"... do any of us really like being dealt with by call centres, particularly if we are ill?"

Patient access again

So, here we go with another model of GP access that will sort us all out. 'Patient access' promises to transform the delivery of primary care.[1] But before the NHS rushes headlong into another poorly understood change, we should understand its impact.

Changing GP appointment systems is fraught, as Tony Blair discovered on BBC's *Question Time* in 2005, when, in his desire to quickly fix delays to see a GP, the imposed targets led to the unintended consequences of many practices offering only a 'book on the day' system and angered many users.

In my practice we've been practising the same model for about 4 months and even as a fairly cohesive team, we disagree on whether this is the solution. This system has ruthlessly exposed our true patient demand, maybe 50% higher than we realised. The impact on patients is complex. A routine appointment could be in 3 weeks and is now 1–2 days, yet some patients are very unhappy with the new system. The most damming phrase was being told that we 'were worse than NHS 111' in the midst of their recent crisis (and one of ours). The difficulties probably go beyond teething problems and are about capacity and patient autonomy. If you are calling back 30 or more patients and seeing many of them, it takes several hours (more than the target of 2 hours) to call someone back. Patients don't know when they will be called or seen, tricky if you are at work or trying to decide if your child needs seeing. However are they a vocal minority? As a lot of our patients (and our patient participation group) have been very positive; an absolute majority in our small survey.

Our patients are attending A&E less, but also using the pharmacists less, and referrals are rising. The impact on doctors is considerable and we are all working a lot harder, with morning surgeries often going on for 5 hours, making it difficult to find time to meet each other or do daily tasks (such as prescriptions). It is difficult to plan what time you will finish, important for those with childcare or meetings to attend. Most of my time is spent now not seeing patients but headset on, triaging and worrying about the backlog. And when we are short on consulting doctors (through sickness or study leave), the system cracks. Other staff are affected too, reception loses its gatekeeping role; while clinically more appropriate, it does de-skill them.

Continuous telephone triage may work with 'out of hours', but I wonder if it is safe in a routine daytime service? Balanced against this concern is the presumed improved safety from reduced patient delays. But do any of us really like being dealt with by call centres, particularly if we are ill? Clinical medicine is ultimately predicated on seeing patients and examining them. Among all this will we squeeze out the ability for the patients to say 'by the way' or spot subtle visual cues, such as frailty?

There are external forces at play too; management consultants charging considerable fees are circling around, but may represent poor value to the NHS. Ultimately an organised practice could change unaided. Clinical commissioning groups and others are keen to get people out of A&E quickly and may leap on this change. However, can one practice meaningfully evaluate the true impact of these changes? The 'published' material is weak, relying on simplistic measures of call demand. There is a need for rigorous evaluations across local health systems, examining the impact on a range of patients and staff.

There is a clear role for organisations such NIHR Health Technology Assessment to fund a well-designed evaluation, before this system becomes entrenched. My hope is that this system will go the way of advanced access; advocated by many but ultimately unsustainable and unloved.

It's an age old problem in health care; how do you balance open-ended demand from patients with the finite resource of clinician time?

Melvyn M Jones,
GP and Senior Lecturer, Research Department of Primary Care & Population Health, UCL Medical School, London.

DOI: 10.3399/bjgp14X677879

ADDRESS FOR CORRESPONDENCE

Melvyn M Jones
UCL Medical School Research Department of Primary Care & Population Health, Royal Free Campus, London NW3 2PF, UK.

E-mail: melvyn.jones@ucl.ac.uk

REFERENCE

1. Liston A. Viewpoint: GP access — time for a radical solution? *Br J Gen Pract* 2013; **63(614):** 483.