Access to primary care:

creative solutions are needed

In her landmark *Lancet* article 'Is primary care essential?'¹ Barbara Starfield described primary health care as being first-contact care that is comprehensive, coordinated, and continuous. To this could be added something about accessibility and effectiveness and, in the UK context at least, care that is provided locally and personally. In these changing times, most of these attributes of good primary care have come under pressure. Comprehensiveness can be threatened by inequalities in access, fragmentation of primary care teams, discrimination, and the effects of the inverse care law.² Continuity is increasingly difficult to deliver, for well-rehearsed reasons, and coordination is often more of an aspiration than an achievement because of dysfunctional communication across the primary-secondary care interface. Finally, access, a crucial dimension of primary care, has become a political and professional battlefield in recent years. In last month's issue of the *BJGP* Simpson and colleagues³ called for a policy rethink on access, and for a more nuanced debate to take us beyond the simple metrics of waiting times and capacity. This month, Access to Care is the major theme of the journal, with articles on the research evidence related to access,⁴ the controversy about 7-day NHS opening,⁵ and the persistent, pernicious influences of deprivation on equity and equality.⁶

ANALYSIS AND EVIDENCE

The need for a more sophisticated discussion of access is emphasised by Campbell and Salisbury's Research Into Practice article,⁴ in which they review the evidence on new opportunities to measure and improve

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access, as well as providing a useful model of the various factors and forces at play. Their careful review serves to show that the evidence base for much organisational thinking and policy rhetoric is based on very thin evidence or no evidence at all, although it is clear that good ideas may work well in some practices, even if they are not transferable. It seems possible that every practice, set in its own community, is a unique ecosystem, in which very complex factors are in play, so that finding unique answers, rather than implementing top-down directives, may be the way ahead. That said, there do seem to be some important 'external navigation' factors to which all practices should pay attention. These include a recognition of the need for clarity in the language used on websites and in the written and spoken language in the surgery, and a recognition of the particular needs of many patient groups, including those with reduced capacity, disability, poor language and communication skills, and those without an understanding of the way that general practice works within the NHS, such as those recently arrived from outside the UK. This is particularly important when explaining how the practice provides access out of hours and in emergencies.

A number of 'internal' practice factors may also need to be considered in an attempt to optimise access. Campbell and Salisbury hint at one of these in their review, when they say that it isn't the total number of doctors, but the number of full-time equivalents, that matters. It is tempting to go further, and to say that, unless new entrants to general practice spend sufficient time each week in patient contact, preferably in the same practice, they will find it difficult to master the skills required to conduct efficient consultations with patients with complex problems.

Practices will need to recognise the access and communication problems faced by particular groups of their patients. In their recent *BJGP* article,⁷ Burt and colleagues identify the difficulties faced by older women of Bangladeshi and Pakistani origin, and by

young white patients recently coming to the UK. In this issue, Huxley and colleagues describe how the judicious use of digital communication between practices and their patients has the potential to improve access, for example, for refugees, those with mental health problems, and for patients requiring language translation.⁸

DEPRIVATION AND ACCESS

The inverse care law is also the subject of a study conducted by McLean and colleagues,⁵ who analysed levels of multimorbidity, patient consultation rates, and practice payments in relation to measures of deprivation in 956 general practices in Scotland. A weak relationship was demonstrated between multimorbidity and consultation rates, with much steeper gradients when consultation rates were related to deprivation. They were unable to show any link between levels of funding and the additional resource requirements to address the additional morbidity created by deprivation, and conclude that, given the present funding structures, general practice may be part of the problem of health inequality, rather than the solution.

