

PATIENT ACCESS

Staff shortages mean people can't get through to their GP at peak times. The upshot is not just dissatisfied patients – it means more end up in hospital, as Kaye Macintosh finds out

HANGING ON THE TELEPHONE

Few things are more frustrating than an automated message saying your phone call is in a queue and will be answered shortly – or just getting the engaged tone. When you are ill, it can be rather more than just one of life's little irritations.

Primary Care Foundation research suggests a third of practices have too few people answering the phone at peak times such as Monday morning, preventing patients who need urgent medical attention from getting through. And once a call is answered, there is no guarantee of an appointment – a third of practices have too few slots to meet average demand.

Dissatisfied patients who cannot get through, or have to leave a message for a doctor who does not call back swiftly, will go elsewhere. And cases that are genuinely urgent may be missed, putting patients at risk of being admitted to hospital when that could have been avoided, warns the Primary Care Foundation's report, *Urgent Care: a practical guide to transforming same-day care in general practice*.

While government reforms on unscheduled care have focused on emergency and out-of-hours demand, little attention has been paid to what happens during daytime general practice, says foundation director Rick Stern. For instance, the 2008 Healthcare Commission report on emergency and unscheduled care, *Not Just A Matter Of Time*, was "an impressive document looking at the whole pathway of care but it had nothing to say about general practice in-hours".

That is despite daytime GP urgent and unscheduled care being responsible for 80

million patient contacts a year, Mr Stern says.

"The whole system is profoundly affected by the myriad small decisions made in general practice. They will shape demand on the rest of the NHS."

The foundation's research published last month was commissioned by the Department of Health. It admits "only a very small proportion" of cases seen in primary care will be urgent on a clinical definition. Coughs and colds, bad backs and depression are more common than heart attacks.

But even conditions that are not severe may demand an early response, to avoid a patient ending up in hospital or resorting to accident and emergency. The authors say it is important to regard any request for same-day care as potentially urgent until assessed by a doctor, nurse or other clinician – so basic access to general practice is vital.

Outpaced by demand

While the report insists many practices do provide a good response to urgent cases, it also reveals significant problems. A survey by the foundation in five primary care trust areas found more than a third of practices "appear to have insufficient staff to respond reliably and quickly" to calls on Monday mornings, a time of peak demand.

"The results show that more than one third of practices would be unable to keep up with demand, even if the reception staff were to focus exclusively on answering the phone in this period. Since in many practices receptionists have other duties to perform, the proportion where patients have difficulty in getting through is likely to be even higher."

'Over a third of practices in a survey appeared to have insufficient staff to respond reliably and fast at peak times'

This picture is familiar to Doncaster PCT clinical lead for urgent care Lis Rodgers.

"Patients say they can't get hold of their doctor via the telephone. They have been saying that for some time – it's incredible there are still practices that don't have decent telephone access for patients."

But British Medical Association GPs committee chair Laurence Buckman says doctors "have to constantly balance the amount of resource we have for the week".

"If we wanted to deliver enough staff on Monday morning we would have to employ a large number of people just for that day of the week," he argues. His practice has 14 phone lines but not 14 receptionists, and with 150 calls an hour on Monday morning it is inevitable callers have to wait, he says.

Even when calls are answered, patients often struggle to get an appointment. Around a third of practices in the survey appeared to have too few slots to meet the expected levels of patient demand, based on the national average of 5.3 consultations per patient per year. The extent of the variation between practices "is striking", the report says – many practices offer 125 per cent or more than the average rate, while in others it is less than 80 per cent.



Key points

- Understaffed GP practices are unable to answer all patients' calls at peak times, such as Monday mornings.
- A third of practices have too few slots to meet expected levels of demand. Those that can meet demand do so through "complex and chaotic" processes.
- Lack of incentives means in-hours unscheduled care is being neglected.

Report author David Carson, also a director of the foundation, says: "The wide variation will be accounted for by a number of factors such as differences in the patient population but it also suggests this is an area that has not had the attention it should have from practices."

The research revealed that in some places receptionists would have no same-day slots within 30 minutes of the practice opening.

"This approach inevitably led to considerable friction with patients, difficulties for reception staff and clinicians and to patients developing techniques to get round the system," the report says.

Dr Carson points out that while many practices may manage to see all the patients who get through on the phone and want a swift appointment, the process is often "complex and chaotic", relying on adding extra slots at the end of routine surgeries.

This can mean surgeries carrying on for an extra hour to 90 minutes – leaving staff

and patients frustrated, while creating a delay before urgent cases are seen.

Dr Carson says: "The more under pressure [the surgery] is, the more difficult it is for patients to access the care they need."

There is also real concern that even when patients do get through, receptionists may miss urgent cases. The survey and a series of workshops with practices found that while front desk staff would recognise classic emergencies such as chest pain, breathlessness and haemorrhage, the response to a wider range of potentially urgent symptoms was "worryingly variable", among receptionists in the same practice as much as between practices.

Patients asking for help with potentially severe allergic reactions, epileptic seizures or babies that had become floppy or drowsy might be told to dial 999, go to A&E, passed on to a doctor straight away or offered a later call-back. In some practices, →30

29 ← receptionists would be reluctant to bother the doctor.

“Practices are effectively relying on the common sense of receptionists,” warns the report. “We do not feel this is an acceptable or safe approach. Clinically urgent cases are rare, so, by definition, experience will be limited.”

The variation in response to urgent care between practices is a picture that many GPs who spoke to *HSJ* admit is familiar.

NHS Alliance chair Michael Dixon says: “The issue is that primary care has gone very much upstream to prevention and long-term conditions, while the core business of general practice, such as heart attacks and febrile convulsions in children, seems to be almost less mainstream.”

