patients. ETHICS AND DISSEMINATION Our work will be disseminated using conferences, workshops, trade journals, electronic media and through a series of publications in the peer reviewed literature. At the very least, our work will serve to prompt discussion on the clinical role of receptionists and assess the advantages of using value streams in conjunction with related tools for process improvement.

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16. **Supporting integration through new roles and working across boundaries.**
Gilburt Helen 2016;:-.

This report looks at the evidence on new roles and ways of spanning organisational workforce boundaries to deliver integrated health and social care. It finds increasing focus on roles which facilitate co-ordination and management of care, development of existing roles to increase the skill-mix and enable the provision of more holistic care, and a limited number of truly innovative roles, the most notable being care navigators and community facilitators, enablers or link workers. Given that many of the skills required for integrated care already exist within the workforce, it suggests the central question is how to use those skills more effectively to support boundary-spanning activities.

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17. **Team-based primary care: The medical assistant perspective.**
Sheridan Bethany Health care management review 2016;:-.

Team-based care has the potential to improve primary care quality and efficiency. In this model, medical assistants (MAs) take a more central role in patient care and population health management. MAs' traditionally low status may give them a unique view on changing organizational dynamics and teamwork. However, little empirical work exists on how team-based organizational designs affect the experiences of low-status health care workers like MAs. The aim of this study was to describe how team-based primary care affects the experiences of MAs. A secondary aim was to explore variation in these experiences. In late 2014, the authors interviewed 30 MAs from nine primary care practices transitioning to team-based care. Interviews addressed job responsibilities, teamwork, implementation, job satisfaction, and learning. Data were analyzed using a thematic networks approach. Interviews also included closed-ended questions about workload and job satisfaction. Most MAs reported both a higher workload (73%) and a greater job satisfaction (86%) under team-based primary care. Interview data surfaced four mechanisms for these results, which suggested more fulfilling work and greater respect for the MA role: (a) relationships with colleagues, (b) involvement with patients, (c) sense of control, and (d) sense of efficacy. Facilitators and barriers to these positive changes also emerged. Team-based care can provide low-status health care workers with more fulfilling work and strengthen relationships across status lines. The extent of this positive impact may depend on supporting factors at the organization, team, and individual worker levels. To maximize the benefits of team-based care, primary care leaders should recognize the larger role that MAs play under this model and support them as increasingly valuable team members. Contingent on organizational conditions, practices may find MAs who are willing to manage the increased workload that often accompanies team-based care.

18. **Unhelpful GP receptionists lead to lower patient satisfaction scores.**
Bower Emma GP: General Practitioner 2016;:1-1.

The article discusses research which showed lower satisfaction rate for physician practices with unhelpful receptionists. It references a study published in the "British Journal of General Practice." Topics discussed include communication with the doctor and helpfulness of the receptionist as important factors for patient satisfaction and implications of the research for training receptionists.

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19. **[How Patients View and Accept Health Care Services Provided by Health Care Assistants in the General Practice: Survey of Participants of the GP-centered Health Care Program in Baden-Wuerttemberg].**
Mergenthal K. Gesundheitswesen (Bundesverband der Arzte des Offentlichen Gesundheitsdienstes (Germany)) 2016;:-.

Background: In recent years, models for the delegation of GP tasks to non-physician medical staff have been tested, implemented in a general practice setting and, to some extent, funded by health insurance companies. Aim: How were changes in the spectrum of tasks performed by non-physician staff viewed and accepted by patients? Methods: Between October 2014 and January 2015, a written survey was conducted among chronically ill patients (≥ 65 years of age) receiving health care from health care assistants (HCA) with or without the additional "health care assistant in the family practice", or VERAH qualification. Using a self-developed survey, based on a previous collection of data, patients were asked about various aspects of health care provided by HCAs. Results: 77 practices participated and a total of 1 266 patients were surveyed. The patients said the HCAs had a role to play in many aspects of their health care. More than half the patients said HCAs could take responsibility for some of the home visits and contacts in the practice. Almost without exception, patients regarded the organisational, healthcare and other supporting services performed by the HCAs as very good. The results were more heterogeneous for specific consulting services. While consultations on vaccinations, preventive services, medical examinations and medication adherence were well accepted, this was much less often the case with advice on lifestyle. Many patients see HCAs as additional and competent persons they can trust, and could well imagine HCAs taking on responsibility for further delegable services. Conclusion: At least among GP-centered health care programme participants, many healthcare services delegated to HCAs were appreciated and accepted by patients. Home visits and case management, in the sense of structured individual health care for patients with special needs, are further services that may be well suited for delegation. This should be investigated in further studies (including qualitative studies).

