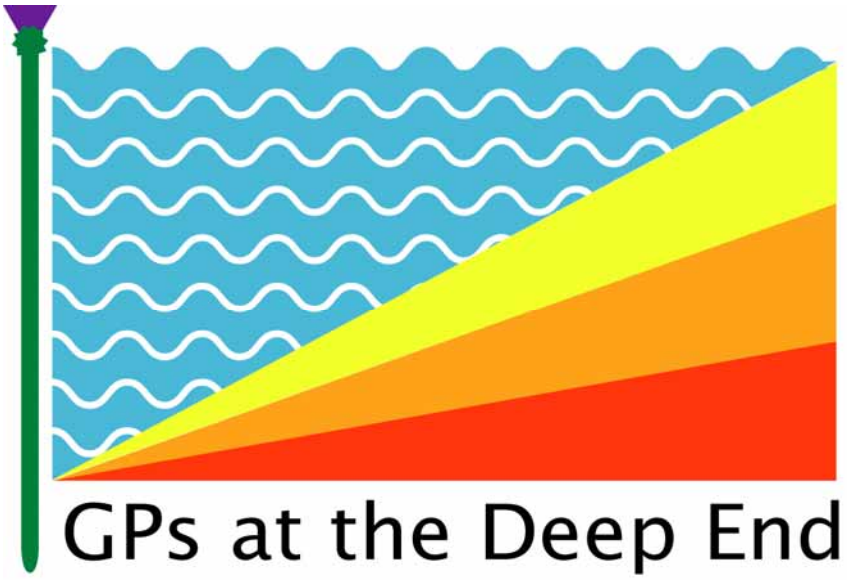


Deep End Report 13

The Access Toolkit: views of Deep End GPs

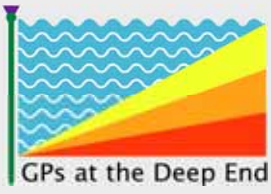
The thirteenth meeting of "General Practitioners at the Deep End"

14 January 2011

Eight GPs met on Friday 14 January 2011 in the Academic Unit of General Practice and Primary Care at the University of Glasgow for a presentation and discussion on the RCGP Improving Access Toolkit and its applicability in practices serving very deprived areas.

SUMMARY

- Deep End practices had achieved similar ratings in recent Government surveys of patient satisfaction with general practice as other practices in Scotland.
- The problem of "poor patient access" as defined by the lowest scoring 10% of practices is not a particular problem of deprived areas.
- Deep End GPs consider that the Access Toolkit includes many useful suggestions as to how patient access may be improved, not only in practices with low survey ratings but also in all practices seeking to improve their services.
- On the other hand, there are aspects of general practice populations in very deprived areas which the Access Toolkit does not take into account and which limit the applicability of some suggestions.
- Telephone access can be problematic and there is a greater expectation of same day appointments, with less use of forward planning. Behaviour change can be slow.
- The meeting demonstrated the value of occasions when practitioners can share experience, information and views, as a basis for reviewing and developing local practice. Several different ways of organising access were described.
- The Primary Care Collaborative was felt to have provided a useful mechanism for practices to work together in developing their services for patients.
- A summary of the problems and possible solutions described at the meeting will be added to the Treating Access website.
- Implementing the Access Toolkit in Scotland will work through facilitated workshops with locum cover for GPs.



"General Practitioners at the Deep End" *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow.*

Contacts for further information

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CONTENTS

ATTENDING

Name	Location	List size	Deprivation ranking
Douglas Rigg	Possilpark	3085	1
Richard Groden	Tollcross	6776	76
Sue Langridge	Possilpark	2165	18
Lesley MacDonald	Crewe MC	8979	97
Ann McGinley	Easterhouse	2462	4
Stephen MacPherson	Bridgeton	3953	42
Alistair Douglas	Possilpark	4167	12
Samantha Ross	Shettleston	3805	88

Dr Ken McLean	RCGP (Chair of Improving Access Working Group)
Professor Graham Watt	Professor of General Practice, University of Glasgow
Mr Paul Alexander	RCGP Scotland

BACKGROUND

Following a presentation by Dr Ken McLean to Scottish Council on the background, underlying principles and implementation of the Treating Access Toolkit, it was suggested that the problems with access and their solutions may not be relevant for practices serving a deprived population. In order to explore this further, a meeting was set up between GPs from practices representing the Deep End project and Dr McLean and Professor Graham Watt.

