

Clinical governance in action

The patient liaison officer: a new role in UK general practice

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ABSTRACT

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.

Keywords: care plans, communication, general practice, integration, primary care, role changes

How this fits in with quality in primary care

What do we know?

The increasing health needs of an ageing population with co-morbidity and multiple long-term conditions can no longer be managed by a traditional model of hospital and institutional-based care, particularly in times of financial constraint. Community based care offers opportunities for greater patient involvement as well as more cost-effective care, but requires effective communication and collaboration between different care providers to ensure a truly integrated service for patients. In the UK, general practitioners (GPs) have traditionally held the role of co-ordinators of care but with increasing roles in clinical management their administrative role requires review.

What does this paper add?

This project demonstrates how developing the skills of medical receptionists as patient liaison officers (PLOs) might improve opportunities for integrated care and effective communication between patients and different care providers whilst reducing the administrative burden of care for GPs. Receptionists demonstrated willingness to take on this new role to support patients and carers, with identified potential to reduce GP administrative time, thereby increasing clinical capacity and improving the patient experience.

Introduction

UK primary care, based in general practice in particular, is facing the most extensive change since the inception of the National Health Service (NHS) in 1948. Population needs have changed, from those predominantly associated with poverty, poor housing and infection, to those related to increasing age (contributed to by medical advances), with complex co-morbidities, and illness related to lifestyle, leading to obesity, heart disease, diabetes and smoking-related disorders.^{1,2} Hospital-led and doctor-focused care no longer has the capacity to meet these increasing needs. A new, integrated approach is required to enable people to live within their communities, sustained by a healthcare workforce that works effectively together, respecting the views of patients and carers to deliver personalised care.³

Within general practice, co-ordination of care has traditionally been a core role of general medical practitioners (GPs), but with the shift of services from hospitals to primary care, there has been an expansion of general practice teams and other community providers to support people living in the community with long-term illness and disability. Effective communication between providers of different aspects of care has become more difficult to achieve, but is vital for successful outcomes. Literature searches through the MEDLINE, Ovid, King's Fund and Cochrane databases identify a number of studies in which integrated care with good co-ordination can help avoid unnecessary hospital admissions and improve the wellbeing of vulnerable patients, but little has been published on developing non-professionals in general practice to undertake the administrative function in this process.⁴⁻⁶ With GPs and the extended primary care workforce expected to provide a greater range of services, the role of co-ordinator of care needs revisiting. This project explores the separation of roles in provision of care and overall responsibility, the remit of the GP and other clinicians, from co-ordination of care, which requires excellent communication skills but is primarily an administrative role that could be developed as a patient liaison officer (PLO).

The *Oxford English Dictionary* defines a liaison officer as 'a person employed to form a working

relationship between two organisations to their mutual benefit'.⁷ Their role is to ensure the best utilisation of resources or services in one organisation from the viewpoint of another. In many areas, social services, community services and general practice have grown apart since the inception of the NHS, whereas the integration of services requires that they work together to develop understanding and unity of effort to achieve 'mutual benefit' and improved care for patients.

The PLO is not unknown in the NHS. In the Patient Advice and Liaison Service (PALS) they work for patients to provide advice and help resolve complaints. Although this role is without formal training, individuals are selected, using job profiles and user feedback, for their skills in customer care, good local knowledge, team-working, IT skills and ability to listen.^{8,9}

This project develops the role of the PLO in general practice, using medical receptionists, but with specific differences from the PALS officer. Instead of patients seeking PLOs when they have problems, the PLO aims to support vulnerable patients in anticipation of their needs, aiming to prevent problems, avoidable hospital admissions and poor communication. Medical receptionists have no mandatory training in UK general practice, generally learning through experience, with training delivered internally or externally as deemed appropriate by individual employing practices. Competencies are variable and therefore a formal training programme and job description have been developed for the PLO role, using the job profiles of PALS as a base for desired competences (Box 1).

Our aim was to support patients with complex care needs and long-term conditions, their carers and clin-

Box 1 Desired attributes of a patient liaison officer

- Experience in liaising with patients, staff and support groups
- Customer care skills
- Good local knowledge
- Good team-working skills
- Good IT skills
- Ability to listen as well as give information

icians in achieving optimal, integrated care through the development of the PLO role.

