BMJ 2018;361:k1962 doi: 10.1136/bmj.k1962

HEAD TO HEAD

Patient commentary: General practice needs radical reform, not tweaks like consultation caps

Jennifer Skillen

My son and I have the connective tissue disorder Ehlers-Danlos syndrome. He also has autism spectrum disorder, and I have hypothyroidism and osteoarthritis. So we're both frequent users of primary care.

Our surgery has responded to the national shortage of GPs by introducing what patients call "double triage" when we phone to make an appointment. First we are triaged by the receptionist and then we wait at home for the GP to phone us.

Sometimes only a face-to-face appointment is suitable—a GP can't feel or hear the crepitus in my joints or see how swollen and red they are on the phone—and double triage seems to have helped me to see a GP more quickly. It may decrease the number of face-to-face appointments for the GPs, but it hasn't decreased the overall contact they have with patients.

Patients, of course, want safe healthcare. A cap on the number of patients a GP sees each day, as advocated by Laurence Buckman,[1] might result in safer working for doctors. But if it reduces the total number of appointments available for patients it might not be safer for us. Arguably, for some patients, no appointment is even less safe than a hurried appointment with a GP who's already been working for 10 hours.

A fifth of patients are already having to wait more than two weeks for an appointment, which is too long.[2] But simply introducing caps to the number of daily consultations would likely make this unsafe situation even worse. We'd also need extra clinics. But where would the extra GPs come from? It would take massive extra funding, and it takes 10 years to train a GP.

Deckchairs on a sinking ship

Capping appointments is like moving the deckchairs on a sinking ship. What the NHS needs is fundamental system change, not sticking plasters. We should look to international models that could transform primary care and make it safer and better for patients and GPs alike.

Consider the Nuka model developed by the Southcentral Foundation in Alaska.[3] The patient is at the centre of, and considered part of, a team that can include not just a GP but also a nurse practitioner and other professionals. A team manager is the patient's point of contact. Teamwork supports GPs by spreading the workload, and this approach encourages continuity of care.

This is very different from primary care in most of the NHS, but with some adaptation it is now working at sites in Wales and Scotland.[4 5]

Our surgery has employed an advanced nurse practitioner, clinical pharmacist, and a social prescriber. This may have helped make it easier to get an appointment, but it may not be with our GP, which sometimes is not ideal.

Patients really value continuity of care, and a cap of, say, 30 appointments might mean that if you are the 31st patient that day you have to go elsewhere or wait for another day. I'd worry if my son and I had to see an unknown GP or community health professional in an overspill clinic, decreasing our continuity of care further.

Worry lines and grey hair

Patients understand the pressures that GPs are under. We are concerned for our GPs' wellbeing, especially when we've known and trusted them for many years. We see the worry lines and the grey hair, and many of us mourn when our GPs retire early because they've had enough.

The current situation isn't fair to GPs—and neither is it fair to patients who pay for and rely on the NHS. The answer must include radical reforms to primary care. These must increase the number of appointments available to patients while reducing GP workloads. We must look beyond short term tweaks and develop long term strategies in the NHS that support GPs to support patients.

Competing interests: I have read and understood BMJ policy on declaration of interests and declare that I am chair of my surgery's patient participation group.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 Buckman L, Griffiths M. Should GPs' daily number of consultations be capped?*BMJ* 2018;361:k1947.
2 BMA. Recurrent and sustainable funding and resources. 2017. https://www.bma.org.uk/collective-voice/influence/key-negotiations/training-and-workforce/saving-general-practice/recurrent-and-sustainable-funding-and-resources]
3 King's Fund. Nuka system of care, Alaska. www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska
4 NHS Wales. Redesigning healthcare. Learning from the Nuka system of care to inform the development of healthcare in NHS Wales. 2014. http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Redesigning%5FHealthcare%5FNuka%5FSystem%5Fof%5FCare.pdf
5 Jones M. Nuka-style models of primary healthcare. *Practice Management* 2017;27:26-9. https://scfnuka.com/wp-content/uploads/2016/09/Practice-Management-magazine.pdf

jennifer@cyberbarn.org.uk