20. **Career progression.**
Storey Karen Primary Health Care 2015;25(10):13-13.

The article discusses what the General Practice Education and Career Framework will offer general practice nurses (GPN) in Great Britain as of December 2015. Topics covered include the need for GPNs to be trained as mentors and to develop the capability of the primary

care workforce, and the existence of a pathway of progression from healthcare assistant (HCA) to advanced nurse practitioners. Also given is a chart on the GPN career framework which indicates level, role, and qualifications.

21. **Positioning Medical Assistants for a Greater Role in the Era of Health Reform.**
Chapman Susan A. Academic medicine : journal of the Association of American Medical Colleges 2015;90(10):1347-1352.

Medical assistants (MAs) are one of the fastest-growing occupations in the United States. As of 2014 there were about 585,000 MAs in the United States, and the Bureau of Labor Statistics projected the MA workforce to grow by 29% from 2012 to 2022. The MA population is primarily female, ethnically and racially diverse, and paid about $15.01 per hour. MAs are primarily educated in private schools, many at for-profit institutions. The MA curriculum and length of training can be quite varied and can lead to uneven preparation for practice. Traditionally, the MA role has involved a limited clinical role and little involvement with team care, particularly in larger practices or clinics. Medical groups, clinics, and health systems are now taking a new look at MAs and how they can play a greater role in reforming health care delivery models. Expanded roles for MAs might include health coach, referral coordinator, disease registry manager, and health screener using protocols. In expanding MA roles, education and regulatory issues need to be addressed by the provider community including current inconsistent regulation and certification requirements and the lack of preparation for expanded roles in traditional MA training programs. MAs are well positioned to help address challenges in the health care delivery system including improving access to care while reducing overall cost. Successful model practices using MAs in expanded roles need further formal evaluation and replication across practice settings.

22. **The Patient Liaison Officer in UK General Practice Co-ordinating Care for Housebound Patients.**
Tavabie Jacqueline A. Quality in Primary Care 2015;23(5):286-291.

Background: Workforce redesign is needed in general practice to recognise the health and social needs of an ageing population with complex co-morbidities. Developing new roles for existing receptionists is presented as one way to support clinicians in administration of complex care, reducing unplanned hospital admissions for housebound patients. Aim: To implement a patient liaison officer role in primary care through development of receptionist skills to support housebound patients in the community Design: A longitudinal retrospective cohort study, following 64 housebound patients over 2 years, before and after introducing a patent liaison officer. Setting: South London general practice with 7200 registered patients Method: Audit of unplanned hospital admissions; Accident

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23. **The place of receptionists in access to primary care: Challenges in the space between community and consultation.**
Neuwelt Pat M. Social Science & Medicine 2015;133:287-295.

At the point of entry to the health care system sit general practice receptionists (GPRs), a seldom studied employment group. The place of the receptionist involves both a location within the internal geography of the clinic and a position within the primary care team. Receptionists literally 'receive' those who phone or enter the clinic, and are a critical influence in their transformation from a 'person' to a 'patient'. This process occurs in a particular space: the 'waiting room'. We explore the waiting room and its dynamics in terms of 'acceptability', an under-examined aspect of access to primary care. We ask ' How do GPRs see their role with regard to patients with complex health and social needs, in light of the spatio - temporal constraints of their working environments?' We engaged receptionists as participants to explore perceptions of their roles and their workspaces, deriving narrative data from three focus groups involving 14 GPRs from 11 practices in the Northland region of New Zealand. The study employed an adapted form of grounded theory. Our findings indicate that GPRs are on the edge of the practice team, yet carry a complex role at the frontline, in the waiting space. They are de facto managers of this space; however, they have limited agency within general practice settings, due to the constraints imposed upon them by physical and organisational structures. The agency of GPRs is most evident in their ability to shape the social dynamics of the waiting space, and to frame the health care experience as positive for people whose usual experience is marginalisation. We conclude that, if well supported, receptionists have the potential to positively influence health care acceptability, and patients' access to care.

