Patient access to general practice: ideas and challenges from the front line

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What does ‘access’ mean to patients?

Across the UK, GP practices are pioneering new approaches to providing patients with access to their services, despite the huge financial and workload pressures facing general practice. This paper explores some of the initiatives being tested and looks at what solutions and challenges are emerging. Its findings are relevant to individual clinicians and practices, but also have implications for commissioners and policy makers at both a national and local level.

Firstly, however, it is important to ask exactly what the term “access” to general practice means to patients. GP access is a popular topic in public debate about the NHS – with politicians and the media often quick to call for initiatives to “improve” access for patients. However, there is little agreement about what ‘good’ access to general practice looks like, and the term is often used to describe a range of quite diverse projects – from offering consultations via skype to providing extended practice opening hours. With some exceptions, there is a lack of evidence around what does and doesn’t ‘work’ in terms of improving access for patients in general practice and how this relates to the outcomes they experience.

The starting point for this paper is that there is no single definition of good access to general practice, and no one-size-fits-all solution that all practices should implement. In fact, access can mean very different things to different people, depending on an individual patient’s priorities. Many practices are already closely monitoring how patients access their services and implementing changes accordingly, and RCGP Scotland has recently published a Toolkit for practices to use for this purpose.

This paper focuses on the following three aspects of access to general practice:

1. **Availability and proximity of care.** Some patients would prioritise being able to access general practice in the right location to suit their needs. For example, people with reduced mobility need their local practice to be physically accessible.

2. **Timeliness of care.** Some patients would prefer to prioritise accessing GP services quickly or at a time most convenient to them, and would prioritise this over (for example) seeing a particular GP.

3. **Ability to see a preferred GP or nurse.** For some patients, being able to see a GP or nurse of their choice takes priority over fast access (this may apply in particular to those with long term conditions for whom continuity of care is an important factor).

This paper explores current initiatives focusing on each of these aspects of access to general practice, before considering what systems and processes underpin effective approaches to improving access for patients. It focuses largely on in-hours access to general practice, and should be read alongside the RCGP’s recent paper on out of hours GP care.

Many of the ideas explored here have only very recently been put into practice on the ground, meaning that there is minimal evidence for their effectiveness as yet. One of the key conclusions of this paper is that we now have an important opportunity to properly test and evaluate different initiatives in this area – and as such, patients and professionals need to be given adequate time and support to undertake such evaluation and share information about what has been shown to work.
Availability and proximity of care: bringing GP services closer to patients

The vast majority of people in the UK have at least one GP surgery close to where they live—almost all are able walk or take public transport to a practice within 30 minutes of their home.

However, practices face a number of challenges in ensuring that all those living in their local community are able to physically access the services they need. For example, practices in areas with a high population turnover may find that a significant proportion of their local population are not registered with the surgery. Even patients who are registered may find that work and family commitments make it difficult to be physically present at their local practice during the week. Carers, in particular, may feel that they are unable to take time out to visit their practice and as a result neglect their own health needs. In addition, a number of patient groups can face specific challenges with accessing their local surgery—including those who have a disability, those with mental health problems, and those who are homeless.

Alongside these challenges, the sheer volume of patients who seek care from general practice—with an estimated 420m consultations across the UK in 2014/15—can act as a barrier to patients accessing services. Most individual practices have relatively small back office functions, which can potentially lead to long waits on hold for patients attempting to contact the surgery by telephone to book an appointment.

With limited resources at their disposal, practices are working to overcome or to some extent mitigate these problems. Some are using technology to provide patients with an alternative means of accessing services without having to be physically present at the practice. Others are finding new ways to bring GP services directly to patients, through outreach programmes and co-location with other parts of the health system. This section explores some of these initiatives.

Online booking systems

Practices are increasingly using online booking systems to provide patients with an alternative to contacting the surgery by telephone to secure an appointment. The Government in England has made this a priority, with the 2014/15 GMS contract requiring all practices to put systems in place to offer online booking systems, as well as repeat prescription services—with the intention of offering these services to 95% of patients by March 2015. In January 2015 NHS England reported that 91% of patients are now registered with a practice that offers online booking (compared to 64% the previous year) and 88% with a practice that offers repeat prescriptions (compared to 64% the previous year).

The key advantages of this approach include:

- Reduced pressure on practice telephone systems
- Greater convenience for patients who prefer to book online. In England the GP Patient Survey found that 33.8% of patients say they would prefer to book appointments online.
- With 73% of people in the UK now having access to high speed broadband (higher than any other Western European country), there is clearly a large pool of people who would find it useful to have the option of booking online.
However, there are some disadvantages that need to be considered:

- It is far from clear that online booking systems will help practices reduce their administrative workload, with some reporting that the cost of employing staff to run their online presence is an added financial pressure. Even with relatively high take up from patients, telephone booking systems still need to be maintained and staffed.
- A significant minority of people in the UK do not have access to the internet, and there is a risk that shifting towards greater use of online services will exacerbate health inequalities.
- Some groups of patients – for example those who are visually impaired or those with learning disabilities – may find that their practice website is not fully accessible to them.
- Patients are free to book a slot that may be too short or long for their needs, which could be frustrating for the individual patient and a source of inefficiency for the practice. Often it is helpful for patients to speak to a receptionist at their practice to ensure they receive an appointment most appropriate for their needs – particularly because the patient and receptionist may have spoken before.

