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Viewpoint

IS CHANGE IN GENERAL PRACTICE GOOD?

Like many GPs I dread the psychiatric consultation that requires an immediate specialist assessment. The referral is disputed by suggesting the patient is not in their catchment area. Once this hurdle is overcome the next obstruction arrives like a bullet as inevitably the patient is aged 17 years or less, or 60 years or more and that falls in the remit of 'the other service'. A phone call to that 'other service' says 'No, no, the service you just rang has informed you incorrectly'. Eventually, after a reluctant agreement that the patient needs to be seen, now exasperated, you are then asked, 'Can it wait until tomorrow?'.

Access to acute NHS services is indeed complex. There is an urgent need for change, but should more services currently based in secondary care, now be run from primary care? In the case of psychiatry, should waiting times for patients with severe depression be reduced together with increasing access to the much hailed, but difficult to get, CBT? Health service change can be good, and practice-based commissioning (PBC) and empowering primary care organisations also have positive points in achieving this aim of improved access, despite some GPs' frequent criticism.

For years there have been, and still are, certain hospital departments that are recurrently reluctant to see patients quickly. One of our many roles as GPs is as patient advocates, and we try to expedite an investigation or treatment, but it is a stressful area as hospital department doors are often closed to our requests.

Consider the scenario where a person injures their knee, has pain and swelling, and cannot work. An avenue for referral is the hospital fracture clinic as routine orthopaedic appointments are lengthy. However, you quickly ascertain that a definite date cannot be allocated and they request you send the person to A&E. It was a revelation to me that our new PBC-initiated local intermediate orthopaedic triage clinic could see a patient, initiate physiotherapy, and obtain an MRI, all in a few days. This can be accessed as the choice of priority through the often maligned enhanced service 'Choose and Book' and is, therefore, the best option.

Through PBC diagnostic and treatment centres can be set up independent of hospitals. Perhaps this is a good thing. Why is it that when you need an urgent radiological investigation, for example, an X-ray or ultrasound, following several phone calls you finally speak to a radiologist and you feel as if you are being granted a special favour? Normally you fax in a request, the patient has to wait for an appointment and 2 weeks after their appointment, the report arrives. It is delayed as it has to be dictated and signed. If 'Choose and Book' and the NHSnet can overcome these issues, then let's all use them. Perhaps the time has come to outsource requests to diagnostic and treatment centres independent of hospitals and move away from this archaic system-centred approach.

These are good examples of how PBC-commissioned services can be used to triage and organise quick and efficient services which, using 'politician speak', provide good access, choice, and are patient-centred. Through these, primary care has responded and changed where secondary care has not, and inevitably there is a risk that such secondary care services will lose funding as the franchise moves into the community. A catalyst for this has been the advance in the use of computers to drive the process and the failure of secondary care to engage quickly enough and work towards a common electronic record.

Change is not all bad and I would dispute the claim by some that general practice is inflexible. Rather, it is leading the way and not least with funding through PBC where secondary care has failed to develop. Let's hope we can achieve similar advances in patient care for specialities like psychiatry and for laboratory services, which some regions of the UK have already achieved.

There are two areas of change where our leaders need to exert caution; and these concern GP-led health centres which may threaten continuity of patient-centred care by a personal doctor. Second, destabilising the GP as a gatekeeper and patient advocate where a franchised private primary care provider, who does not know the patient, may unnecessarily refer. This has implications for patient stress through unnecessary investigations and their associated expense to the NHS. Any improved outcomes from the above changes in relation to patient care have yet to be measured scientifically. Fragmentation of primary care is potentially a threat to the jewel in the crown of the NHS, now in its 60th year.

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