

Factors affecting decisions to extend access to primary care- results of a qualitative evaluation of general practitioners views

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BMJ Open Factors affecting decisions to extend access to primary care: results of a qualitative evaluation of general practitioners' views

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ABSTRACT

Objectives To report general practitioners' (GPs') views and experiences of an Enhanced Primary Care programme (EPCP) funded as part of the Prime Minister's Challenge Fund (second wave) for England which aimed to extend patient access to primary care.

Setting Primary care in Sheffield, England.

Participants Semi-structured interviews with a purposive sample of GPs working in 24 practices across the city.

Results Four core themes were derived: GPs' receptivity to the aims of the EPCP, their capacity to support integrated care teams, their capacity to manage urgent care and the value of some new community-based schemes to enhance locality-based primary care. GPs were aware of the policy initiatives associated with out-of-hours access that aimed to reduce emergency department and hospital admissions. Due to limited capacity to respond to the programme, they selected elements that directly related to local patient demand and did not increase their own workload.

Conclusions The variation in practice engagement and capacity to manage changes in primary care services warrants a subtle and specialist approach to programme planning. The study makes the case for enhanced planning and organisational development with GPs as stakeholders within individual practices and groups. This would ensure that policy implementation is effective and sustained at local level. A failure to localise implementation may be associated with increased workloading in primary care without the sustained benefits to patients and the public. To enable GPs to become involved in systems transformation, further research is needed to identify the best methods to engage GPs in programme planning and evaluation.

Strengths and limitations of this study

- There is a wide variation in general practitioner (GP) opinion and preference for local improvements and service redesign needed to achieve access. Practice complexity may account for different views.
- Sampling methods took account of geographical and demographic differences in the city but not the size of the practice or the practice group but extended consultation across the diversity of practice perspectives should be prioritised.
- The framework analysis was a rigorous way of synthesising the diverse views and perspectives of GP and enabling the development of an initial programme theory.
- A GP's perspectives on programme change is an important issue for policy implementation and more research is needed into how best to use a consortium to represent the views of GPs.
- The study was embedded within a particular city context and so generalisability to all Enhanced Primary Care programmes cannot be assumed.

INTRODUCTION

Incentives to manage the satisfaction, pay and sustainability of general practice are currently being reviewed in response to systems-level compressions: workload intensity, workload volume, administrative activities, increased time needed for complex patient care and increased out-of-hours commitments.¹ The General Practice Forward View² is a comprehensive policy and performance framework

that recognises the under-resourcing of primary care³ and the legacy of the Quality and Outcomes Framework to respond effectively to financial pressures faced within general practice. Some studies have suggested that GPs are influenced by the introduction of funded policy implementation programmes⁴ and that 'systems' level interventions can support change⁵ to achieve policy aspirations.

The current policy seeks to extend access for patients and to expand the range of services offered in primary care and to sustain a 'high-functioning team'.⁶ This in turn is intended to strengthen primary care to enable improved population-level health outcomes and lower hospitalisation rates.⁷ The relative focus on GPs and the capacity of the primary care workforce is a critical factor in the delivery of these policy ambitions, including the improved access to family practice.⁸



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Extending primary care

The Prime Minister's Challenge Fund for England (first wave), launched in 2013, was a £50million investment to improve general practice by increasing access for patients. The national schemes were competitively tendered, and 20 pilot schemes were delivered in cities across England, commencing April 2014. Analysis of these first wave evaluations suggested that schemes had reduced excessive emergency care in London⁹ by demonstrating how weekend take-up of appointments reduced demand on primary care throughout the week. In Greater Manchester, populations registered to primary care practices with extended access, demonstrated a 26.4% relative reduction and a cost saving of upwards of £405 per visit to emergency departments (EDs). The use of children's EDs in relation to take-up of out-of-hours (OOH) services also showed a 9% reduction in admissions via emergency departments¹⁰ and a disproportionate reduction in ED attendances among patients of higher socioeconomic status that changed their behaviour to access general practice at weekends.¹¹ These results from the first wave were consistent with the European examples of specific additional appointments being used to alleviate the demand on EDs.¹¹

Both waves of the programme were reliant on sustaining incentives for GPs to work at weekends and were dependent on a model of short individual appointments, with GPs positioned as the core provider to achieve health outcomes. A lack of knowledge about running costs of extended access and an inability to measure health outcomes at local level made decision-making very difficult for healthcare planners.¹² The evidence for extended opening hours being clinically worthwhile and financially viable is currently weak, with pilots of extended hours failing to attract patients to their service, especially at weekends.¹³ This supports the view that patient satisfaction with new ways of working can vary depending on patients' needs for essential care outside of the traditional working week (typically Monday to Friday, 9 am to 5 pm).¹⁴ In the evaluation of the first wave Enhanced Primary Care programme (EPCP), the GP perspective was limited to a survey of collective staff satisfaction¹⁵ and GPs' perspectives in relation to the national policy implementation of the EPCP have not been explored.