**Case study: Online booking – individual practice**

Granville House Medical Practice in Chorley, Lancashire, has instituted an online booking system for its patients. Patients request to be added to the system, and after providing their information and proof of identification are given a password for the online service through which they can view and book directly available appointments. The surgery estimates that around a quarter of all their advance appointments are booked in this way.

These appointments are only available for GPs as the precise nature of the need for the appointment is often not known until the patient is present.

Granville House finds this system to work very well for their surgery by empowering patients. They have in particular found the system to be very popular with their elderly patients.

However, while the surgery itself is very positive about online booking, the implementation and upkeep of the system has associated staffing and administrative costs, which not every surgery may be able to afford. In addition, not all patients have access to the internet or feel comfortable using online services.

**Case study: Online booking – Bury GP federation**

Bury GP Federation – which covers 30 of Bury’s 33 GP practices – is implementing a dramatic increase in online access to booking systems for member practice patients. This will involve making it easier for patients to register with their local practice, which has been seen as a barrier to greater uptake of online bookings in the past. The federation will also be rolling out a website allowing patients to more easily compare services and performance across member practices so that they can make informed choices about their care.

Two factors have made this initiative possible. Firstly, the pooling of resources across the federation makes designing and implementing online booking systems simpler and more efficient. Secondly, the practice has been able to access additional funding through the Prime Ministers’ Challenge Fund to implement this scheme.
Smartphone apps

A small number of practices have gone further than simply offering online booking and have funded and developed their own smartphone app. Whilst there are some benefits to using this approach, an obvious limitation is that patients who do not use smartphones are excluded – it is currently estimated that at least 54% of the UK population use such devices. Although there is very little evidence in this area at present, existing cases in which apps have been used suggest that they can help improve access in combination with other measures. This approach builds on the already widespread use of automated appointment reminders that are sent via text message to patients’ mobile phones.

Whilst current examples of apps being developed appear to be on an individual practice level, it is highly unlikely that most practices would have the resources and time to pursue this on their own, and this would also lead to unnecessary duplication and a large number of different user interfaces. It seems likely, therefore, that any scaling up of the use of apps will be taken forward by federations of GP practices working together.

Case study: Practice smartphone app

The Robin Lane Medical Centre has developed a smartphone app through which patients can request appointments, send secure messages to clinicians and set appointment reminders. The development of the app was funded by the practice itself and cost £5,000. In addition to the convenience the app offers to some patients, the practice has found that it has helped to reach patient groups who may not ordinarily interact with their GP – for example young people seeking confidential advice about sexual health.

Although a smartphone app inevitably will not reach some patients, the practice uses a number of other means to engage with the local community more widely – including setting up a local wellbeing centre next to the practice, run in partnership with voluntary sector organisations. The app is now being used by around 700 patients.

Web consultations (including Skype)

The use of video conferencing in general practice – particularly the programme Skype – has received significant attention from politicians and the media in public debate about the future of access to general practice. The opportunities presented by the rapid growth of online video conferencing services for general practice are clearly worth exploring – and many practices are already doing so. Practices are also trying out other online services that often receive less attention, such as real time webchat consultations.

Whilst telephone consultations have been in use for some time, there are some clear advantages to patients being able to communicate with their GP from the comfort of their own home (or workplace) using web based services:

- Some patients may prefer to retain an element of ‘face to face’ contact with their GP through video conferencing as compared to speaking on the telephone. Such consultations may better enable both GP and patient to pick up on non-verbal cues, for example. It should be noted, however, that there is little evidence about the experiences of patients and clinicians in using such technology for consultations, and the quality of the picture and audio is obviously an important factor.
• Wider availability of these sorts of technologies could help break down some of the physical barriers that prevent groups such as long term carers or the physically disabled from receiving care.
• Webchat services provide a more discreet method of communication, which may encourage some patients who wouldn’t normally seek care to approach their GP.