SEVEN-DAY WORKING

In the sensitive discussions about a 7-day NHS, it is difficult to set aside the evidence that emergency admissions at weekends result in worse patient outcomes. It also seems wasteful for expensive equipment, such as MRI scanners, to be idle on Saturdays and Sundays, when waiting times for weekday examinations are long. There are increasing reports of hospitals getting to grips with different forms of 7-day opening. Fourteen early-adopter hospital trusts are now working on 7-day week strategies with NHS Quality Improvement. There are political and professional, as well as health services research, dimensions to consider in a decision that GPs reject this government mandate. However, the article by Ford and colleagues provides timely new evidence on this controversy.⁵ The responses of over 880 000 patients

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participating in the General Practice Patient Survey 2014 show that most patients do not think they need weekend opening, although Ford and colleagues conclude that it may benefit certain patient groups, such as younger people in full-time work. They also comment that Sunday opening, in addition to Saturday, is unlikely to improve access. A recent *BJGP* article,⁹ based on an analysis of data from all practices in England, showed that demographic, population factors are by far the most important predictors of A&E attendance, rather than potentially modifiable practice factors, so that it seems possible to separate the call for 7-day working from concerns about pressures on emergency departments. Once again, a more thoughtful and flexible response to concerns about access is required by government, particularly when this policy requires expanded GP capacity at a time when recruitment to general practice is at a historical low point.

DEMAND MANAGEMENT

Attempts to 'manage' demand are also discussed by Campbell and Salisbury, and once again the evidence is slim and often inconsistent. Various forms of triage, teleconsultations, consultations with nurse practitioners and physician associates, and combinations of booked and open appointment slots may work, but may not be transferable. A surprising number of practices now state on their websites that patients should only bring one problem to each consultation, even for booked, as opposed to emergency, appointments. This is at odds with what we understand about our patients, who typically bring a number of interrelated problems into our surgeries. Salisbury and colleagues¹⁰ showed that the average number of problems presented in a consultation is 2.5, with 41% of patients bringing >3 problems. This downward pressure on patients may ultimately be self-defeating, and certainly flies in the face of the concepts of 'comprehensive' and 'personal' first contact medical care.

PRIMARY AND SECONDARY CARE

For many patients access to primary care is only the first step in the journey

towards diagnosis and treatment. For truly effective care, GPs must have ready access to specialists when serious disease is suspected. New data on the use of the 2-week cancer waiting rules¹¹ suggest that patient outcomes are superior in practices that use the 2-week wait more frequently than those who do not, for example. Open access for GPs to relevant imaging services is also important, and the judicious establishment of one-stop clinics for specific conditions, such as dyspepsia, chest pain, or gynaecological problems, also has a part to play in ensuring that patients are diagnosed and managed expeditiously. Dedicated teleconsultations between specialists and GPs often work well, providing management advice that can forestall or redirect referral or investigation. It is not simply the gatekeeper role of general practice that causes delays in diagnosis and treatment. Developing multiple points of entry to the healthcare system, in response to different patient needs, rather than slavishly following the traditional referral system, should be pursued. Clinical commissioning groups are strongly placed to take a lead in adopting a much broader concept of access and pursuing the opportunities provided in the NHS Five Year Forward view for better primary-secondary care integration and the development of smoother, faster pathways for investigation and treatment.

BRIGHT IDEAS

Finally, of course, the answer is not simply about open doors and empty waiting rooms. Each practice will need to find its own ways of coping, and must be given the support, information, and resources to do so. Many readers will feel that they have already solved some of these access problems, and we would encourage them to share their experiences with other colleagues. An excellent example is Slack's account of changes in her own practice in last month's *BJGP*.¹² Please write an eLetter to the *BJGP* to tell us about imaginative ways in which you are approaching access problems, or consider contributing to the *BJGP Blog*. The RCGP Clinical Innovation and Research Centre (cirq.rcgp.org.uk) has recently established a new initiative called

ADDRESS FOR CORRESPONDENCE

Roger Jones

Royal College of General Practitioners, 30 Euston Square, London NW1 2FB, UK.

E-mail: roger.jones@kcl.ac.uk

Bright Ideas, designed to showcase and disseminate practice innovations. This is an ideal opportunity for you to pass on your experiences and knowledge.

Roger Jones,

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Provenance

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