Further implementation at systems level

Funding of £100million for a second wave of EPCP was announced in September 2015 for a further 37 projects to focus on supporting GPs to integrate OOH services. The Prime Minister's Challenge Fund emphasised the need to improve patient access to GPs—specifically OOHs options. Extending this idea further, the Sheffield EPCP was established to enhance access to local community-based and primary care services and to manage more care in OOH settings.

The Sheffield programme had six goals:

- a. To deliver care closer to home;
- b. To increase availability of GP appointments for adults and children in practices and satellite units across the city (particularly targeted at areas of high ED utilisation);
- c. To further integrate health and social care services;
- d. To improve transitions between services with better communication across the traditional providers of care, in and OOH;
- e. Better use of technology in care processes; to improve communication and information sharing across providers;
- f. To initiate locally based innovations to address the needs of some marginalised local communities and to support people to manage their own care.

The Sheffield EPCP piloted 16 schemes, each addressing at least two of the programme goals. The largest schemes, in financial terms, included OOH 'satellite' clinics, community pharmacy provision and Single Point of Access provision for social care and mental health services.

GP participation in the scheme was voluntary. Contracts for participating practices were based on a per-patient payment and a requirement to offer sessions at OOH clinics. Eighty-seven practices across four city localities were involved in the Sheffield EPCP.

One component of the evaluation of the Sheffield EPCP programme focused on the GP perspective, in response to the previously identified evidence gap. This paper reports on that component which aimed to understand how GPs responded to the implementation of the EPCP in the context of pressure on hospital admission rates and ED attendance. This element explored views and experiences of involvement with the programme.

METHOD

We used a purposive sampling approach managed through a staged process. This involved a one in four sampling technique from the GP practices list, organised by locality, to identify 21 potential participants from a list of 87 practices across four localities in the city, ensuring good geographical spread. This sample was cross-referenced to scheme engagement to ensure that there was comprehensive coverage across and inclusion of all schemes. We contacted the managers of all of the 21 practices and requested a GP partner interview. Fourteen of the 21 practices responded and we recruited 1 GP from each practice. We then recruited 1 GP from each of a further 10 practices to ensure that our sample adequately reflected demographic factors, practice configurations and included both partners and salaried GPs with relevant involvement and experience in the programme. Interviews were completed by SFD, HP and SP. Data collection took place in May and June 2016 through a 30min semistructured telephone interview. An information sheet, consent form and a common topic guide was sent to each participant prior to the interview. Verbal informed consent was secured and recorded at interview.

GPs' reflections on their use of each scheme, factors which had influenced their adoption and perceptions of the usefulness of the programme were explored.

Interviews were audio recorded and transcribed and the data analysed using a framework analysis approach.¹⁶ There were five data management steps: familiarisation with the data through repeated reading of transcripts and notes, development of an initial framework based on interview topic guides, indexing the transcripts to apply the framework to the data, sorting and summarising the indexed transcripts to create thematic charts and building and refining categories and subcategories.¹⁷ We held frequent detailed and critically reflective discussions within the research team to achieve consensus on the analytical decisions. To refine the analysis, we also discussed our emergent findings with the patient and public involvement group who were associated with the EPCP. The systematic processes within framework analysis offer a high degree of transparency which contributes to analytic rigour.

FINDINGS

The participants in the study were 24 GPs, including 14 partners, 9 salaried GPs and 1 locum. The participants were evenly distributed across the four localities, from practices serving diverse demographic populations and in all areas of low to high social deprivation. Practices ranged in size from approximately 3000 to approximately 29 000 with 8 practices larger than 10 000. The partners represented their own views but also related these to their experiences of working in practices that varied in size of between 2 and 10 partners and reflected a range of area/locality configurations and pre-existing practice groups.