There are some significant limitations that need to be considered carefully as use of these services increases:

• Online interaction between GPs, nurses and patients should not be considered a replacement for real face-to-face contact. Much of the value of general practice lies in the development of a trusted relationship over time between a patient and their GP, and it is more difficult to achieve a strong rapport when communicating remotely. For example, Skype consultations may not be helpful or appropriate for children.
• There are legitimate concerns that have yet to be fully addressed about the security of information exchanged through third party programmes such as Skype – which routes its data through servers that are outside of the jurisdiction of EU law.
• Where practices have offered these services, they have felt it necessary to require users to register in person first – which may to some extent negate some of the advantages described above.
• There is little evidence at the moment that online consultations reduce workload or save practices money. They still require GP/nurse time and there are also costs associated with setting up and maintaining IT infrastructure. One pilot in Central London has reported that Skype consultations took up on average 10 minutes of practice time per patient compared to five for a telephone call

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**Case study: Skype consultations**

The South King Street Medical Practice in Blackpool has recently begun offering its patients consultations via Skype. When the local CCG revamped their computer systems to include computers with inbuilt cameras, the possibility of using Skype was introduced into the practice. As the service is free there are no associated technological costs, and the practice report that the user friendly nature of Skype has led to little or no extra administration.

The service has been taken up by a wide range of patients, but has proven to be particularly popular with the housebound elderly. While it can be a good alternative to home visits the service is primarily used as a means of increasing the types of access available. The service is advertised on the practice website and within the surgery. The patients will book an appointment in the normal way, and it is often suggested as an alternative to telephone consultations. Examples of consultations are district nurses using the service as part of their home visits in order to involve the GP, examination of skin complaints and eye complaints, or its use to involve relatives in another locality who have an interest in the patient’s care.

There are limits to the service as it cannot be used for a large number of examinations and complaints.

There is no evidence that this service is currently freeing up time for clinicians in surgery – however, if there were a greater use of the service across the healthcare system especially by district nurses then it is envisioned that this could be the case.

The feedback from clinicians and users has been very positive. However, the uptake has been limited by high levels of deprivation in the local area and therefore a lack of access to the associated technology. Indeed it should be noted that the use of this technology was only made possible due to an upgrade of the practice’s wider computer system.
Co-location of general practice with other services

An alternative approach is to physically move GP services into other settings within the health and social care system. In particular, there are a number of examples of GP services being attached to hospital emergency departments, particularly during the out of hours period.

Case study: Co-location of general practice with secondary care

North Manchester General Hospital has been rethinking the design of its busy A&E department, which sees almost 100,000 patients a year. The hospital has recruited GPs with a special interest in emergency medicine and integrated them directly into the team alongside hospital consultants. These GPs typically work for part of the week in a local GP surgery, providing a direct link between primary care and the emergency department.

The merit of this approach is that with an estimated 15% of patients in England presenting at hospital emergency departments who could have been treated in primary care, the presence of a GP in this setting helps to reduce the burden on secondary care but also ensures that patients receive care that better fits their needs.

However, whilst some areas have found this approach to be helpful there are some important limitations that need to be considered. Many out of hours GP services such as those described in the case study above do not provide a walk-in centre, which may hamper the ability of secondary care to transfer patients directly into primary care. In addition, the presence of GP services in A&E may further encourage patients to see hospital emergency departments as a 'one stop shop', putting the NHS on a reactive footing when potentially a better approach would be to strengthen primary care so that more proactive services are delivered closer to patients’ homes.

Home visits and district nursing

One effective means of ensuring hard to reach patients are able to access general practice services is to undertake more home visits and outreach services, including working in close collaboration with district nurses. Home visits have long been used by general practice for this purpose, but are becoming increasingly difficult to fit in alongside other demands on practices’ time. Between 1995 and 2008 the number of home visits conducted in England declined from 0.3 consultations per patient-year to 0.1 per patient-year (although to some extent this can be explained by changing patterns of out of hours care).

Inevitably, the time needed to properly arrange and conduct home visits can prove a barrier to increasing their use. One solution to this challenge is closer joint working between district nurses and GP practices – for example through the use of technology to ensure that district nurses can remotely access and share information about patients with their practice.

Implementing this approach, however, requires investment in IT systems and hardware and relevant training for staff. One potential further barrier to greater uptake of this model is the shortage of district nurses, of which there are an estimated 40% less than a decade ago.
Case study: District nurses with remote access to patient information

A GP practice in South Yorkshire is piloting an initiative in which doctors and district nurses are given handheld Personal Digital Assistants (PDAs) enabling them to access and share information about patients they are visiting with the GP practice.

Benefits include improved efficiency and patient experience, with doctors and district nurses no longer required to return to record or access relevant information about the visit. The new approach has also reduced duplication of records, making it easier to manage and organise home visits.

In some areas, an entirely different approach to this problem is being taken. To reduce pressure on general practice some localities are investing in specialist transport services that can help patients (often the frail elderly) who are otherwise unable to travel to their GP surgery to have an appointment at the practice. This has obvious advantages in terms of saving the practice the additional time needed to organise and conduct a home visit, but could also have positive benefits for those patients who feel isolated and unable to leave their home without support – although robust evaluation is needed to verify these benefits.

Case study: Ealing Community Transport

Ealing CCG has invested in a community transport pilot through which residents with mobility difficulties are eligible for free transport to their GP appointment.

