GPs at the Deep End

Deep End Report 19

Access to specialists

The 19th meeting of "General Practitioners at the Deep End"

February 2013

Seven Glasgow GPs met on Friday 15 February 2013 in the Department of General Practice and Primary Care at the University of Glasgow for a discussion about the problems patients in very deprived areas have in accessing specialist care in the NHS, and how these problems might be overcome.

SUMMARY

- In contrast to the marked social gradient in emergency admissions and out-of-hours service use, ***the social gradient for outpatient referrals is generally flat***.
- This pattern could be due to over-referral in affluent areas or under-referral in deprived areas. It may also reflect the relatively ***flat distribution of GPs*** and, therefore, their capacity to deal with patients' problems.
- It is possible to identify a ***number of factors*** – at patient, GP/practice, and secondary care levels – that may act as ***barriers to accessing specialist care*** in areas of severe socio-economic deprivation.
- ***Patient factors*** include: late presentations, competing demands, lack of confidence, literacy or language problems, and financial/travel difficulties.
- ***GP/practice factors*** include: lack of time, the burden of advocacy (e.g. re-referrals for those who miss appointments), volume of workload, and assessment of who is unlikely to attend an outpatient appointment, and for whom emergency admission may be the safer option.
- ***Secondary care factors*** include: referral processes (e.g. opt-in systems) being harder to navigate for the most vulnerable patients, communication problems (both with individual patients and with the primary care team), difficulty accessing specialist advice, inconsistency of service provision from specialist nurses, and under-resourcing of mental health services.
- ***Potential solutions*** to these challenges include:
    1. Better data collection to describe and explain variations in referral
    2. More targeted approaches, addressing the needs of patients in deprived areas
    3. Attached link workers to support the uptake of referral services
    4. Improved joint working relationships between health professionals
    5. Smarter use of information technology
    6. Clearer accountability of colleagues providing shared care
    7. Valuing and supporting the "specialist generalist" role for patients under 65
    8. Additional, targeted resources for mental health services in deprived areas.

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PARTICIPANTS

Name	Location	List size	Deprivation ranking
Alistair Douglas	Possilpark	4167	12
Alex Dowers	Townhead	12990	159
Richard Groden	Tollcross	6776	76
Sue Langridge	Possilpark	2165	18
Caitriana Park	Midlock	8343	65
Petra Sambale	Possilpark	3085	1
Marie Wilson	Easterhouse	2462	4
David Blane	Academic GP fellow, University of Glasgow (recorder)		
Breannon Babbel	Postgraduate student, University of Glasgow (observer)		

BACKGROUND

Equity in healthcare can be defined in relation to the accessibility of services, patient's use of services or health care outcomes and assessed in relation to socio-economic status, age, ethnicity, gender or geographical region [1]. This report is concerned with equity of access to, and use of, secondary care services in Scotland, in relation to patients living in areas of severe socio-economic deprivation.

The NHS is at its most equitable in relation to access to emergency care, with a steep social gradient for emergency admissions and out-of-hours service use [2,3]. This pattern relates in part to higher levels of morbidity in deprived areas, particularly multimorbidity and mental health problems [4], but a contributory explanation may be that general practice is less able to prevent avoidable emergency hospital admissions, via the delivery of preventive care, including access to specialists, in areas of greater deprivation compared to less deprived areas [5].

The recent Audit Scotland report on cardiology services highlighted the socio-economic inequalities in access to cardiology interventions in Scotland [6]. A report from the Glasgow Centre for Population Health (GCPH) also showed that the social gradient for outpatient referrals is generally flat [2]. This pattern could be due to over-referral in affluent areas or under-referral in deprived areas. It may also reflect the relatively flat distribution of GPs and, therefore, their capacity to deal with patients' problems. The GCPH report did not take account of referrals to private health care.

The economic reality of austerity policies provide the context for the discussion that follows. All public services are under financial pressure but there is a growing concern that those who are most in need of these services may be least able to access them [7].

This report is presented in two sections. First, it describes the challenges associated with access to specialists in very deprived areas; second, it proposes possible solutions.

SESSION 1 Review of the problems

A key issue hindering meaningful discussion of access to specialists is the reliability of data on referrals and the complexity of factors that influence the referral process. For example, previous research has demonstrated, but not fully explained, wide variation in referral rates to different specialties, with patient, practice and GP factors explaining less than half of the observed variation [8]. Put simply, there is no benchmark for an "appropriate" rate of referral.