24. **A new model for nurse practitioner utilization in primary care : increased efficiency and implications.**
Liu Nan Health Care Management Review 2014;39(1):10-20.

BACKGROUND: Nurse practitioners (NPs) play an important role in providing quality primary care. However, little is known about organizational processes that best utilize NPs in care delivery and what kind of resources and support NPs need to deliver quality care within their organizations. In primary care settings, NPs often receive little support from ancillary personnel compared with physicians. PURPOSE: The aim of this article was to compare the productivity and cost efficiency of NP utilization models implemented in primary care sites with and without medical assistant (MA) support. METHODOLOGY/APPROACH: We develop queueing models for these NP utilization models, of which the parameters are extracted from literature or government reports. Appropriate analyses are conducted to generate formulas and values for the productivity and cost efficiency. Sensitivity analyses are conducted to investigate different scenarios and to verify the robustness of findings. FINDINGS: The productivity and cost efficiency of these models improve significantly if NPs have access to MA support in serving patients. On the basis of the model parameters we use, the average cost of serving a patient can be reduced by 9 per cent -12 per cent if MAs are hired to support NPs. Such improvements are robust across practice environments with different variability in provider service times. Improving provider service rate is a much more effective strategy to increase productivity compared with reducing the variability in provider service times. PRACTICE IMPLICATIONS: To contain costs and improve the utilization of NPs in primary care settings, MA assistance for NPs is necessary. [Abstract]

25. **Comparing the implementation of team approaches for improving diabetes care in community health centers**
Van der Wees PJ BMC health services research 2014;14:608.

BACKGROUND: Patient panel management and community-based care management may be viable strategies for community health centers to improve the quality of diabetes care for vulnerable patient populations. The objective of our study was to clarify implementation processes and experiences of integrating office-based medical assistant (MA) panel management and community health worker (CHW) community-based management into routine care for diabetic patients. METHODS: Mixed methods study with interviews and surveys of clinicians and staff participating in a study comparing the effectiveness of MA and CHW health coaching for improving diabetes care. Participants included 24 key informants in five role categories and 249 clinicians and staff survey respondents from 14 participating practices. We conducted thematic analyses of key informant interview transcripts to clarify implementation processes and describe barriers to integrating the new roles into practice. We surveyed clinicians and staff to assess differences in practice culture among intervention and control groups. We triangulated findings to identify concordant and disparate results across data sources. RESULTS: Implementation processes and experiences varied considerably among the practices implementing CHW and MA team-based approaches, resulting in differences in the organization of health coaching and self-management support activities. Importantly, CHW and MA responsibilities converged over time to focus on health coaching of diabetic patients. MA health coaches experienced difficulty in allocating dedicated time due to other MA responsibilities that often crowded out time for diabetic patient health coaching. Time constraints also limited the personal introduction of patients to health coaches by clinicians. Participants highlighted the importance of a supportive team climate and proactive leadership as important enablers for MAs and CHWs to implement their health coaching responsibilities and also promoted professional growth. CONCLUSION: Implementation of team-based strategies to improve diabetes care for vulnerable populations was diverse, however all practices converged in their foci on health coaching roles of CHWs and MAs. Our study suggests that a flexible approach to implementing health coaching is more important than fidelity to rigid models that do not allow for variable allocation of responsibilities across team members. Clinicians play an instrumental role in supporting health coaches to grow into their new patient care responsibilities.