Background

The development of care plans for patients with multiple and complex long-term conditions was piloted in the clinical commissioning group (CCG) area for a year before this project. Feedback from practices showed that GPs and practice managers recognised the benefits of co-ordinated care. Progress was limited by the time needed to establish appropriate communication channels and ensure patient and carer engagement. Identifying the potential to develop existing receptionist skills to relieve clinical time pressures, one practice piloted the concept of the PLO, using supported receptionists to act on and monitor care plans. This role was enthusiastically developed by receptionists and well received by patients and carers. GPs were more willing to develop and review care plans, confident that they would be implemented and followed by PLOs.

Objectives

- To develop a job description for PLOs in general practice that focused on the co-ordination of care plans and support for patients and carers.
- To design and implement a training programme addressing core competencies, working with academic and commercial organisations with experience in competency areas.
- To evaluate outcomes from the provider and participant perspectives.

Method

Key competencies for the PLO role were identified from the PALS description of desired attributes (Box 1).⁸ These were applied to potential roles within general practice and a job description was developed through discussion with local practice nurse and practice manager forums (Appendix A). This was shared with university educationalists and commercial providers who developed educational programmes to meet the requirements of the job description. Receptionists were recruited from local general practices, with all practices guaranteed a place. Remaining places were offered to second applicants from local practices and neighbouring CCG practices. Practices received a contribution towards backfill costs to encourage participation. The programme was delivered as a series of half-day workshops over four months in the locality. It was evaluated using narrative thematic analysis,

cross-checking what was said by participants to identify underlying meaning using feedback from participants, teacher and observers, and through two semi-structured focus groups with participants three months after completing training.¹⁰ An observer was present at each workshop to co-ordinate and monitor the process. Written consent was obtained from participants for their comments to be used in evaluation. Each focus group comprised eight participants available on specified dates, with a minimum of four participants who had completed all seven workshops. Focus groups were tape-recorded and transcribed verbatim and analysed by the authors separately, before discussion and assimilation of findings.

Design

Seven workshops were designed for up to 75 receptionists, with group size determined by the teaching methods and the intimacy of the anticipated discussion. Participants were encouraged to share their experiences through the use of scenarios. Planned group size varied from eight to 75 with the smallest catering for individual use of an electronic risk stratification tool and the largest enabling participants to meet and interact with local community providers. The content of the seven workshops is described in Table 1.

Training was designed for participants to complete all seven workshops. However, each workshop could be delivered as a stand-alone topic and this enabled practices, where necessary, to send different staff to workshops, with a comprehensive portfolio of learning material building as a practice resource. The commitment from practices was to ensure that all workshops were attended by at least one member of staff with others utilising learning material provided, in order for practices collectively to develop competencies of the PLO.

Outcomes

Attendance

Thirty-nine of a possible 46 practices within the CCG took part (86%), with an additional ten practices from outside the CCG area participating. Eighty-eight participants attended, with 39 completing a minimum of six workshops (44.3%) and 26 completing all seven workshops (30%). Eighty-five percent of the total 503 available places at workshops were booked, with 358 confirmed attendances (71%). Sickness and bad weather were the main reasons for non-attendance.

Evaluation

Feedback was taken from participants, teachers and observers after workshops using standard forms

Table 1 Patient liaison officer workshops

Workshop title	Content
1. Communication skills	Communication techniques (verbal, non-verbal, written) Factors that impact on effective communication Self-awareness Setting boundaries Dealing with challenging situations Key principles of record keeping
2. Local resources and contacts/integrated care	Background to the NHS and social care changes Presentation from local service providers on available services Question and answer session Log book for contacts
3. Co-ordinating case conferences	Identification of vulnerable patients (discussion with colleagues; use of risk stratification tools) Practicalities of organising meetings Alternatives to traditional meetings (e.g. tele-conferencing) Time management Components of case conferences and use of care plans
4. Minute taking and reports	Note-taking and summarising Listening and seeking clarification Clarity of purpose Structure and accuracy of reports Confidentiality and discretion Analysing information and detailing recommendations
5. Running carers meetings	Chairmanship Dealing with personality differences in groups Motivation of participants Principles of feedback and referral Identifying group needs Engaging external resources
6. Customer care and information governance	Confidentiality Prioritising needs Record keeping Understanding boundaries and when to seek help
7. Utilising risk analysis and reporting software	Practical introduction to the use of risk analysis software How to monitor patients using risk stratification tools and care plans How to collate information for review by clinicians