Notwithstanding these limitations, several factors may conspire to reduce access to specialists in areas of severe deprivation. These are grouped below into patient, GP/practice and secondary care factors.

1. **Patient factors**

Patient factors may act as barriers to access to a specialist in secondary care at every step in the process, including recognition and prioritisation of symptoms, navigation of services in order to attend the GP, articulation of symptoms and negotiation of referral, receipt and understanding of the referral appointment and problems with travel to and from secondary care.

Examples of such patient factors include:

- *Late presentations* – e.g. "normalisation" of symptoms such as chest pain or cough [9].
- *Competing demands* – e.g. patients may have more pressing social or financial issues to deal with, so health is lower down on their list of priorities.
- *Low confidence/poor self-esteem* – e.g. psychological co-morbidities are significantly more common in deprived areas and can affect how an individual responds to symptoms and their ability to navigate the referral process.
- *Literacy or language difficulties* – e.g. patients may be unable to understand appointment letters.
- *Financial/travel difficulties* – e.g. patients may be unable to afford travel costs, negotiate patient transport arrangements or complete complicated and lengthy journeys.

2. **GP/practice factors**

Several characteristics of general practices in very deprived areas were felt to interact with the patient factors described above to reduce access to specialists. Overall, there was a feeling that GPs in deprived areas do not under-refer – certainly not intentionally – rather, referrals in more affluent areas are more likely to be patient-driven, with a higher demand for, and expectation of, a specialist assessment.

The main GP/practice factors identified during the discussion were:

- *Lack of time* – this affects many aspects of the referral process, from determining the need for referral at initial consultation (where it may be more challenging to differentiate multiple symptoms in individuals with multimorbidity and social complexity), to the time taken to write a thorough referral letter that engages the specialist in the patient's situation, to the time taken to chase up DNA (did not attend) appointment letters, which are more common in more deprived areas (and often result in more time arranging re-referral). These latter two aspects could be considered as part of the advocacy role of the GP, something which was felt to be more time-consuming in more deprived areas.
- *Volume of workload* – this relates to lack of time, as above, and to the increasing complexity of patient care. Specific concerns were raised around the volume of Docman correspondence from hospitals and the time it takes to clarify discrepancies. For example, patients with multimorbidity and polypharmacy frequently have medications stopped or re-started, with potentially serious consequences, and this can vary depending on what specialty they have been admitted under.
- *Adjudication* – as described in the literature on access to healthcare [10], there is at times a degree of "adjudication" on the part of the GP as to whether a patient is likely to attend an outpatient appointment (particularly if there are obvious competing demands and a history of non-attendance). In some cases, this may result in an emergency admission as the patient may be more likely to engage with the process when they are sitting in front of you – i.e. a "strike while the iron is hot" approach.

3. Secondary care factors

Challenges at the primary/secondary care interface include:

- *Process factors* – Opt-in systems are a particular barrier to access for some of the most vulnerable patients. Similarly, the process for arranging hospital transport, where a telephone number is provided on the appointment letter for the patient to arrange themselves, requires levels of self-esteem and assertiveness that some patients find difficult. Other problems with the use of letters to communicate appointments include failure to receive the letter (e.g. moved address, not delivered) and lack of clear instructions.
- *Communication* – there are numerous examples of where communication could be improved. One example is the transfer of information following a hospital admission or outpatient appointment, which is very variable and at worst can be inaccurate, insufficient, and slow. The situation of a patient being discharged with no diagnosis and no follow-up is not uncommon. Communication between specialists and patients could be improved. There is perhaps not the degree of adaptation in communication, on the part of the specialist, that some patients require. It is not unusual for a patient to make a GP appointment following an outpatient clinic, to ask for clarification of what actually happened at the hospital visit.
- *Access to advice* – If GP access to specialists for advice, by telephone or email, were easier, it is likely that some referrals could be avoided, while others might be initiated or expedited. In either case it is likely that the referral would be more "appropriate". Secretaries are the traditional point of contact for access to specialist advice but their numbers are being cut, and appointments are now arranged through a separate layer of administration.
- *Specialist nurses* – Specialist nurses are now a first point of contact for some patients, but access to this service can be variable. As with other services –

such as voluntary sector services – funding has been reduced for some specialist nurse services, affecting their capacity.

- *Mental health services* – Access to mental health services in deprived areas was felt to be a particular issue. Community Mental Health Teams only see patients with “severe and enduring” mental health problems; while Primary Care Mental Health Teams, which see people with mild-to-moderate mental health problems, struggle to meet demand. Addiction services have improved considerably but many patients with co-morbid mental health/addiction problems “slip through the net”.

