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PRIMARY COLOUR

Helen Salisbury: Knowing the size of the problem in general practice

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No one is doubting that general practice is in trouble—but how much, and how can it be fixed? Repeated interventions have aimed to improve patient access through online booking, e-consultation forms, and new telephones. None of these have created new capacity, and some have contributed to increased demand.[1] One attempt to plug the gap between demand and capacity has been the recruitment of lots of other clinical staff who are not doctors, through the primary care networks' Additional Roles Reimbursement Scheme.

On the face of it, this has worked. Activity is up, with four million more general practice appointments in January 2023 than January 2022.[2] However, only half of all appointments were with doctors, and I'm concerned about efficiency. So, another question is: do we know what percentage of the other half were placed appropriately with a physio, paramedic, pharmacist, or physician's associate working within their own area of expertise, and how many patients still needed to see a GP afterwards? Sometimes this means another appointment, but often these further consultations remain invisible, part of the large amount of GP work that goes into training and supervising these extra staff.[3]

Despite the increase in appointments being offered there are still places where demand hugely exceeds capacity, leading to patients being advised to call again the following day or ring NHS 111. By contrast, some practices seemingly manage to answer demand each day.

There's also variability in how much a practice can offer continuity of care. This is widely recognised as valuable to doctors and patients, but it can be hard to achieve if you're running a service with few permanent doctors and a high proportion of patient contacts offered by other clinical staff or in other settings such as urgent care centres. The extent to which practices can provide the level of care that they know their patients need (and that they want to give) is not randomly distributed. Work by the Health Foundation tells us that your likelihood of seeing a doctor rather than another member of clinical staff goes down with increasing levels of deprivation, despite deprivation being associated with higher health needs.[4]

Continuity of care is not just the preserve of doctors: seeing the same midwife or nurse is equally important. However, having a GP who knows you personally—who is familiar with your history and your family, and can make decisions with you about your care in the light of that knowledge—is surely what we aspire to in general practice.

What I haven't been able to glean from the published evidence is how many patients still have access to a responsive service where they can see a doctor who knows them, and how many are left feeling as though they have no GP and can't rely on their local surgery. This seems like one of the most important questions, as the answer determines what resources we need to fix the problem.

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1 Salisbury C, Murphy M, Duncan P. The impact of digital-first consultations on workload in general practice: modeling study. *J Med Internet Res* 2020;22:e18203. doi: 10.2196/18203. https://www.jmir.org/2020/6/e18203/. pmid: 32543441

2 NHS Digital. Appointments in general practice, January 2023: official statistics, experimental statistics. 23 Feb 2023. https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/january-2023

3 McDermott I, Spooner S, Goff M, et al. Scale, scope and impact of skill mix change in primary care in England: a mixed-methods study (*Health and Social Care Delivery Research* no 10.9). National Institute for Health and Care Research. 2022. doi: 10.3310/YWTU6690. https://www.ncbi.nlm.nih.gov/books/NBK580322/

4 Fisher R, Dunn P, Asaria M, Thorlby R. Briefing: Level or not? Comparing general practice in areas of high and low socioeconomic deprivation in England. Health Foundation. Sep 2020. doi: 10.37829/HF-2020-RC13