(Appendices B–D). Main themes in the analysis of learning were:

- listening skills – to listen more and speak less, giving more time to vulnerable patients such as the deaf and elderly
- personal awareness – awareness of self in communication, including non-verbal communication and tone of voice
- clarity of purpose – awareness of the purpose of meetings and communication; who needs to be

involved, and how to ensure correct information is passed on effectively

- record keeping – clear records accessible when needed but maintaining appropriate confidentiality
- consistency – a consistent and dependable approach to managing patient care, with clear boundaries and lines of accountability and
- identification of patients at risk – through the use of a risk stratification tool and discussion with clinicians.

The main concern from participants was their uncertainty about how their new skills could be implemented in general practices. Most recognised this as a new role, with the need for additional resources and regular review of their work with GPs in managing care plans and liaising with patients and other agencies.

Feedback from CCG observers and teachers noted enthusiasm for the style of learning and content, and participant willingness to share experiences and engage with the course material.

The single workshop, involving community providers and all participants, was delivered in a lecture format, with question and answer sessions. It was felt to be valuable for information sharing but had insufficient time for interaction. Speakers were enthusiastic about the development of a PLO role in general practice and were keen to engage with participants to establish clear communication channels for the integrated care of patients.

Two focus groups were held with a CCG manager acting as investigator on both occasions. A semi-structured format (Appendix E) enabled each group to address similar issues.

Focus group evaluation

Five themes emerged in the analysis, as detailed below.

Uncertainty about the PLO role and its integration into current practice

Uncertainty included personal job security in a previously untested role: 'is it real – are they going to pull the funding and you are going to end up losing working hours?'; 'has the PLO got the clout to get, you know, to get things moving?'; and about how practices would develop the role: 'so it's like new skills and how you put it into action?'; 'it will be down to the surgeries giving us more time?'; 'everybody I came across was very enthusiastic about the role but was mindful of the constraints'.

Benefits of the PLO to practices and health services

Participants could see benefits for practices: 'They (the doctors) are going to do less administration and less chasing'; 'trying to find vulnerable patients or patients who need care will save so much money for all the surgeries in the future'; 'patients who want telephone consultations with the doctor and that is possibly something that the PLO will be able to do, leaving the slot free for the doctor to do something else'. They also saw benefits for the health service in better communication: 'you have the direct contact and you don't have to go round the houses you know to get to the appropriate person for the patient'; 'we will be able to strengthen the communication for all staff'.

Benefits for patients and carers

Developing effective relationships with vulnerable patients was highlighted: 'if you know them better, then it is easier to approach them and I think that is good and really important'; 'that they (PLO) would have a name and can I speak to her again as she knows what is happening'; 'maybe the patient will feel a bit more special as they have someone that they can go back to at the doctors' rather than just anyone who picks up the phone and takes a message'. Practical suggestions emerged including: 'a PLO website would be useful and you can have information on there'; 'an awful lot of elderly patients miss appointments because they have forgotten them – a quick call to some of those patients will save the doctors and hospitals a lot of money'.

Importance of GP support

Participants recognised their need for support with access to GPs to share information and concerns, and questioned willingness of GPs to accept a new role in their practices. They recognised GPs' increasing workload, which they felt was causing exhaustion and preventing doctors from looking at new ways of working. They felt practice managers might understand and help implement the role better: 'I don't think they (GPs) realise the content of this – they see their appointment systems full up, they see their patients and they go home exhausted at the end of the day'; 'the GPs didn't understand what it was about, why I was going'; 'I am not sure the doctors have got it – the practice managers have got it'; 'the doctors need to take the role seriously and really back it up and support whoever is the PLO and give them their support or it wouldn't work at all'.

Personal development

Participants felt they had learnt from training and were enthusiastic to develop the PLO role: 'it has certainly opened my eyes that I can do more than

just answer the phone'; 'before I forget it I want to use it'; 'so it's like new skills and how you put it into action'. They wanted a chance to improve quality of patients' lives: 'it's just looking at one individual and thinking can I make a difference? You are not going to change it all but if you can manage to change one person's life it's good'; 'it's about teamwork and creating a team that shares and helps'.

