UNDERSTANDING ACCESS TO GENERAL PRACTICE

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List of Abbreviations

A&E	Accident and Emergency
AGMA	Association of Greater Manchester Authorities
APMS	Alternate Provider Medical Services
BJGP	British Journal of General Practice
BMJ	British Medical Journal
CBPR	Community-Based Participatory Research
CBPT	Community-Based Project Team
CCG	Clinical Commissioning Group
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
DES	Direct Enhanced Service
DiD	Difference in Difference
DNA	Did not attend
EHR	Electronic health records
EAPMC	Equitable Access to Primary Medical Care
GM	Greater Manchester
GMCA	Greater Manchester Combined Authority
GMS	General Medical Services
GP	General Practitioner
GPPS	GP Patient Survey
HSCA	Health and Social Care Act
ICO	Integrated Care Organisation
IMPACT	Innovative Models Promoting Access-to-Care Transformation
MPC	Medical Practices Committee
NHI	National Health Insurance (Act)
NHS	National Health Service
NIHR	National Institute for Health Research
OOH	Out-of-Hours (Services)
PCC	Primary Care Commissioning Strategy
PCT	Primary Care Trust
PCN	Primary Care Network

PI	Principle Investigator
PMCF	Prime Minister’s Challenge Fund
PMS	Personal Medical Services
PPG	Patient Participation Group
PPI	Patient and Public Involvement
QOF	Quality Outcomes Framework
RCGP	Royal College of General Practitioners
T&G	Tameside and Glossop
UK	United Kingdom
WHO	World Health Organization

Abstract

Access to primary health care is an important aspect of health systems in terms of their ability to address population health inequalities. For multiple reasons, since the founding of the National Health Service (NHS) and through the last several decades, access to general practice has increasingly become a policy focus in the United Kingdom. However, when I applied a broad conceptualisation of access following a review of the theoretical access literature, I was able to demonstrate that past interventions have been based on a narrow, or absent, conceptualisation of access and relatedly, have lacked a contextual understanding of the existing issues around access to general practice. As a result, past efforts have potentially worsened health inequalities by not addressing, and hence perpetuating, existing problems of access. In a time of a growing and ageing population and a developing healthcare workforce shortage, this research aimed to understand how population access to general practice can be optimised, to make the best use of available resources and improve health inequalities.

To address this aim, I performed a qualitative, participatory instrumental case study of access to general practice in an area of Northwest England, consisting of the Tameside and Glossop Clinical Commissioning Group (CCG) footprint. I worked with, and employed multiple methods to understand the perspectives of, patients, carers, health service staff, commissioners, and voluntary sector workers. I applied the broad conceptualisation of access, as the interaction or fit of health services and population needs, in order to understand a wide range of people's experiences in context. The community-based project team (CBPT) that I formed early in this work met 35 times over 4.5 years to plan and execute this project with me. In total I conducted 19 semi-structured interviews, 7 focus groups, 13 observation sessions across 8 general practice sites (totalling 45 hours), and 12 observation sessions in relevant public meetings and events (totalling 26 hours). An ongoing, iterative, and abductive analysis process facilitated the purposive sampling and understanding of emerging concepts until data saturation was achieved.

As a result, in this thesis, I present a novel description of access problems as a paradox of demand on general practice and unmet need in the population, which was created and perpetuated by layers of reactive, rigid rules, the undermining of continuity, and resulting extra work. I apply the understanding of the paradox, in addition to the broad conceptualisation of access, to critique the main intervention to improve access to general practice during the time of this study: seven-day extended access. I demonstrate that, like previous interventions, this politically-driven idea lacked grounding in an appropriate understanding of access and of existing problems, and continued to perpetuate the problems within the paradox, including unmet need within the population. I also apply the paradox to critique another policy trend in general practice of increasing practice size. I demonstrate that several issues within the paradox were exacerbated at larger practices, where the demand felt greater, the rules tended to be more complicated and rigid, and continuity was further undermined. I compare this to the smaller practices where the proactive approach required to address needs within certain groups of the population was facilitated by a less overwhelming feeling of demand, an ability to flex rules, and a preservation of various types of continuity, both with clinicians and other practice staff, which made work more efficient.

The above findings and my analysis processes enabled me to advance an understanding of access called 'people-centred access,' in which access is the fit of *human factors* of *people* on both the service and population sides of interactions. Applying this advanced understanding of access, I demonstrate *how* to optimise population access to general practice and improve population health by directly addressing the longstanding and complex issues with the paradox of access problems. Subsequently, this work has important implications for people and practice, policy, and research around *how* to approach this important issue to achieve improved population health.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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The National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) Greater Manchester sponsored this PhD and provided my stipend and project costs, including support for Patient and Public Involvement. The views expressed in this thesis are my own and do not necessarily reflect those of my funders or related organisations.