SESSION 2 Potential solutions

Improving equity of access to specialists is a complex challenge. This section is limited to suggesting practical solutions for some of the challenges listed above, focusing on organisational and structural changes within the health service. Broader social and political changes that could positively impact on patient behaviour, for example, are beyond the scope of this report.

1. Better data collection

In order to improve our understanding of the variation in access to specialists, better data collection and analysis are required, including information on: the outcome of referrals, rates of emergency re-admission, utilisation of specialist nurses by deprivation quintile, rates of “return to referrer” letters, and rates of referral versus attendance.

It is recognised that the uptake of screening (e.g. breast and bowel screening) is lower in more deprived areas, resulting in late presentation of established disease. Uptakes could be improved if the screening process was re-connected to the practice level, with easily accessible feedback on uptake of screening by individuals. This would allow easier opportunistic engagement with patients who had not attended screening.

2. More targeted approaches

A potential solution to poor attendance at specialist clinics would be a more targeted approach to patients who are known to have struggled with attendance previously, or who might be expected to have more difficulties with attendance. It should be recognised that “one size does not fit all”. This personalised approach could be applied in different ways – for example, it could involve different means of communicating appointment times to patients (e.g. by phone, email, or text message), or different methods of information exchange at outpatient clinics.

Extending the example of screening above, the use of a mobile screening clinic in areas of low uptake, or an attached link worker (see below) could augment the more targeted approaches.

3. Attached link worker role

The idea of attached workers is not new, but as far as we are aware, the potential for an attached link worker to reduce DNAs has not previously been explored. The link worker could receive a list of all patients in their area (perhaps covering a number of practices) who were to have first outpatient appointments in the following week. They could then contact the patient to ensure that they are aware of the appointment, that they still need the appointment, and are happy with transport arrangements.

The other strength of the link worker is the potential for improving links between the primary care team and other community services (i.e. social prescribing), which could reduce the need for some secondary care referrals.

4. Improved relationships between health professionals

Secondary care barriers such as communication breakdown and process factors cited in Section A of this report could be reduced by improved relationships between health professionals in primary and secondary care, fostering trust and communication, and encouraging shared learning and feedback on referrals, possibly via shared CPD sessions for both GPs and specialists [11].

5. Smarter use of information technology

Several examples were put forward showing how technology could be used to improve the referral process and information sharing, and to reduce non-attendance:

- "Mjog" automated text message appointment reminders, used by many GP practices, could also be used for hospital appointments.
- Sharing of patient information between primary and secondary care, e.g. access to test results via NHS Portal.
- More sensitive flagging of potential interactions on primary care computer systems – there are currently so many warnings on EMIS that there is a tendency to ignore them.
- Sharing of information on DNA letters – e.g. reason for referral, date and time of follow-up appointment, if given – and for these to be addressed to the referring doctor.

6. Clearer accountability in shared care

There needs to be clearer accountability in shared care, with GPs and specialists sharing responsibility for patient care and introducing "safety-nets" whereby a patient would no longer be able to leave the outpatient clinic with no follow-up arrangements in place. A further aspect of accountability could involve patients providing confidential feedback on communication and information sharing at outpatient appointments.

7. Valuing and supporting the "specialist generalist" role for patients under 65

Multimorbidity starts 10 to 15 years earlier in the most deprived decile of the Scottish population compared to the most affluent decile and is characterised by more psychological co-morbidity. [4] While the prevalence of multimorbidity increases with age, the actual number of people living with multimorbidity under the age of 65 is greater than those aged 65 and older. This presents a double challenge for GPs working in the most deprived areas in Scotland: not only are they likely to be caring for more complex patients with multimorbidity under the age of 65 (where there is no equivalent of the Care of the Elderly "specialist generalist"), but their patients are also more likely to have associated mental health or addiction problems. Hospital physicians also need to adopt a more holistic, generalist approach and for this to be supported in their training and workforce planning.

8. Targeted resources for mental health teams

Mental health services in areas of severe deprivation require targeted resourcing to match the higher prevalence of mental health problems in these areas. There should not be a higher threshold for making a diagnosis of severe mental illness in one area compared to another. Therapeutic relationships require serial encounters, not cycles of re-referral and re-assessment. These problems are generated by a system that is over-whelmed and under-resourced.

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