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26. **Following the roadmaps towards national standards of competency.**
GALLOWAY MANDY Practice Nurse 2014;44(8):7-7.

The author comments on the competency framework (CF) for healthcare assistants (HCA) in general practice (GP) that was published by the Royal College of General Practitioners's GP Foundation in August 2014. Topics covered include the requirement for HCA to have a Certificate of Fundamental Care before they can provide care for patients, the main goal of the CF, and a plan by a sub-group of Health Education England to create a national education framework for GP nursing.

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27. **Improving health and well-being through community health champions : a thematic evaluation of a programme in Yorkshire and Humber.**
Woodall James. Perspectives in Public Health, 2013;133:-.

The contribution that lay people can make to the public health agenda is being increasingly recognised in research and policy literature. This paper examines the role of lay workers (referred to as 'community health champions') involved in community projects delivered by Altogether Better across Yorkshire and Humber. The aim of the paper is to describe key features of the community health champion approach and to examine the evidence that this type of intervention can have an impact on health. A qualitative approach was taken to the evaluation, with two strands to gathering evidence: interviews conducted with different stakeholder groups including project leads, key partners from community and statutory sectors and community workers, plus two participatory workshops to gather the views of community health champions. Seven projects (from a possible 12) were identified to be involved in the evaluation. Those projects that allowed the evaluation team to explore fully the champion role (training, infrastructure, etc.) and how that works in practice as a mechanism for empowerment were selected. In total, 29 semi-structured interviews were conducted with project staff and partners, and 30 champions, varying in terms of age, gender, ethnicity and disability, took part in the workshops. The results were, becoming a community health champion has health benefits such as increased self-esteem and confidence and improved well-being. For some champions, this was the start of a journey to other opportunities such as education or paid employment. There were many examples of the influence of champions extending to the wider community of family, friends and neighbours, including helping to support people to take part in community life. Champions recognised the value of connecting people through social networks, group activities, and linking people into services and the impact that that had on health and well-being. Project staff and partners also recognised that champions were promoting social cohesiveness and helping to integrate people into their community. The conclusions were, the recent public health White Paper suggested that the Altogether Better programme is improving individual and community health as well as increasing social capital, voluntary activity and wider civic participation. This evaluation supports this statement and suggests that the community health champion role can be a catalyst for change for both individuals and communities. Cites 24 references. [Journal abstract]

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28. **Making a new support role work for everyone.**
Griffin Richard Nursing Standard 2013;27(25):70-71.

Defining and designing an HCA [healthcare assistant] position is fraught with potential problems. Richard Griffin has seen the right and wrong ways. [Introduction]

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29. **Opportunity for progress.**
Carlisle Daloni. Nursing Standard, 2013;:-.

The Cavendish review into HCAs and support workers highlighted the contribution such staff make to patient care, and called for them to be supported with improved training, career opportunities and status. This article shows how some enlightened employers are leading the way in developing their HCA workforce. [Journal abstract]

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30. **The changing role of the healthcare assistant.**
Anon. Practice Nurse 2013;43(7):12-14.

The article looks at the changing role of healthcare assistants (HCAs) in Great Britain as of July 2013. There has been an increase in the number of HCAs since the introduction of the new General Practitioner (GP) contract in 2004. The increasing pressures and demand for extra staff in general practice is cited as the reason for the development of the HCA role.

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31. **The patient liaison officer: a new role in UK general practice.**
Tavabie Jacqueline A. Quality in Primary Care 2013;21(5):303-313.