Discussion

This project ran over a short time following successful bidding for funding, with little time to embed the concepts of the new role before its development. More time would have enabled greater engagement with patients, and patient participation groups, but this will be addressed in feedback sought as the role is implemented and modified accordingly. Despite this, uptake and feedback were positive, with requests already received from general practices for further courses. Although initially sceptical, GPs are now seeing potential benefits of a PLO to support new QOF targets which require greater focus on community management of complex care and long-term conditions, such as support of carers and development of care plans for vulnerable patients. The CCG has supported development of the role through offering practices incentives for activities suited to PLO functions.

Future training will incorporate feedback suggesting more time with other care provider organisations in Workshop 2 (Table 1). Locally based and appropriately timed training proved important positive factors, which was predicted, considering likely family commitments of participants. The enthusiasm of the participants was evident in feedback, and may reflect an acknowledgement of the need for training and recognition of their value in the health service. Participants demonstrated, through discussion, significant skills and understanding of communication, and an ability to reflect on learning whilst also generating ideas for improvements at their practices, including the use of emails for patient contacts and the sharing of care plans with PLOs, as well as reminding patients with poor memory of appointments made. There was overwhelming support for the NHS and a willingness to work within financial constraints to improve patient services.

PALS job profiles proved useful in identifying common attributes in working effectively with patients, and although the roles are different, this provided the starting point for discussions to develop the medical receptionist as a co-ordinator of care. It will be important that, as the role develops, PLOs are seen

as facilitators of care and communication, and not as barriers to access to clinicians. Importantly, participants recognised their non-clinical role and the need to work under clinical supervision with clear boundaries and lines of accountability, with responsibility for confidentiality and record keeping.

The limitations of this project relate largely to the speed with which the project was implemented and the possibility that only enthusiastic practices and receptionists participated. However, a high proportion of practices took part, and several who did not have shown interest in future courses. Funding for the new role was highlighted as a constraint in its development, but, given changing receptionist roles, with increasing automation of traditional activities, the PLO offers reception staff the opportunity for development, with additional funding requirements met through incentive schemes, and achievement of health targets and outcomes for patients.

This project has yet to be evaluated with patients and carers, but preliminary feedback suggests that patients and carers like a named contact and welcome greater involvement in their care through regular contact with their practice PLO. Participants identified how they felt patient care could improve through their input, and this will be evaluated in 2014, together with patient, carer and general practice feedback.

Conclusion

The PLO role is being developed in practices supported by local incentives to develop and manage care plans for vulnerable patients at risk of hospital admission and at risk of falls, together with the identification and support of carers. Future training programmes will incorporate feedback from PLOs in practice and a PLO discussion forum will be established to enable continued development and evaluation of the role and its impact on patient care. The intention is to realise increased clinical capacity in practices through sharing administrative roles of complex patient care with PLOs; to improve communication between care provider agencies, including general practice, and to enable the patient's voice to be heard in the process of delivering healthcare. In the broadest sense, as stated by one participant, 'it's about teamwork and creating a team that shares and helps'.

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ETHICAL APPROVAL

Ethics committee approval was not sought as this is service design project rather than a research project. Written consent was obtained from all participants for use of their comments in evaluation and focus groups. Tape-recordings and transcriptions from focus groups were destroyed after six months.

PEER REVIEW

Not commissioned; externally peer reviewed.

CONFLICTS OF INTEREST

None.

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Appendix A

Job description

Job Title:

Patient Liaison Officer

Base:

General Practice

Responsible to:

Practice Manager

Practice Partners

Summary of role

1. To facilitate communication between the practice, patients/carers and external agencies.
2. To co-ordinate agreed health interventions by the practice, patients and external agencies.
3. To support the practice in achieving effective care for vulnerable and housebound patients.
4. To keep accurate records for the practice to know how it is performing in relation to supporting vulnerable patients in the community.