The following four themes were generated in analysis:

Theme 1: Receptivity to the aims of the EPCP

Receptivity is the degree to which an individual is able or ready to accept or adopt an innovation.¹⁸ The extent to which the GPs were able or ready to accept or adopt the programme was highly variable and was influenced by their views about the role of the general practice and the contribution of the EPCP to the overall aims of general practice. While some appeared to view the EPCP programme as a short-term centrally driven initiative with little to offer in terms of the core aims of primary care, others saw it as a pragmatic solution to manage additional demand.

This factor can be further analysed into subthemes relating to contrasting orientation at practice level.

Improving access

Overall, GPs were sceptical about the need to offer a 7-day service in general practices. Local (practice-based) capacity to manage patient access was a key factor influencing their views on the investment in OOH appointments.

We manage our services very well (at the practice) ... We don't have access problems and if we don't have a big problem we are reluctant to change practice.

We've got a very severe problem with patient access. So yes, the Satellite clinics have helped.

Quality of provision

A number of GPs rejected the idea that the main programme, satellite services delivering OOH clinics, provided the same level of care for patients. They were sceptical about the use of additional appointments for non-urgent cases and questioned their relative benefit to recipients of care.

They have to be triaged through a doctor or a nurse practitioner at their practice, but a lot of the things I'm seeing are ongoing problems or have been ongoing for weeks and weeks. ... And I think that's been frustrating for some of the patients because they've come with the expectation that it's the same as seeing your own GP when it isn't.

Whether the patients have actually noticed any improvement in access, or any benefit to the care they're getting, I doubt it ... Perhaps if they were coming here (to their own practice) rather than to a satellite, it might have been more convenient and better for them to have a familiar doctor seeing them. So it's not necessarily been a good thing from their point of view.

A financial imperative

Financial imperatives were seen as key drivers for involvement in the programme. GPs saw the opportunity to use incentive payments within the EPCP as additional funding for their practice. The business imperative to cover the cost of their surgeries and balance the books was an important factor in their decision to engage with the programme.

I suppose we're getting more and more involved because of the fact that, because of the massive funding cut that we've had, we now have to look at every opportunity we can to get some of this politically driven money.

However, they expressed frustration that this was not a good use of resource and several suggested it was not the best way to address the needs of their practice population. They proposed that funds could have been better used by devolving them to individual practices.

We're thinking really we could have done with the money invested in the Prime Minister's Challenge Fund at our own surgeries so we could have employed more staff to provide a better service. As it is we're trying to find ways of cutting costs.

Theme 2: Capacity to support integrated care teams

Capacity in this context is the process through which individuals and organisations obtain, improve and retain the skills and knowledge which ultimately enable the system to respond to the needs of patients. This theme relates to those schemes which involved adoption of additional professionals and services into primary care.

Most GPs indicated limited awareness of most of the schemes which were intended to provide new ways of working.

I'm not aware of anything that's changed, so again I think there's probably a lot of information I'm not aware of here.

Few recognised that such schemes were designed to strengthen multidisciplinary working across primary care and there was little focus on this way of working in their practice context. Instead, the GPs tended to focus on operational processes associated with managing their own workload. This localised view of practice was prevalent across all GPs based on their role as partners in practices and their knowledge and responsiveness to their own population. The example offered by one GP illustrates how they preferred to manage their team at practice level.

We would rather have developed our own existing and very good relationships with our District Nurses and our (practice) team—used our own local pharmacist and managed an increased telephone services with more training for own receptionists.

The scheme most evident to the participating GPs was one that piloted incorporating pharmacy specialists into individual general practices. There was general enthusiasm for this scheme and acknowledgement of the contribution of these additional professional knowledge and skills. Where practices had successfully managed the team integration, the pharmacy scheme was deemed to add value by adding capacity to an existing operation.

And she's been part of the team, the enormous paper chases ... So loading people's medications onto the computer, all their repeats and then reviewing them. So for our circumstances it's been timely.

(The Pharmacy Programme) has improved our clinical care undoubtedly. And it's been an added extra bonus for the patients to have their medications reviewed. And it's been good for the NHS coffers because the work that she's done has been cost effective for the NHS.

However, they identified the variation in levels of skills and the need to invest in new practitioners coming into the service.

Pharmacists within other people's practices seem to be doing loads of stuff, you know, adding drugs that have been discharge summaries from hospital, doing medication reviews, that type of thing. We've

got quite a junior Pharmacist so I'm not sure at the moment that it massively reduces our workload but I could see how it could.

Theme 3: Capacity to manage urgent care

A key purpose of the EPCP was the management of urgent care, although capacity development was not a feature of the overall programme. The variable responses in the way the programme had been used to manage urgent care reflected local capacity demands. Some GPs who evidently needed to manage capacity and demand within the finite resources and workforce reflected on the opportunities afforded by additional OOH clinics.