BACKGROUND: The population health needs of an ageing population, with increasing demands and opportunities for intervention, mean that the National Health Service (NHS) in the United Kingdom (UK) faces inevitable change. Maintaining traditional boundaries and professional roles is placing an unmanageable burden on the NHS and its workforce. Redesigning roles and developing capacity for integrated working across traditional boundaries of primary and secondary may provide ways of sustaining the health service whilst involving patients and carers in a community care model. AIMS: This project explores development of a patient liaison officer (PLO) in general practice to support delivery of integrated community care for patients with complex health needs and long-term conditions. It seeks to improve communication and administrative functions between

different care providers, and incorporate patient and carer voices in care planning and delivery. It supports the UK national agenda for increasing care in the community and identifies learning needs for this new workforce. It provides career development opportunities for existing medical receptionists with potential to reduce administrative work for general practitioners (GPs). METHOD: A new role in general practice was developed through discussion and formal training based on identified key competencies of a liaison officer. Based in Bromley Clinical Commissioning Group (CCG) in South London, UK, 39 of 46 possible practices were involved. Outcome measures included: the development of a new role; the design and implementation of training and evaluation of the participant; and teacher and observer feedback, including post-training focus groups, using thematic analysis. RESULTS AND CONCLUSIONS: Positive uptake and feedback indicated significant potential for developing this role. Investment in implementation may facilitate the achievement of improvements in healthcare and new Quality and Outcomes Framework (QOF) targets through better co-ordinated care. Future evaluation will include patient surveys and measures of impact on avoidable hospitalisation for vulnerable patients, and GP feedback on whether time has been released for new clinical work through reduction in administration carried out by PLOs. [Abstract]

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32. **Using clerical staff to free up ward sister time.**
Mazengarb Sue Nursing Times 2013;109(29):12-13.

The head and neck unit at Nottingham University Hospitals Trust trialled the introduction of a ward administrator. This role takes on some of the ward sister's administrative and clerical tasks, enabling the sister to spend more time on the ward, be a visible leader to staff and patients, and monitor standards. This article outlines how the role was introduced and the key outcome measures used to evaluate its impact on patient and staff satisfaction, complaint reduction and nursing metrics. [Abstract]

33. **Getting the skill mix right in general practice is crucial.**
Bishop Tina Practice Nurse 2012;42(19):5-5.

In this article the author discusses the important role played by health care assistants (HCAs) in general practice. She cites an article on the changing role of registered nurses in general practice. She mentions the positive effect of registered nurses on patient outcomes as noted by the Willis Commission of nurse education. The author also emphasizes the need to get the notion of skill mix right in general practice.

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34. **The developing role of the HCA in general practice.**
Hand Tanis Practice Nurse 2012;42(19):14-17.

The article reports on the evolving role of the health care assistant (HCA) in the general practice setting in Great Britain. It presents a background of the consequences of the evolving role of the practice nurse (PN) and the development of advanced nursing practice. The article also cites ways in which practices can maximise the role of the HCA, which include defining role boundaries and protocols and the provision of training and education.

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35. **Healthcare assistants in general practice : a qualitative study of their experiences.**
Vail Laura Primary Health Care Research and Development 2011;12(1):29-41.

The emergence of healthcare assistants (HCAs) in general practice raises questions about roles and responsibilities, patients' acceptance, cost-effectiveness, patient safety and delegation, training and competence, workforce development, and professional identity. There has been minimal research into the role of HCAs and their experiences, as well as those of other staff working with HCAs in general practice. Lessons may be learned from their role and evidence of their effectiveness in hospital settings. Such research highlights blurred and contested role boundaries and threats to professional identity, which have implications for teamwork, quality of patient care, and patient safety. In this paper it is argued that transferability of evidence from hospital settings to the context of general practice cannot be assumed. Drawing on the limited research in general practice, the challenges and benefits of developing the HCA role in general practice are discussed. It is suggested that in the context of changing skill-mix models, viewing roles as fluid and dynamic is more helpful and reflective of individuals' experiences than endeavouring to impose fixed role boundaries. It is concluded that HCAs can make an increasingly useful contribution to the skill mix in general practice, but that more research and evaluation are needed to inform their training and development within the general practice team. [Abstract]

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36. **Interprofessional care teams : the role of the healthcare administrator.**
Begun James W. Journal of Interprofessional Care 2011;25(2):119-123.