The CCG received feedback from patients that there was demand for an existing service providing transport to hospital appointments to be expanded to include general practice. In February 2015 the CCG reported that the scheme now encompasses 15 participating practices with another 13 soon to be included.

Ensuring homeless people and other socially excluded groups can access general practice

In 2013/14 the number of households considered legally ‘homeless’ stood at 52,270 in England, 29,326 in Scotland and 5,115 in Wales. In Northern Ireland 9,878 households were considered homeless in 2012/13. This presents challenges for GPs across the UK – particularly those practicing in areas with high levels of deprivation.

Whilst tackling homelessness requires a multi-agency response, general practice has a vital role to play as a point of access to the NHS for those of no fixed address. GPs and their teams can build trust with socially excluded groups, working in partnership with other parts of the health and social care system as well as the voluntary sector.

In 2013 the RCGP published a paper on ‘Improving access to health care for Gypsies and Travellers, homeless people and sex workers’, calling for radical changes in the way the needs of these patient groups are met, including:

- More ‘one-stop’ healthcare hubs where vulnerable groups can receive multiple services in one place at one time.
• Greater community engagement to allow vulnerable groups to have their voice heard and develop support networks.
• More localised decision making for commissioners, who should seek greater collaboration with vulnerable groups to deliver mutual health and financial benefits.
• More communication and joined up working between health, social care and voluntary services targeted at marginalised groups.
• Greater integration between health and housing services to identify and treat health problems associated with poor living conditions.

Case study: Homelessness GP services in Watford

The Meadowell surgery in Watford offers enhanced access to primary healthcare for homeless and disadvantaged people living in the local area. ‘Homeless’ in this context includes people in temporary accommodation, staying with friends or at risk of being made homeless, as well as those who find themselves sleeping on the street.

Having started as a direct Primary Care Trust (PCT) provided service, Meadowell became a social enterprise when NHS Hertfordshire was forced to divest itself of the provision of community healthcare services. Subsequently, Meadowell submitted a successful bid for a block contract under the Alternative Provider Medical Services (APMS) framework, for a term of 5 years.

As a social enterprise, Meadowell is able to act in relative freedom, providing for the needs of more than 600 patients with a range of services.

Meadowell provides a holistic, ‘one stop shop’ service, and is able to address health problems together with housing departments.

As homeless people often find it hard to engage with health services, aside from a schedule of planned appointments, Meadowell offers daily drop-in sessions.

Besides full range of primary care services, Meadowell also provides:
• Specialist services for the treatment of drug and alcohol misuse in primary care
• Joint working with specialist services to help people recover from alcohol and drug abuse
• A hepatitis C treatment centre.
• Cognitive behavioural therapy (CBT) on site
• Alcohol home detox support
• Housing and welfare advice and support

Working with the voluntary sector to reach patient groups who typically report poorer levels of GP access

A number of patient groups often report difficulties and frustrations with access to general practice – including carers and those with physical or mental disabilities. Some practices are working with national or local voluntary sector organisations to improve access for these patients.

In Wales, the RCGP has worked closely with EquiP Cymru to develop a set of tools that patients and practices can use to improve access to general practice for people with disabilities.
Case study: Improved access for patients with hearing loss in Northern Ireland

Action on Hearing Loss, a national voluntary sector organisation, have been working with GP practices to improve access for patients with hearing loss. The Hunter Family Practice in Northern Ireland have implemented a number of changes – including establishing a new protocol for booking a sign language interpreter, installing hearing loops and providing training to practice staff – designed to improve the experience of patients with hearing loss who visit the practice. The practice has used Action on Hearing Loss’s ‘Louder than Words’ benchmarking tool to ensure they fully meet the needs of this patient group.

The practice have reported that staff now feel more confident in helping patients with hearing loss, where in the past they might have felt unsure or embarrassed about how best to interact with these patients. Patients with hearing loss have reported that the changes have led to a more positive experience when they book an appointment and visit the practice.

Practice boundary pilots

The government in England recently piloted allowing practices to register new patients who live outside their practice boundary area. This approach aims to offer flexibility to patients who would find it more convenient to use the services of a GP practice in a locality other than their home – for example near their workplace or child’s school. As of January 2015, all practices are able to register patients from outside their practice area.

The RCGP has previously warned of the risks of taking this approach. The principle that GP surgeries serve a defined geographic location underpins continuity of care and acts as a bulwark against health inequalities. Removing or relaxing practice boundaries could have serious unintended consequences in terms of fragmenting GP services and destabilising local health economies. We may see a split emerging between practices dealing with young, mobile and relatively healthy patients and those serving a population with a high number of patients with complex care needs. Some practices could find that a large influx of new patients through this initiative leaves them with less resource to dedicate to the most unwell patients living within their boundaries.

