Editor's Briefing

RANDOM ACCESS

Long before the Declaration of Alma Ata[1] linked the human right to as healthy as possible a life with access to good quality primary care, patients in the UK had unparalleled access to their GPs, 24 hours a day. For almost 60 years after the foundation of the NHS, patients phoning their practice out of hours would, as likely as not, hear the familiar voice of their GP, or their partner, at the other end of the line. The original GP contract had given GPs 24-hour responsibility for their patients. Those days are almost completely over, as new contracts for GPs have given rise to an often bewildering variety of ways of accessing care after surgeries have closed their physical doors.

Access to general practice in-hours remains a contentious subject. It is known that shorter opening hours are associated with poorer patient outcomes, and that a substantial minority of practices still close during core hours, defined at present as 8 AM to 6.30 PM. However, the Department of Health's pressure on all practices to provide 7-day-a-week, 12-hour access by 2020 at a time of severe staff shortages — one of the reasons why some practices have to close during the day — is creating real problems, and runs counter to both evidence and demand. The most recent annual patient survey[2] found that less than half of patients were in favour of Sunday opening and a report earlier this year from the National Audit Office (NAO) provided a forensic and highly critical analysis of these plans. The NAO report recommended that NHS England should properly consider the consequences of plans to extend access, and seek greater assurance that in-hours services meet the reasonable demands of patients. Not only should examples of good practice in providing better access be shared more efficiently but the Department of Health and NHS England should *'seek to improve the existing data from general practice to better understand the capacity of, pressures on and demand for services'*.[3]

The access issues intersect significantly with those of continuity of care. Many studies have shown that some patients are prepared to trade convenience with access to a doctor who they know and trust and who will listen to them.[4] The introduction of new professional roles in general practice to enhance access remains at an early stage, and seems unlikely to provide an acceptable answer for many patients.

This month's issue of the *BJGP* looks at a number of facets of access to care, including variations in access and referral for psychological problems, the significance of non-attendance of children at outpatient appointments, the complex interactions of travel time, rurality, and cancer outcomes, and the recurring conundrum of frequently attending patients. Blood pressure self-monitoring facilities in general practices may lead to improve detection and control of hypertension, while young adults may benefit from proposals to use the familiarity and confidentiality of general practice as a base to provide advice on sexually transmitted diseases and contraception.

In *Life & Times* this month the parlous state of the NHS is highlighted by Gervase Vernon's references to momentous events such as the sinking of the Titanic and the Dissolution of the Monasteries; both seemingly inconceivable, before they actually happened. Charlotte Sidebotham, in a wise and touching personal view, invokes the much-missed and wonderful Leonard Cohen to remind us that we need to be careful about striving for perfection, and that the Principle of Good Enough isn't a bad touchstone for juggling the demands of professional and personal life.

Roger Jones,
Editor

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