Beyond targets

Chris Peterson, chair of South Central practice based commissioning consortium in Liverpool, agrees the response to urgent cases can vary widely between practices, but adds: “If patients ring GPs with an urgent problem I would be astonished if practices don’t have systems for seeing them rapidly. That is not the kind of care I would offer.”

Fay Wilson, a member of the British Medical Association’s GPs committee and a contributor to the report, says: “Unscheduled care is not part of the must-do targets, it is not incentivised or resourced... the poor old patient with their disorganised symptoms that don’t tick any boxes gets pushed out.”

The 24 and 48-hour access targets, and the idea that primary care “should deal with today’s work today” made it harder to book advance appointments, she adds.

“Culturally it has become embedded in the consciousness of patients that you need to call at 8.30am and hang on the phone, even if practices have abandoned that system.”

Dr Wilson says GPs need to “seize back” bread and butter practice – dealing with patients who are ill – and PCTs must support general practices in addressing unscheduled and urgent care.

So how can this be achieved? The Primary Care Foundation suggests action is required from practices themselves, PCTs and emergency care networks. Practices should take charge, reviewing what they do to come up with solutions that meet the needs of their own patient populations, locality and skill mix.

“We are saying there are a lot of quite simple things you can do,” says Mr Stern, “Looking at demand so there are the right number of appointments on the right days, for instance.”

HOW TO IMPROVE IN-HOURS URGENT CARE

Practices should:

- ensure patients who need urgent care can access the system however they present, in person or by phone
- provide enough phone lines and people answering calls for patients to get through
- consider how staff would identify and respond to a range of urgent cases, not only obviously life-threatening emergencies
- review receptionist training to ensure staff

spot potentially urgent cases and handle them correctly

PCTs should:

- review the number of appointments available each week to ensure they meet patient demand, and ensure the balance of same-day to advance slots matches the pattern of demand
- support practices with reviewing and improving the process for handling requests for same-day care

‘Culturally it has become embedded in patients’ minds that you have to call by 8.30am and then hang on the phone’

Imposing solutions from above would be counterproductive, he insists, but there is an important role for the wider NHS – both PCTs and urgent and emergency care networks need to recognise that “unscheduled care is not just out of hours but what GPs do”, Mr Stern says.

PCTs should support practice based commissioning groups in this – “telling practices what to do will not have much impact but GPs addressing this with peers who are interested in reducing costs in the system to free up resources to commission more alternative services might do”.

Dr Rodgers agrees. “PCTs should use practice based commissioning as a vehicle – there is a real opportunity to put in peer review and peer pressure is your tool to make things change.”

Playing back calls

Doncaster ran two of the pilot schemes highlighted in the report, changing the way practices handle urgent cases, including changing phone systems so calls could be recorded and played back for discussion by practice staff.

“It’s not about beating practices up, but getting them to engage in development and supporting them in change,” says Dr Rodgers, who also believes PCTs have a role to play in identifying clinical leaders who can encourage practices to look at the way they handle access and urgent care.

While it is not possible to state exactly how much money could be saved by reforming the approach to in-hours urgent care, there is evidence a more strategic approach could reduce avoidable

admissions and A&E attendances dramatically (see box).

The report says practices have to realise that a more systematic approach to urgent care can help them deal with “intolerable” workloads.

It recommends practices review access by phone and in person and review capacity to make sure there are enough appointments (including telephone consultation slots) to meet expected levels of demand, paying particular attention to peak times such as Monday mornings or after a bank holiday.

Practices should consider keeping a third of appointments for people who want to be seen the day they call or visit, with two-thirds available to book in advance. The report says this appeared “the right mix for the normal demand facing many practices” across a series of studies into GP workload.

Practices should review how the team – from the person answering the phone to doctors and nurses talking to patients in person or by phone – identifies and responds to a range of urgent cases, not just obviously life-threatening emergencies, and ensure receptionists are trained in identifying potentially urgent cases.

They should set their own deadlines for the length of time from the phone ringing to assessment by a doctor, nurse or other healthcare professional, and to clinical intervention in urgent cases. It has to be the practice itself that sets the standard to reflect its own patient population and the skill mix of its staff, the report explains.

Practices should recognise that response to urgent cases is a clinical governance issue and carry out regular audits. And PCTs should “support practices with recurrent resources, expertise and advice”.

Surgeries also have to “believe patients know best and they will make good decisions about their care”, Mr Stern adds. Where things are not working and practices are overstretched, there is a tendency to blame patients for not using the system correctly.

“But going against the grain of how patients access services will often lead to people gaming and finding ways round the system. Some GPs fear if they make it easier for patients to get in it will open the floodgates, but when we have worked with practices we have shown that is not the case. There is a better way to manage workload that is better for patients and staff.” ●

FIND OUT MORE

Urgent Care: a practical guide to transforming same-day care in general practice is available from the Primary Care Foundation

→ www.primarycarefoundation.co.uk

MODELS OF GENERAL PRACTICE URGENT CARE

Immediate telephone assessment

A project led by Paul Everden of the Birchwood practice in North Walsham, Norfolk, reduced admissions to 16 per cent fewer than other local practices by introducing a team of a GP, nurse and emergency care practitioners that responds to any patient presenting with an urgent need, offering immediate telephone assessment and rapid face-to-face consultations where necessary.

Telephone callbacks and home visits

A home visiting service in St Helens in Warrington, Merseyside, covering nine practices has reduced emergency admissions by 30 per cent and saved £1m by offering prompt callbacks to patients from their own doctor or nurse, followed where appropriate by a home visit from the acute visiting service, usually within an hour.