Given that practices work closely with other local teams in the community – such as mental health and occupational health services – it is unclear how relaxing practice boundaries will impact on this. Recent focus on promoting integrated multi-disciplinary working across defined local populations seems to clash with the aspirations being pursued here.

There is relatively little evidence that patients want practice boundaries to be relaxed, or on the pros and cons of this approach. A pilot undertaken by the government in England reporting in 2014 found that whilst those patients who made use of the additional flexibility had positive feedback, in general take up was very low, with more than a third of the practices who took part failing to register a single new patient under the scheme. The pilot evaluation reported that (then) PCT managers expressed concerns about practice populations becoming socio-economically segregated, and the potential costs of managing referrals for patients living outside the practice boundaries. Whilst the pilot was not costed in detail, the evaluation reported that there was little sign of major increased cost.

It is vital that ongoing, detailed and robust evaluation of this initiative takes place to establish a better understanding of the positive and negative implications for patients, general practice and the wider NHS.
Timeliness of care

Ensuring that patients can access general practice at a time convenient to them is a growing challenge for the NHS, with practice capacity and resources failing to keep pace with demand for appointments.

A straightforward international comparison shows that the UK performs well in relation to short-term access to front line medical care. In a comparison of fourteen industrialised nations’ healthcare systems carried out by the Commonwealth Fund in 2014, the UK was found to be a high performer in regard to short term access to care (see Chart 1). This is supported by the findings of various patient surveys conducted in England, Scotland, Wales and Northern Ireland, with relatively high proportions of respondents saying they are able to obtain an appointment quickly and at a convenient time.

However, there is evidence that patients are finding it increasingly difficult to access general practice at a time convenient to them. In England, the proportion of patients who report they were unable to secure an appointment has been creeping upwards, with patients unable to get an appointment within a week on an estimated 62.4m occasions in 2014. In Wales, an estimated 658,000 patients found it “difficult” to get a convenient GP appointment in 2013 – and if trends continue this could rise to as many as 800,000 by 2017. Patients in Scotland had to wait more than two days for an appointment with a doctor or nurse on an estimated 3.2m occasions in 2013/14.

Practices across the UK are exploring a number of different approaches to ensuring that patients can rely on timely access to their services with the limited resources at their disposal. Many practices are opening for longer hours to fit in more consultations and offer patients greater access in the evenings and at weekends. Some are looking at what systems can be put in place to manage the flow of patients interacting with the practice – for example by having GPs speak to patients when they first call to request an appointment, or by offering walk in sessions, in which patients can be seen by a GP on a first come, first served basis within the practice at specific times. Others are looking at what systems can be put in place behind the scenes to increase efficiency – for example by experimenting with different forms of ‘skill mix’ that allow GPs to focus on patient care. The following section analyses some of these different approaches.

Extended hours

One obvious tool practices can use to offer patients more timely access is to extend (or make more flexible) their opening times beyond core contracted hours. It is estimated that in England around 60% of practices currently provide some form of extended opening (outside 8am - 6.30pm), with 17% open over the weekend, and 53% providing extended opening during the week.
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 Whilst additional funding is available for practices who choose to open outside core hours, there are a number of barriers to increasing uptake of this additional service by surgeries:

- Problems with recruiting and retaining a GP workforce to staff extended hours provision is a frequently cited problem. There is a risk that attempting to provide longer hours will leave the practice overstretched, having a negative impact on care during core opening times.
- Lack of sufficient demand from patients. Some practices have found that services in the evenings and at weekends are not popular enough to justify longer opening times.
- In Northern Ireland (where several extended hours pilots are being implemented this year by the Health and Social Care Board) some practices have found the same patients are booking into evening slots as in the day – raising the question of whether it would be more effective to increase capacity during core hours.

One solution to the problems outlined above is for groups of practices to work together in federations or networks in order to share both resources (in terms of GP and non-GP workforce, and back office functions) and patient demand across a particular locality.

Case study: Extended hours shared across federated practices

Hambleton, Richmondshire and Whitby GP Federation is instituting eight to eight opening for GP services during the week and for four hours on Saturday and Sunday.

The service will be staffed on a rota system, operating on three sites, meaning that patients who have an appointment within this area in the extended time period will often be seen at a different surgery than their normal one, or the community hospital at weekends. By allowing doctors to access patient records across the locality through EMIS web the project aims to ensure a certain amount of continuity of care.

Patients can pre book appointments with the service in the normal way through their existing surgery. If they attempt to book an emergency appointment at their surgery in the out of hours period their call will be directed to the service.

This service operates in addition to existing out of hours services, and delivers routine GP care, in contrast to the out of hours service which only treats emergency or urgent medical concerns. The aim is to provide increased access to standard general practice services in the out of hours period.

However, despite the advantages of a system such as this it has only been possible to implement with the additional funding directed to the project via the Prime Minister’s Challenge Fund. In addition, there have been problems with recruitment, leading to the creation of a rota system rather than the extended opening of every surgery in the local area.

