



## ALL PARTY PARLIAMENTARY GROUP

### Primary Care and Public Health

All Party Group on Primary Care & Public Health  
Inquiry into GP Access & Health Improvement in Primary Care

#### Extra Oral Evidence Session – 29<sup>th</sup> October 2008

#### Addendum to GP Access Inquiry Report

##### APPG Attendance:

Dr Howard Stoate MP	Co-Chair
Sandra Gidley MP	Co-Chair
Stephen Hesford MP	Secretary
Baroness Masham	Treasurer

##### Speakers

David Pink	National Voices
Mark Platt	National Voices
Clive Blaire-Stevens	National Social Marketing Centre
Angela Mawle	Public Health Association

Government proposals to require general practitioners (GPs) to provide an extra half-hour's opening per week for every 2,000 patients registered with their practice are not logical, a recent enquiry by the All-Party Parliamentary Group on Primary Care and Public Health has heard.

These plans could lead to small rural and inner-city practices opening for just one extra hour each week, while big suburban practices could have a full eight hours extra opening, said MP (Labour) and GP Howard Stoate, co-chair of the group. He asked: is that fair distribution?

We cannot use a single formula to apply to the whole country, agreed Clive Blaire-Stevens, director of strategy and operations at the National Social Marketing Centre, while David Pink, chief executive of National Voices, the new umbrella group representing users of health and social care, added: "there is no logic that I can see that says you don't need longer hours if you have a small practice." He suggested that patients will simply move to bigger practices to access longer opening hours, and Labour MP Stephen Hesford added that they might well choose to use the proposed GP-led health centres in every Primary Care Trust (PCT) area which will have 8am-8pm opening hours. However, Baroness Sue Masham (Crossbencher) pointed out that, in rural areas, these could still involve patients travelling very long distances.

Dr Stoate asked: is the government right in saying that access to GPs is a big issue for the public?

Recent research by health care policy group the Picker Institute suggests this is so, and “if the people who are being served say there is a problem then, by definition, there is,” said Mr Pink. GP opening hours operate differently to the way the rest of society now organises itself, with accessibility of services being driven more by the needs of the people served rather than the efficient organisation of those who run the services, he noted.

Mr Blaire-Stevens agreed. Increasingly, consumers expect responsiveness to their world from both private and public services, and if we do not show that responsiveness, clearly there is a problem, he said.

The British Medical Association (BMA), which has resisted wider opening, clearly does not see it that way, and nor is there agreement on the issue across the political parties, Mr Hesford pointed out.

But the BMA does not represent all doctors – it holds the political line but does not reflect totally what GPs do, replied Mark Platt, director of policy and public affairs at National Voices. Surveys showing patient satisfaction with GP access are filled in by people at the surgery who have therefore seen their GP, he said, and pointed out that: “GP access is not a pressing requirement until you need to see a doctor.”

50% of all GPs have now increased their hours, the inquiry heard, and Dr Stoate wondered if longer hours will inevitably mean doctors working shift systems and a move away from direct one-to-one patient care. He asked: how will this affect continuity of care?

Continuity is not incompatible with a shift approach to working, but the issue is not about having either a 24/7 access model of impersonal care versus your own personal doctor from cradle to grave. “It is not beyond the wit of the BMA and the government to negotiate a path between those two extremes,” commented Mr Pink.

It is important to define whether the issue is about access to a GP or to primary care, said Mr Blaire-Stevens. He noted that, while some people are happy to see a practice nurse or other health professional, others feel they have to see a GP, who must be male, or female, etc. The Service must respond to diverse and different needs, and while the “one size fits all” approach has now gone, the fear of it still exists in some services. However, he added: “we must tailor people’s expectations to what is deliverable.”

The inquiry also examined whether access is being jeopardised by perverse consequences of target-setting. Patients must now be able to see a GP within 48 hours but, said Baroness Masham, if you suddenly become ill, you need a GP now, while other patients are able to wait for weeks. She asked: should the appointments system be more flexible?

The panel also heard of the “nonsense” of patients asking to see a particular doctor, and being told that they are away and that they cannot, at that time, book an appointment to see them on their return because of the “48 hours” rule.

“It is a sad reflection on how we run our services that people should behave like this to meet central targets,” said Mr Pink. While all the evidence shows that central targets have led to some huge improvements in recent years, they cannot be used as determinants of how everyone in the system is behaving. Slavish target-meeting can lead to inefficiency and people doing “silly, brainless and Machiavellian” things, he warned.

It is essential to keep targets under review, to avoid the development of perverse incentives, added Mr Blaire-Stevens.

But if the issue is really about access to primary care, how can patients decide whether they need to see a GP, a practice nurse, a pharmacist or other health care professional, or to visit a GP-led health centre, a walk-in centre or A&E, or to call NHS Direct? And with the huge diversity of the NHS, are patients the right people to make these decisions?

The fact that any A&E department throughout the country is full of people who probably shouldn't be there, receiving care which is completely inappropriate for them and delivered by the wrong people, shows the extent of the problem, said Dr Stoate. People go to A&E because they do not know how to manage their condition – primary care should give them the skills to do so, said Mark Platt, while Angela Mawle, chief executive of the UK Public Health Association, said that inappropriate use of A&E shows there is a problem with the service. There are huge inequalities here, and a local team process is needed to give people access to advice and then acceleration through the system to the right person for their needs, she said.

Most health care interactions are in fact exchanges of information, and much of this can be done over the telephone - greater use of the phone could improve access hugely, said Mr Pink. Dr Stoate championed NHS Direct which, some years ago, the government had believed would develop as the portal for the NHS. This potential has not really matured, yet it enables the patient to make one phone call and for the system to then take over, connecting them with the service they need.

Patients are the best people to decide which part of the Service they need because they are the consumers, but one type of response - human, electronic, telephone - is not enough, as this is not about choice but about the options people have, said Mr Blaire-Stevens. “It is critical to have navigators to help find the right solution tailored to the patient's own needs – that's what good commercial companies know and we can learn a trick or two from them,” he added.