If I'm snowed under with too much work, and know I'm not going to cope with the amount of work coming my way, I have used them to book in in that situation. So it's a bit of both: some is capacity and some is using it as an emergency backup service.

Others levelled criticism against those surgeries which used OOH and other schemes to apparently 'off load' their patients onto OOH clinics.

I mean if people are booking those appointments at nine o'clock in the morning, you have to question why they're not seeing that patient themselves. And a lot of it is not urgent need, certainly the week day evenings is not urgent need.

Some suggested the value of generating a guideline or criteria based referral process to build consensus on the use of additional capacity in the system, based on a more strategic view of managing shared demand in a systematic way.

I'll have to be honest, I mean some surgeries are not using the service properly. We are seeing cases which shouldn't be seen here ... But they are not exactly acute or emergency cases. So I think the service is not being used appropriately at the moment. I think possibly these needs to be, I don't know, guidelines or something, referral criteria.

Theme 4: Value of schemes to enhance locality based primary care

Most GPs regarded the centralisation of the programme as an imposition; upsetting the balance between their public health responsibilities and their patient-centred ethos.¹⁹ Their viewpoints reflected the priorities of their own practice as the primary organisational unit and the specific patient population associated with that practice. Those who were already managing access to appointments questioned the value of the schemes.

I think we have really good access as a practice. We tend to try to see our own patients. We have quite a lot of on the day slots that we can book into.

GPs were cognisant of the needs of different populations of patients, especially children, and highlighted

the benefits of access to OOH appointments for the well-being of young families.

We've had lots of children with fevers and acute illnesses that have been seen. We've sent lots of adults with again potentially infectious diseases, cellulitis and chest infections, and people with abdominal pain, all sorts.

However, they questioned equality of access. Some were doubtful that patients with English as a second language and/or with a lack of personal transport were equally served by the schemes to enhance OOH primary care. Population knowledge was a determining factor for the GP's involvement in using centrally delivered schemes and many elected not to use the new capacity on offer.

Quite a few of my patients haven't got cars or easy access to cars. ... again quite a fair number of my patients don't have, either have no English or limited English. And for that reason I know myself and my colleagues are tending to not use (out of hours appointments).

GPs also questioned the acceptability of a centrally delivered scheme to patients who are best served by ensuring continuity of care.

I think people really need to feel that they've got a GP or a team of GPs that they know really well and they see regularly and they know that someone knows what is going on with their health.

Lots of patients refuse to go to the (satellite service)—we need to balance access with continuity ... most want to see their own GP

DISCUSSION

The evaluation of the Sheffield EPCP included this specific enquiry into the perceptions of GPs in relation to the programme of systems change. A synthesis of our findings suggest that GPs share an awareness of the focus of the policy landscape but had limited capacity to support integrated working other than where the new schemes were very closely aligned to current practice, as in the case of pharmacist services. There was also an apparent need to build a consensus about urgent care, based on the variation in OOH referrals and a consequent frustration caused by the perception of uneven take-up of additional appointments.

New capacity was apparently generated through funding for the programme schemes and this was construed as a short-term investment and a means of managing financial constraints. Our findings suggest that participants, GPs across the city, would prefer practice-level solutions to managing demand. Their engagement with the programme appeared to be based on selected elements of the programme that met the perceived local need.²⁰ GP perspectives offer detailed insights into the reality of implementing programmes at practice level and a

nuanced picture of the changes taking place in general practice that include: changing professional hierarchies, role distribution, particularly with nurses and practice managers and critically the relation with patients.

Evaluation of the second wave programmes identified that extended opening hours were associated with a marginal increase in satisfaction for patients who could not take time off work to see a GP.²¹ The Sheffield EPCP was unable to offer organisational development to manage sustained programme change and engage widely with GPs as stakeholders in the planning process. As a consequence, the implementation was characterised by a strong centralist managerial function²² that would have been enhanced by a specific communications strategy and feedback mechanisms to galvanise participation. A realist review of large-system transformation in healthcare identified five 'simple rules' to follow to assure sustained results and residual leadership capability. One of these is the level of engagement with physicians which is critical for transformative efforts at a local practice level.²³ Programme planning in future may benefit from organisational development infrastructures to enable a shift in focus from operational to strategic planning with the aim of yielding better population health outcomes.⁷ For example, evidence has shown that associations between general practice groups enable some shared management of increased patient demand,²⁴ particularly where local improvements in continuity of care in general practice may reduce secondary care costs for the heaviest users of healthcare.