Systems that manage patient flow

For many patients, the first person they speak to when contacting their local practice is a receptionist, who often has an important role in ascertaining whether enquiries are urgent or non-urgent. However, some practices are pursuing a different approach by placing GPs at the front-end of the service as a means of managing the ‘flow’ of patients through the system more effectively. Such systems help ensure patients receive more timely care by identifying
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those whose needs can be dealt with quickly, in theory freeing up time for the practice to focus on patients with more complex problems.

An approach that is increasingly being used to manage the flow of patients through the system is having GPs speak to patients over the telephone before any appointment is made. A number of specific models such as 'Doctor First' and 'Patient Access' have emerged and are being tested out across the country. In these models, typically a GP calls back all patients in the first instance, and then either offers a face-to-face appointment with a GP or nurse (usually on the same day), gives advice over the phone, or issues a prescription for the patient to pick up.

Similarly, some practices offer walk in sessions at specific times, with patients guaranteed an appointment if they visit the practice during these hours. Such models have a number of potential advantages:

- Patients are able to see or speak to a GP on the same day, benefiting those patients who wish to prioritise speed of access to general practice. Anecdotally, some GPs who have used these systems in their practices have reported that the approach is popular with patients because they trust it to deliver timely access. One practice in Worcestershire has reported that this system led to a reduction in the average time between first contact with the surgery and definite diagnosis of malignancy from 53 days to 37 days over two years.\(^{23}\)
- More efficient use of consultation time, with simple problems dealt with more quickly.
- Better continuity of care for patients. Whilst patients may not always see or speak to their usual GP, their interaction either via telephone or walk in session is captured in the practices’ systems and can result in any relevant follow up (e.g. an overdue check-up can be spotted and booked in for the patient). This level of continuity would not be achievable if the patient visited a stand alone walk in centre or a hospital emergency department.

However, although some practices using these models have reported encouraging results, others have been less positive. There is limited independent research on their effectiveness and it is therefore difficult to draw reliable conclusions about whether they could be implemented on a wider scale. There are a number of limitations to these models:

- An obvious limitation of telephone consultations is the lack of visual information – such as non-verbal cues or a physical examination – as well as challenges around relationship building and communication.
- A barrier to effective implementation of the 'Doctor First' model in some areas is that English may not be the first language for many of the population. Telephone consultations are also potentially less effective for certain groups of patients, such as those with learning difficulties.
- There is an ongoing debate (hampered by lack of sufficient evidence) about whether such systems do reduce workload. Evidence recently published from the ESTEEM study (which focuses specifically on telephone triage of patients requesting same day consultations in general practice) found that the number of overall patient contacts increased, but noted a reduction in face-to-face GP contacts. It concluded that the new system largely redistributed workload without leading to either a reduction or increase in cost.\(^{24}\)
- Walk in clinics can lead to a long queue of patients at the surgery who have been guaranteed a same day appointment, meaning that the service could overrun (impacting on other aspects of care) or GPs could feel they have only limited time to see each patient.
There is a clear need for more evidence as to the effectiveness of these models. Research currently being conducted by Professor Martin Roland and NHS Cambridgeshire – funded by the National Institute for Health Research (NIHR) and due to report in 2017 – will help strengthen the evidence base in this area.

Case study: GP-led telephone triage (using the Doctor First model)

Denburn Medical Centre in Aberdeen was formed when two smaller practices merged into one. Upon merging they struggled to meet demand so they decided to switch to the Doctor First telephone triage model. Under this system, patients can ring at any time and a doctor will call them back for a phone consultation. But if patients need – or still want – to be seen by the doctor or a Nurse Practitioner they can be offered an appointment that day or at a time which suits them.

The practice has found that in two out of every three cases the problem can be dealt with over the phone. Through the use of this system the practice has achieved the following:

- Reduced emergency admissions
- Over 20% reduction in out of hours presentations between May-August 2012 and May-August 2013
- GPs much more accessible to patients and other members of the multi-disciplinary team
- Weekly patient contacts up by 100% meaning more people are being helped but there is no backlog
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Ability to see a preferred GP or nurse

For many patients, access to general practice is as much about quality as it is about quantity (or speed). Being able to see a preferred GP or nurse is more highly valued by some patients than speed or convenience of access, and indeed general practice is often considered to work best when there is continuity of care between a patient and their doctor, facilitating an ongoing therapeutic relationship. There is a compelling case for promoting continuity of care in general practice as part of delivering a patient centred NHS.