As the delivery of healthcare services increasingly emphasizes interprofessional activity, one major occupation, healthcare administration, is conspicuously absent from the discussion. This situation reflects the structure of healthcare delivery organizations as professional bureaucracies, with clinical professionals practicing with relative autonomy and with administrators viewed as quasi- or semi-professionals. Not only is this a missed opportunity for administrators, but it seriously weakens the potential for change and improvement promised by interprofessional practice. In this article, we argue that healthcare administrators are important to the success of interprofessional care because they often are in a strong position to champion and implement the system-wide cultural and structural conditions for successful interprofessional care. We also note that changes are needed in the role expectations and education of healthcare administrators to increase the familiarity

and comfort of administrators with clinical care and to help them more effectively influence the organizational conditions for collaborative interprofessional exchange. Changes in the expectations and education of clinical professionals also will help accomplish the goal of greater "complementarity" between administrators and clinical healthcare professionals. Such changes are consistent with larger societal forces that are increasing professionalism among administrators and creating more accountability from both administrators and clinical professionals for the quality, cost, and collaboration of services. [Abstract]

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37. **Receptionist input to quality and safety in repeat prescribing in UK general practice : ethnographic case study.**
Swinglehurst Deborah BMJ 2011;343(7831):983-.

OBJECTIVE: To describe, explore, and compare organisational routines for repeat prescribing in general practice to identify contributors and barriers to safety and quality. DESIGN: Ethnographic case study. SETTING: Four urban UK general practices with diverse organisational characteristics using electronic patient records that supported semi-automation of repeat prescribing. PARTICIPANTS: 395 hours of ethnographic observation of staff (25 doctors, 16 nurses, 4 healthcare assistants, 6 managers, and 56 reception or administrative staff), and 28 documents and other artefacts relating to repeat prescribing locally and nationally. MAIN OUTCOME MEASURES: Potential threats to patient safety and characteristics of good practice. METHODS: Observation of how doctors, receptionists, and other administrative staff contributed to, and collaborated on, the repeat prescribing routine. Analysis included mapping prescribing routines, building a rich description of organisational practices, and drawing these together through narrative synthesis. This was informed by a sociological model of how organisational routines shape and are shaped by information and communications technologies. RESULTS: Repeat prescribing was a complex, technology-supported social practice requiring collaboration between clinical and administrative staff, with important implications for patient safety. More than half of requests for repeat prescriptions were classed as "exceptions" by receptionists (most commonly because the drug, dose, or timing differed from what was on the electronic repeat list). They managed these exceptions by making situated judgments that enabled them (sometimes but not always) to bridge the gap between the idealised assumptions about tasks, roles, and interactions that were built into the electronic patient record and formal protocols, and the actual repeat prescribing routine as it played out in practice. This work was creative and demanded both explicit and tacit knowledge. Clinicians were often unaware of this input and it did not feature in policy documents or previous research. Yet it was sometimes critical to getting the job done and contributed in subtle ways to safeguarding patients. CONCLUSION: Receptionists and administrative staff make important "hidden" contributions to quality and safety in repeat prescribing in general practice, regarding themselves accountable to patients for these contributions. Studying technology-supported work routines that seem mundane, standardised, and automated, but which in reality require a high degree of local tailoring and judgment from frontline staff, opens up a new agenda for the study of patient safety. [Abstract]

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38. **Benefits and challenges of employing health care assistants in general practice: a qualitative study of GPs' and practice nurses' perspectives**
Petrova Mila. Family Practice 2010;27(3):-.

Estimates suggest that over half of general practices in England currently employ a healthcare assistant (HCA) but there is little evidence of their impact, effectiveness and acceptability to patients and primary care team members. The objectives of the study were to explore the role of HCAs in general practice and the benefits and challenges associated with their employment. Semi-structured interviews were performed with six GPs and 13 practice nurses as part of a larger qualitative study that also included HCAs. Interviewees were from 16 general practices from two Primary Care Trusts in the West Midlands. Transcripts were analysed using thematic and framework analysis. HCAs were seen as a valuable addition to the primary care team. They were reported to accelerate, rather than extend services, allow more appropriate use of nurses' skills and enable cost containment. Their training and supervision were felt as time intensive, demanding of time and commitment. Patient safety was raised as a concern, although no specific experience of it being compromised was reported. Nurses recognised the usefulness of HCAs, helped to make the role work, but were often anxious about the impact on their own roles and professional identity. Patients were perceived as being generally neutral or positive. The conclusion was, cost-effectiveness, patient safety, quality of care, potentially contested role boundaries and patient attitudes are among the issues that policymakers, commissioners and those responsible for workforce development and training need to consider in relation to HCAs in general practice. There is also a need for more in-depth evaluation of this role. Cites 33 references. [Journal abstract]