The Improving Access toolkit and a suite of supporting documents are available at http://www.rcgp.org.uk/treating_access_scotland.

Dr McLean outlined the background and research used in the formulation of the toolkit (See Annex A) and asked Deep End GPs to discuss:

- Does the advice in the Treating Access toolkit hold true for Deep End practices?
- Are there differences in the means of implementing the advice in the toolkit with respect to Deep End practices?

DEEP END COMMENTS ON PATIENT ACCESS

The Scottish Government Health Department had endorsed the RCGP toolkit and is providing funding to help 10% of practices to improve their access arrangements.

These 10% of practices ranked lowest in the results of PE7 and PE8, comprising postal questionnaires of patients on practice lists. The survey focuses on patients with experience of contacting their practice in the previous 12 months.

The overall response rate of the survey was 30%, with higher rates in affluent practices and lower rates in deprived practices.

Doubts were expressed by the attending GPs as to how accurate and reliable the surveys had been in capturing a representative picture.

It was noted that Deep End practices featured in the list of practices with reported poorer access no more frequently than expected on a pro rata basis. The corollary was that most Deep End practices, including 7 of the 8 practices attending the meeting appeared to have achieved satisfactory access arrangements.

The question then arose was whether the toolkit provided useful advice for the Deep End practices with poor reported access arrangements, or if there might be more to learn from the apparently more successful arrangements of other Deep End practices. The general view was that the toolkit is helpful but not sufficient.

Levels of demand were questioned and discussed. It was considered imperative that a balance is struck between access and demand. Too much access puts pressure on capacity. Appropriate access is the key.

It was agreed that demand is predictable by certain variables and that the suggested exercise in measuring demand in the toolkit could be very useful. This was countered with the problem of a restricted capacity to meet the demand.

Educating patients in very deprived areas is more complicated than in affluent areas. Patients from affluent areas often actively want to learn, which is less so in deprived areas. Much more effort is needed to educate and change the behaviour of patients in deprived areas.

Self-referral suggestions to deal with the patients' problems are considered less workable in Deep End practices.

Some of the specific recommendations would be harder to implement. In particular, the suggestion of increasing telephone access was highlighted as less useful due to patients in deprived area often having no credit on their mobiles to call back and the fluid ownership of mobiles with numbers changing regularly. Many patients also have the habit of not answering their phone to unknown numbers.

Issues of demand are fundamentally different in Deep End practices. For example, there is much less demand for planned appointments. Patients in deprived areas are more likely to want same day appointments, than patients in affluent areas who are more often content to book ahead. There is also a "cultural dependence" in deprived areas of expecting to see the GP for most problems.

Behavioural responses are more extreme in deprived practices. Issues such as benefits/sick lines/desperation are all more pronounced and cause more extreme reactions which lead to demands for instant access.

"Activity doesn't equal demand". This concept resonated with some Deep End GP.

Access methods utilised by Deep End practices tend to grow organically around the needs of the patient and has resulted in widely varying systems of providing access. It was agreed that some access arrangements have grown around the needs of the practice which leads to demand and capacity being mismatched over the course of the working week.

The suggestion of using patient groups to achieve better access was considered less promising due to inherent issues of representation. The feeling was that with some notable exceptions Deep End practices struggle to form useful patient groups.

At this point the discussion opened up into a much broader consideration of the pressures facing Deep End practices in addressing high levels of complex need and demand in severely deprived areas. While there is little routine data recording of these levels of need and demand, there is no doubt as to the reality of practice in the Deep End and the stresses that practitioners are under.