Main responsibilities

1. To support the practice in identifying at-risk patients, through the use of electronic risk tools.
2. To maintain a register of vulnerable/at-risk patients for whom care plans are developed by the practice.
3. To regularly review care plans and ensure that action points are progressed.
4. Under the direction of the practice, to set up and co-ordinate reviews for vulnerable patients, to include: case conferences, one-to-one meetings, telephone/electronic/written contact, according to patient needs.
5. To keep accurate records of all encounters/meetings undertaken related to vulnerable patients.
6. To liaise with doctors/nurses/practice manager to clarify action plans and report back on progress.
7. To work with the practice to identify carer needs, to set up and co-ordinate a carer's group in the practice and to collate feedback to inform future meetings.
8. To maintain regular contact with identified at-risk/vulnerable patients, and their carers, to monitor progress within their care plans.
9. To communicate any concerns directly to the responsible doctor or practice manager.
10. To support the practice in producing reports on work relating to vulnerable patients and integrated care.
11. To identify and maintain accurate details of commonly used community support services, and to liaise as instructed with these agencies to facilitate timely and appropriate health and social care for vulnerable patients.
12. To work with patients and their carers to ensure that they have access to information and advice, whether through direct discussion or provision of literature, website addresses, etc.
13. To convey messages between patients, their carers and professionals accurately, promptly and to make clear records of all contacts made.
14. To maintain confidentiality for all patient/carers information outside the remit of professional contacts.

Person specification

Qualifications

GCSE pass level or equivalent in English.

Evidence of ongoing personal learning and appraisal.

Experience

Experience of working in general practice.

Knowledge

Good understanding of confidentiality issues in general practice and associated information governance (IG).

Good knowledge of local service resources and contact details.

Knowledge of health and safety rules and processes in the practice.

Skills

Good organisational skills.

Good team-working skills.

Good oral communication skills, including tact and listening skills.

Ability to use the practice computer system.

Ability to access information and record information electronically.

Appendix B**Patient liaison officer training programme*****Participant evaluation form***

Your Name

Date of workshop

Title of Workshop

GP Practice

PLEASE NOTE RECEIPT OF THIS COMPLETED FORM WILL ENABLE A CERTIFICATE OF ATTENDANCE TO BE GENERATED WHICH WILL BE SENT TO YOUR PRACTICE

A = Strongly agree; B = Agree; C = Disagree; D = Strongly disagree; E = Not applicable

Please circle your answer, where required.

The day was generally well organised.

A B C D E

Comments:

The structure was well thought out.

A B C D E

Comments:

The teaching was innovative and thought-provoking.

A B C D E

Comments:

The teaching was clear and concise.

A B C D E

Comments:

The teaching methods encouraged participation.

A B C D E

Comments:

The teaching sessions were at an appropriate level that I understood.

A B C D E

Comments:

I feel able to apply all of the teaching to practice.

A B C D E

Comments:

The lecturer was helpful, listened to and responded to any questions.

A B C D E

Comments:

The teaching environment was appropriate and conducive to learning.

A B C D E

Comments

My personal expectations of the day have been met.

A B C D E

Comments:

How relevant was this study day in enabling you to do your job better?

Highly relevant Relevant Limited relevance Not relevant

What were two key learning points for you in the workshop?

SHOULD YOU HAVE ANY ADDITIONAL COMMENTS, PLEASE ENTER THEM HERE:

Thank you. Please hand this form to the co-ordinator before you leave.

Appendix C

Patient liaison officer training programme

Clinical commissioning co-ordinator/observer – evaluation report

Workshop title:

Date:

Name of supporter:

Reflect on:

Engagement of participants

Any areas not covered from objectives

Any other issues raised

Style of session – did it work? (Why/why not?)

Timing/venue – did it work? (Why/why not?)

Appendix D

Patient liaison officer training programme

Presenter – feedback report

Workshop title:

Name of presenter:

Date:

Excellent (√)	Satisfactory (√)	Poor (√)	Comments
Venue			
Facilities			
Participation of attendees			
How well did the attendees understand the workshop			
Perceived relevance of information to attendees			
How well did the length of the workshop match the intended learning			
Other comments			

Appendix E

Framework for PLO focus group meetings

- What did you feel were the best parts of the course? Why was this?
- What parts would you change in future and why?
- What skills have you been able to use in your current roles?
- What have you been able to share in your practice and with colleagues?
- How would you like your role to develop in the future?
- What would help you develop your role?
- What would hold you back from developing your role?
- What further development needs do you have?