There is evidence that it is becoming more difficult, in the face of rising workloads and falling resources, to offer patients the opportunity to see their preferred GP or nurse. Patient survey data across the UK supports this conclusion:

- In England a majority of patients have a preferred GP (54%), but there has been an increase in the proportion of patients reporting that they only see their preferred GP “some of the time” (31% in 2015 compared with 28% in 2012) or that they “never or almost never” see them (8% in 2015 compared with 6% in 2012).
- In Northern Ireland 55% of patients who have a preferred GP said they “always or almost always” got to see them in 2011, down from 57% the previous year.
- In Scotland 76% of patients who have a preferred doctor said they were usually able to see their preferred doctor. This is a three percentage point decrease compared to 2011/12.

This is a worrying trend, and there is a danger that policy initiatives relating to access to general practice will prioritise increasing speed of access over enhancing continuity of care. Whilst both are important elements of an effective system of primary care, it is noticeable that recent policy initiatives have focused much more on the former than the latter. With care for people with long term conditions now accounting for 70% of spend on health and social care, it is vital that measures to promote continuity of care in general practice are also promoted.

In the face of this challenge, practices are pursuing a number of approaches to promoting continuity of care and ensure patients who wish to are able to see their preferred GP or nurse. One model beginning to be explored in some areas is the setting up of GP ‘micro teams’ – groups of two or more doctors who work together to provide continuity of care to an allocated number of patients. Increasingly, however, practices are also seeking to proactively identify patients who would most benefit from improved continuity of care, and using a care planning approach – led from within general practice but in partnership with other professionals – to ensure these patients have access to more personalised, integrated care. This section explores initiatives being piloted in these areas.

GP ‘micro teams’

GP ‘micro teams’ involve allocating a shared group of patients to a small number of GPs within a practice – usually two or more doctors and potentially involving a practice nurse. When patients contact the surgery to arrange an appointment, but their preferred GP is not available, they are assigned an appointment with another member of the micro team. Some of the advantages of organising care in this way include:

- Improved continuity of care for patients as compared to randomly allocating an alternative doctor where the preferred GP is unavailable. By being given access to a
micro team patients are likely to see a smaller number of doctors over a period of time.

- Improved peer support amongst GPs, reduced isolation, and better processes for jointly reviewing the care of patients with complex needs.

Case study: GP micro teams in Tower Hamlets

Tower Hamlets CCG in London is currently piloting micro teams of GPs across the borough. Receptionists first attempt to book a patient with their chosen doctor and if that fails, with another member of the micro-team. Only if that fails would the patient be booked with a doctor from another team. Exceptions to this rule could be where certain doctors in the practice provide specialist services; women's health for example. Administration can also be streamlined and aligned to support the micro-teams.

One North London practice has reported that after implementing a micro team approach, the percentage of patients seen by their regular GP rose from 27% to 42%.

Some practices are exploring this concept on a wider scale, using cloud technology combined with existing GP systems such as EMIS to enable GPs and other practice staff to access patient notes across a group of federated practices.

Proactive care planning and promoting self care

The College has long advocated for the implementation of a care planning approach led from within general practice as a means of improving care for patients with long term complex needs – particularly those living with multiple morbidities. Embedding a care planning approach into primary care stands out as a solution that has the potential to both improve quality of access for patients and help manage demand in general practice by empowering patients to become experts in their own care. This approach, based on the ‘house of care’ model, involves patients living with long term conditions co-designing their own care plan with a community based team of health professionals led from within general practice. This approach is set to become increasingly prevalent throughout the UK in the coming years. The Government in England has made it a requirement that all patients over the age of 75 have a ‘named GP’ responsible for managing their care through a personalised care plan (based on a national template). Governments in Wales, Scotland and Northern Ireland are also implementing plans to promote care planning.

A full analysis of the benefits of care planning is beyond the scope of this paper, but it is worth noting that this approach can have the following specific benefits for patients in terms of access:

- Care planning improves continuity of care for patients and focuses on raising the ‘quality’ of the patients’ interaction with their GP practice. It offers those with complex needs access to more person-centred care, taking into account the physical, mental and social background of the patient.
- Care planning puts access to general practice on a more proactive footing. Rather than the onus being on the patient to approach their GP, the practice identifies patients in need of long term support and works with them to design their care according to their needs and goals.
- There is strong evidence that care planning leads to improved self management by patients themselves, enabling that person to make more informed and personally relevant decisions about accessing health or social care resources. As the number
of consultations required by the patient decreases, this frees up practice resources that can be used to improve access for other patients.

- Care planning facilitates access to more than just general practice – it can provide a platform for multi-disciplinary team working, involving GPs and practice staff working alongside other professionals in the community, or colleagues in secondary care.

**Case study: Pooling practice resources to deliver planned care for care home residents in Cumbria**

An initiative called ‘Better Together’ has been launched in Wokington, Cumbria, combining five practices covering 33,900 patients. As a means of increasing access, these practices have banded together to establish a new team providing dedicated services for residents in local care homes, focusing on proactive (rather than reactive) care. This team will undertake scheduled visits in order to create proactive care plans for patients, as well as undertake end of life care and medication reviews. This project has been undertaken in response to local concerns around the level of access to GP services and historically poor health outcomes linked to levels of deprivation in the local area, and it is hoped that it will help manage demand for GP services in a proactive fashion alongside improving the overall health of their population. The project is being taken forward using additional funding from the Prime Ministers’ GP Challenge Fund.