Research evidence was noted that Patient Enablement is flat across the board, but Deep End practitioners experience greater work stress to achieve this. It was universally agreed that stress (for GPs, practice staff and patients alike) is the primary factor that must be alleviated

It was also noted that behavioural change in deprived areas is as challenging in relation to how patients seek appointments as it is in relation to health behaviours such as smoking, exercise and diet.

Many examples were cited, however, of how general practice has changed in the last 20 years, and how both patients and practitioners have come to accept new

arrangements. Change is certainly possible and the challenge is to how to support change more consistently across the range of practice arrangements.

There is considerable variation between practices in how they configure their resources to provide access for patients. It was said that Monday is the most challenging day, and that if practices do not address this challenge successfully, they can spend the rest of the week catching up.

CONCLUSIONS

Conclusions on the applicability of the toolkit to Deep End practices

Deep End GPs agreed with all the main recommendations outlined in the Access Toolkit but point out the differences outlined above.

These particular differences will be listed on the Improving Access website (See Annex B).

Comments on the implementation of the toolkit in Deep End practices

More time is needed for busier Deep End practices to take forward the recommendations of the Toolkit. Protected Learning Time is hard to come by.

The value of facilitated training workshops was accepted. It was agreed that these would work best if GP locum cover is provided. It was agreed that practice managers and admin staff should also be involved.

General conclusions

The meeting highlighted the lack of opportunities for practices to share experience, to determine best practice and to increase the possibility of practices changing their arrangements in the direction of best practice.

It was felt that the Primary Care Collaborative (PCC) approach of small groups of practices addressing common problems, with support, had been an acceptable and effective way of promoting such change. However, the PCC has been disbanded (although retained in some areas). It is not clear whether and how support for such a scheme could be re-established, given that all new areas of NHS activity are likely to require disinvestment in other activities.

If such a scheme could be established, it would be important to involve all members of the practice team. Practice managers were quoted as saying that the problem in making new arrangements within practices was often the intransigence of GP partners and their reluctance to change familiar arrangements.

ANNEX A POWERPOINT PRESENTATION

ANNEX B USING THE TREATING ACCESS TOOLKIT IN DEPRIVED PRACTICES

This text will be added to the Access Toolkit Website

It is accepted that there are differences in the access issues and their solutions for practices serving deprived communities. These differences in approach have been highlighted by practices working in the Deep End (the 10% most deprived practice populations in Scotland). Possible solutions are in italics.

Educating the patients living in areas of deprivation is not as easy as educating those in areas of affluence. Patients from affluent areas will actively want to learn, which is less so for those in deprived areas. Therefore, much more effort is needed to educate and change the behaviour of deprived patients.

Consider using a variety of means of education including educating by the GPs during consultations, written material in the waiting room and consider involving community groups.

Self-referral suggestions to deal with the patients' problems are considered less workable in Deep End practices.

Make sure that your patients know about and use the Minor Ailments Service.

Increasing telephone access may be less useful due to patients in deprived area often having no credit on their mobiles to call back and the fluid ownership of mobiles with numbers changing regularly. Many patients also have the habit of not answering their phone to unknown numbers

Ask for the number for the GP or nurse to call back on and enter that in the appointment book rather than depend on registration telephone numbers.

The issues of demand for Deep End practices are fundamentally different as there is much less demand for planned appointments. Deep End patients tend to require instant access.

As suggested in the toolkit, the average mix of one third book on the day and two thirds book in advance appointments will need to be altered to a higher percentage of book on the day.

Behavioural responses are more extreme in deprived practices. Issues such as benefits/sick lines/desperation are all more pronounced and cause more extreme reactions which leads to demand for instant access.

As above, offer mainly book on the day appointments.

The suggestion of patient groups being used to achieve better access is considered to be less effective due to inherent issues of representation. The feeling is that with some notable exceptions Deep End practices struggle to form useful patient groups.

Some practices in deprived areas do have very active and productive patient participation groups. Speak to them and learn from them.