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39. **Front desk talk : discourse analysis of receptionist-patient interaction.**
Hewitt Heather British Journal of General Practice 2009;59(565):571-577.

BACKGROUND: GP receptionists are the first point of contact with the NHS for most patients and have an important role in facilitating access to healthcare services. There is evidence that they are often perceived as impersonal, insensitive, or officious. AIM: To analyse the communicative styles of GP receptionists when dealing with patients. DESIGN OF STUDY: Ethnographically situated discourse analysis of audio recordings. SETTING: Three NHS GP surgeries in Scotland. METHOD: Fine-grained transcription and stage-by-stage analysis of digital audio recordings of 283 encounters between receptionists and patients engaged in front desk business. Participants were 16 receptionists and 283 patients. RESULTS: Interaction between receptionists and patients consists mainly of verbal routines that are shaped by the administrative tasks completed through them. Receptionists adhere to these established patterns of use at all times, even when dealing with non-routine situations. Within the routine framework, receptionists communicate with patients using styles that display three dominant approaches: task centred, conventionally polite, and rapport building. Receptionists who adopt a task-centred approach use forms with minimal interpersonal content, while those who use conventionally polite forms or those associated

with rapport building, give attention to establishing positive relationships with patients. There is no evidence that any stylistic approach is more efficient than another. There is, however, evidence that excessive adherence to routine verbal behaviour has an adverse impact on problem solving. CONCLUSION: Most receptionist discourse consists of the repetition of established verbal routines. Receptionists adopt verbal styles that are predominantly task centred, conventionally polite, or rapport building. Although all three styles enable the completion of reception work with similar levels of efficiency, task-centred styles may appear over-direct. The use of a routine approach when dealing with problematic situations can inhibit and delay their resolution. 4 tables 24 refs. [Abstract]

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40. **The role of the health-care assistant in general practice.**
Brant C. British Journal of Nursing 2009;18(15):926-933.

The role of the health-care assistant (HCA) has developed rapidly in general practice and has occurred on an ad hoc basis across the UK, with the precise role shaped by the requirements and culture of individual practices. Currently, there is no regulation of HCAs and little published material about the remit of the role. This study aimed to describe general practice colleagues' perceptions of the HCA role; identify key areas of inter-professional agreement and disagreement about the role; and describe the likely impact of these on the direction and development of HCAs. The study used a multiple-method qualitative study, using focus groups and semi-structured interviews and was set in general practices across one primary care trust. It featured uni-professional focus groups of practice nurses, HCAs and practice managers and interviews with GPs and practice managers. Transcribed material was analysed using constant comparison to derive robust themes. Participants focused on issues surrounding communication and teamwork and the fact that the individual nature of practices will affect the development of the HCA role. Questions regarding the development and structure of the HCA role were also broadly debated. The study concluded that the development of the HCA role in general practice is variable and the success of the role within a practice depends on good preparation for its future direction as well as the broad inclusion of team members in discussion and decision-making about the role.

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41. **Healthcare assistants in general practice : practical and conceptual issues of skill-mix change.**
Bosley Sara British Journal of General Practice 2008;58(547):118-124.