Whilst overall care planning can be cost neutral, the need to invest resources, time and energy into designing and implementing new systems to support it can act as a barrier to wider take up. There are also technical and regulatory barriers to sharing information about care plans between health and social care professionals.

**Case study: Overcoming barriers to sharing care plans in Wales**

In Mid and West Wales local Councils and the Hywel Dda University Health Board are working together to implement a new approach to caring for older people with complex needs based on personalised care planning.

Having identified system constraints preventing the sharing of individual care plans across agencies, Carmarthenshire County Council and Hywel Dda are working together to develop an interface between the NHS’ Myrddin system and the Council’s CareFirst system. This will enable staff to access one system and transport data from the other through one access point, and is currently being piloted with multi-agency staff in Llanelli. Work is also underway to set up mobile working options for community teams and provide access to Wi-Fi at certain hotspots across the County including Council and Health buildings so staff do not have to return to their base of work to upload patient data.
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Drivers of better access to general practice for patients

A central conclusion of this paper is that there is no one-size-fits-all solution to improving access to general practice. The ideas and case studies outlined are likely to work in some areas, but have a limited effect in others. However, some broad conclusions can be drawn about what factors are important to the successful delivery of high levels of access to general practice.

Based on the ideas and challenges explored above, the following five key drivers of improved access can be identified:

- Financial investment in infrastructure and service redesign
- Ensuring there is sufficient workforce to meet access demand
- Harnessing the power of technology to engage patients
- Enhanced continuity of care for patients with complex needs
- Pooling resources and expertise across practices

What next for access?

Access to general practice is frequently cited by politicians as an issue the public are concerned about, and in the run up to the 2015 general election parties from across the political spectrum are likely to include promises to ‘improve’ GP access in their manifesto documents. With general practice already under huge strain and GPs delivering more patient consultations than ever before, turning political rhetoric into practical action will require a significant increase in resources for general practice along the lines of that called for by the RCGP in its Put patients first: Back general practice campaign.

As noted above, it is also vital that policy initiatives aimed at increasing or enhancing access to general practice focus on both those patients who want to prioritise speed and the growing number of people who would benefit from greater continuity of care with their GP.

Given the number and range of ideas currently being tested out in general practice in this area, it is vital that projects are properly evaluated, and evidence is gathered and published on what has been shown to ‘work’ in some areas and what has not. Whilst much of this work needs to be taken forward by those implementing ideas themselves, there is a role for policy makers in ensuring that the current burst of initiatives in this area does lead us to a better understanding of how we can improve and enhance access for patients.
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References


4 The Future of GP Out of Hours Care, RCGP, 2015.


8 GP Patient Survey results, July 2014: https://gp-patient.co.uk/surveys-and-reports#july-2014 Note: this question has been dropped from the GP Patient Survey as of January 2015.


11 Patients give thumbs up to GP Skype pilot, Pulse, 9 February 2015. Available here: http://www.pulsetoday.co.uk/home/finance-and-practice-life-news/gp-patients-give-thumbs-up-to-skype-pilot/20099161.article#.VOadmi45g8c


13 National Nursing Research Unit at King’s College London, District nursing – who will care in the future?, Policy +, Issue 40, September 2013


16 These resources are available on the RCGP website here: http://www.rcgp.org.uk/clinical-and-research/practice-management-resources/disabled-people-guidance-on-improving-access-to-gp-services.aspx


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20 RCGP analysis based on data from the National Survey for Wales


23 Improving telephone access to general practice reduces time to diagnose cancer, Pamela Smith, Jonathan Leach, British Journal of General Practice Nov 2014, 64 (628) 564; DOI: 10.3399/bjgp14X682225

24 Prof John L Campbell et al, Telephone triage for management of same-day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis, The Lancet, 2014

25 NIHR, HS&DR - 13/59/40: Tele-First: Telephone triage as an alternative to face to face contact in general practice. Available here: http://www.nets.nihr.ac.uk/projects/hsdr/135940

26 Freeman G, Hill A, Promoting Continuity of Care in General Practice, RCGP, 2011


28 GP Patient Survey results, 2012-2015, Ipsos Mori


32 For detailed guidance on enhancing continuity of care aimed at practices, please see the RCGPs continuity of care toolkit: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~media/Files/Policy/A-Z-policy/Continuity%20of%20Care%20Toolkit.aspx


34 See for example the RCGPs work with the Coalition for Collaborate Care: http://coalitionforcollaborativecare.org.uk/

35 Care planning: Improving the lives of people with longterm conditions, RCGP 2010, Mathers et al.