The implications of this study relate to the needs of individual GPs coming together to plan and implement measures that improve population health within their traditional role.²⁵ The General Practice Forward View² suggests that GPs have an ongoing responsibility for new ways of integrated working. They effectively share the responsibility for chronic disease management²⁶ expanding the range of services offered in primary care.⁶ Individuals were contracted to participate in EPCP, but the financial reward for substantial effort was less of an incentive.²⁷ A collective voice in the planning and implementation of large-scale systems transformation has not yet been heard, and we found limited consistency with GPs' views about the challenges of implementation. The dimensions of access, approachability, availability and affordability are known factors in the provision of primary healthcare and are important when considering service redesign.¹

As a consequence of limited knowledge and activity in the programme, GPs saw the EPCP as peripheral to their main task of sustaining their general practice, and this is a risk to programme implementation and systems transformation. Evidence suggests that there is a need for a prepared and proactive primary care team who have the right information, tools and people, with the correct level of systems knowledge, to provide a satisfactory level of the patient-provider relationship.²⁸ The local and operational focus of most GPs militated against a strategic

systems perception of organisational change. Receptivity to systems change was dependent on the development of an interface with GPs whose espoused values included continuity of care and personalised patient management through a model of family care.²⁹

Strengths and limitations

The GP perspective on transformational interventions which this paper addresses a significant gap in knowledge. While we would not claim that the findings arising from this EPCP scheme are equally applicable to other EPCP schemes, we suggest that this project offers important insights into the variation in demand management in primary care and these insights have widespread applicability.

The overall sampling approach ensured geographical spread and coverage of all key characteristics at practice level. We did not purposively sample for practice size and demographic complexity which may have extended the range of viewpoints and experiences. At practice level, those who volunteered to participate were effectively self-selected. However, we were not seeking to recruit a representative sample and the sample size, which was substantial for this type of study, enabled us to capture a wide range of insights and experiences from GPs.

CONCLUSION

This study reports on factors that affected GPs' decisions to engage in extending access in the Sheffield EPCP. It reveals unique evidence on how GPs engaged with a programme of system-wide transformation. The schemes of new primary care deployed within the programme were not universally taken up or deemed a useful way of improving access. GPs were not fully engaged in the programme that sought to increase access and were more motivated by their own particular local delivery and concern for individual patient and population practical needs.

The mapping and interpretation of charted data to policy, systems and practice demonstrated a complex picture of involvement at different organisational levels, systems, localities and individual practices. The financial incentives were insufficient to attract GPs as stakeholders in the proposed change and so the engagement was limited to the short-term contract that tied them into a contract arrangement but did not persuade them to commit to new ways of working and to manage operational demand in different multidisciplinary ways. The variation in practice capacities and capabilities to manage change in services suggests that a more inclusive, subtle and specialist approach to programme planning and a strategy is needed to fully engage GPs.

The EPCP sought to introduce new ways of working and was a practical means of arranging additional capacity, with additional money, but critically, it did not allow GPs the flexibility to make local improvements that met the needs of their particular subpopulations of patients with

complex needs. If high-quality integrated care is to be achieved, then information and evidence of useful and progressive methods of delivering care needs to be shared with GPs who have been recognised as crucial to the quality of care and its cost effectiveness.⁹ More research is needed to identify how to improve access without generating unnecessary additional demand³⁰ or compromising continuity of care.³¹ One conclusion may be that EPCP initiatives are popular with affluent, working age people who require simple clinical access, but such initiatives may not benefit elderly people, immigrants, homeless people or others from hard-to-reach groups³² who access surgeries during the week and require a wide range of provision for complex care needs.

Contributors All authors met the four criteria of the ICMJE. Contributions are as follows. SFD: led the work stream, designed the study and managed the data collection, analysis and reporting, drafted the paper and finalised the interpretation; HP: contributed to data collection, analysis and codrafted the paper; SP: contributed to the data acquisition and analysis and synthesis and commented on drafts of the paper; BT: supported the data extraction and analysis. SK was PI on the evaluation programme and commented regularly on drafts and final submission.

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Data sharing statement A Microsoft Excel file holds the qualitative data extracted from the transcribed interview data. The data is anonymised and is stored securely in the SHU research archive. The data are available by request via the corresponding author and with permission from the PI-SK. The qualitative dataset can be accessed via Sheffield Hallam University upon request.

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