The emergence of healthcare assistants [HCAs] in general practice raises questions about roles and responsibilities, patients' acceptance, cost-effectiveness, patient safety and delegation, training and competence, workforce development, and professional identity. There has been minimal research into the role of HCAs and their experiences, as well as those of other staff working with HCAs in general practice. Lessons may be learned from their role and evidence of their effectiveness in hospital settings. Such research highlights blurred and contested role boundaries and threats to professional identity, which have implications for teamwork, quality of patient care, and patient safety. In this paper it is argued that transferability of evidence from hospital settings to the context of general practice cannot be assumed. Drawing on the limited research in general practice, the challenges and benefits of developing the HCA role in general practice are discussed. It is suggested that in the context of changing skill-mix models, viewing roles as fluid and dynamic is more helpful and reflective of individuals' experiences than endeavouring to impose fixed role boundaries. It is concluded that HCAs can make an increasingly useful contribution to the skill mix in general practice, but that more research and evaluation are needed to inform their training and development within the general practice team. 66 refs. [Abstract]

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42. **Pulling together in general practice.**
Carlisle D. Nursing Times 2007;103(45):20-21.

Nurse practitioners and HCAs have been central to a radical new model of care, discovers Daloni Carlisle.

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43. **Reviewing the roles of nurses and health care assistants in general practice.**
Vaughan P. Primary Health Care 2007;17(7):14-16.

Paul Vaughan and colleagues describe the outcomes of a rapid review of general practice nurse and healthcare assistant roles in primary care.

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44. **Skill mix evolution: HCAs in general practice.**
Andrews H. Practice Nursing 2007;18(12):619-624.

The role of the nurse's aide has been important since the inception of the NHS in 1948. Under the title of health care assistant (HCA), this role has grown in general practice since the 1990s, contributing to the skill mix of the general practice team. However, data on the number of HCAs working in general practice is difficult to obtain. A telephone survey was undertaken to estimate how many HCAs are working in general practice in England. The sample comprised 922 practices (11.1% of the total). It was found that 55% of practices employed one or more HCA.

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Strategy

1	HMIC	("care navigat*" OR "link worker*" OR Co-ordinator* OR "patient liaison").ti,ab	472
2	HMIC	(community OR patient OR nurse OR outreach OR health).ti,ab	177267
3	HMIC	(navigat*).ti,ab	217
4	HMIC	(workforce).ti,ab	4422
5	HMIC	(develop*).ti,ab	61013
6	HMIC	(impact).ti,ab	19477
7	HMIC	(signpost*).ti,ab	208

8	HMIC	(receptionist OR administrator OR "general practice nurse" OR "patient liaison officer" OR "health champion" OR "health care assistant" OR HCA OR "medical assistant").ti,ab	338
9	HMIC	("general practice").ti,ab	7976
10	HMIC	("primary care").ti,ab	16929
11	HMIC	(3 OR 4 OR 5 OR 6 OR 7)	78262
12	HMIC	("clinical personal assistant").ti,ab	0
13	HMIC	("personal assistant").ti,ab	14
14	HMIC	(1 OR 2 OR 8 OR 13)	177518
15	HMIC	(9 OR 10)	22642
16	HMIC	(14 AND 15)	15237
17	HMIC	(role OR responsibil* OR position).ti,ab	36095
18	HMIC	(16 AND 17)	3046
19	HMIC	(11 AND 18)	1500
20	HMIC	(9 AND 14)	4995
21	HBE	(receptionist OR administrator OR "general practice nurse" OR "patient liaison officer" OR "health champion" OR "health care assistant" OR HCA OR "medical assistant").ti,ab	13204
22	HBE	("general practice").ti,ab	5057
23	HBE	(21 AND 22)	72
24	Medline	(receptionist OR administrator OR "general practice nurse" OR "patient liaison officer" OR "health champion" OR "health care assistant" OR HCA OR "medical assistant").ti,ab	7908
25	Medline	("general practice").ti,ab	32198

26	Medline	(24 AND 25)	88
27	CINAHL	(receptionist OR administrator OR "general practice nurse" OR "patient liaison officer" OR "health champion" OR "health care assistant" OR HCA OR "medical assistant").ti,ab	7894
28	CINAHL	("general practice").ti,ab	6037
29	CINAHL	(27 AND 28)	97

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