About the author

Before moving to England in 2014 to begin my PhD, I was a practicing family doctor and health services researcher in the United States. I have always had an interest in combining research with clinical work, and my previous research efforts spanned the history of medicine, genetics, medical ethics, international health, and health services research. Prior to moving here, I had focused my interest on understanding access to primary health care and its relation to health inequalities. This PhD, sponsored by the National Institute for Health Research Collaboration for Leadership for Applied Health Research and Care (NIHR CLAHRC) Greater Manchester, provided a unique opportunity for me to understand these issues within the context of Britain's National Health Service and to develop my skills as an independent researcher.

I completed my undergraduate degree with honours in the History of Science/History of Medicine at Yale University in 2004. During that time I wrote my undergraduate thesis about collaborative efforts to advance early neurosurgical techniques. I also performed laboratory research about the genetics of cerebrovascular malformations leading to stroke. I earned my Medical Doctorate with honours from Yale in 2009. During medical school, I undertook a year-long research fellowship, during which I conducted qualitative research about end-of-life discussions between doctors and patients, spending six months in the Netherlands. For these research efforts I won The Wilbur Downs Prize for Best Thesis in International Health from Yale School of Medicine in 2009. During medical school I also interned at the World Health Organisation in Geneva, working on the Age-Friendly Cities Initiative, and undertook public health and clinical experiences in El Salvador, Uganda, and England.

I completed my clinical training in Family and Community Medicine at Thomas Jefferson University Hospital in 2012. During that time, I was a visiting scholar at the Robert Graham Center for Policy Studies in Family Medicine and Primary Care in Washington, DC. I researched mechanisms to improve primary care physician payment in the United States to address workforce gaps, and highlighted the need for more dedicated time for research for primary care physicians. I then completed a two-year research fellowship through the Robert Wood Johnson Foundation Clinical Scholars Program in 2014, earning a Master of Health Science degree from Yale. During this time, I undertook a qualitative study understanding the importance of primary care home visits. Along with my co-fellows, I also executed a community-based participatory research project to address issues of access to primary care within the local underserved community at a time of significant health policy change.

After beginning my PhD in October 2014, I obtained a Certificate of Eligibility for GP Registration (CEGPR) and was accepted on to the General Medical Council's GP Register in 2016. I began working as a general practitioner in Tameside in 2017. I took a six-month maternity leave from my PhD, and a one-year leave from clinical work, following the birth of my daughter in 2017.

During the time of my PhD, I have lived in Glossop, a town within the area of my PhD case study. I have continually reflected, both independently and with my collaborators, on my varying roles and identities of resident, immigrant, student, researcher, patient, parent, and general practitioner in the area in which I have lived, worked, and carried out this research. These roles have provided me a deep sense of meaning and privilege around the opportunity and responsibility to complete, disseminate, and build on this work.

Chapter 1. Introduction

Access to primary health care is an important aspect of health systems in terms of their ability to address population health, including inequalities (Starfield, 2005). However, despite general recognition of the importance of and the attention given to ‘access,’ the concept has historically been, and continues to be, variably defined in practical, policy, and research contexts (Chapman et al., 2004; Cowling and Gunning, 2016; Penchansky and Thomas, 1981; Simpson et al., 2018), with important implications. In the context of the United Kingdom (UK), access to general practice has received increasing political and policy attention since the inception of the National Health Service (NHS) (Klein, 2010; Peckham and Exworthy, 2003; Simpson et al., 2015a), and especially in recent decades (Bostock, 2019; NHS England, 2016b). However, as I will demonstrate, how politicians and policies define access (often narrowly as ‘timely access’ (Simpson et al., 2015b)), and the extent to which they are informed by frontline experiences of patients and providers (often not adequately (National Audit Office, 2017)), remain as barriers for these efforts to ‘improve access,’ particularly in a way that addresses population health inequalities (Chapman et al., 2004).

In light of the above, as well as a growing general practice workforce shortage (Majeed, 2017), this thesis aims to understand access to general practice from multiple perspectives in order to inform how population access can be optimised by making the best use of available resources to meet the needs of all those in the population. Below, I will provide an overview of this thesis, including how I applied a broad conceptualisation of access within a qualitative participatory case study to address the above aim, and in the remainder of this chapter, I will expand on the above points to clarify the context of the contribution of this work.

1.1. Thesis overview

This thesis is concerned with understanding access to general practice both deeply and practically. As I will explain, by applying a broad conceptualisation of access, I identified gaps between the theoretical literature, real-life experiences, and interventions to address problems. I addressed these gaps through the design of a case study of an area of Northwest England, in which I used a participatory research approach and qualitative methodology to learn about existing issues of access and critique the effects of ongoing efforts to ‘improve access’ and of other trends within general practice. My findings comprise a novel description of access problems as a paradox of demand and unmet need, and a novel critique of current trends in general practice, which perpetuate these problems. My theoretical insights build on the broad conceptualisation of access, which I applied in this work, to propose a concept of ‘people-centred access.’ I ultimately address the aim of this thesis by demonstrating *how* applying this concept to the existing paradox of access problems in general practice could, in turn, optimise population access, by providing both different targets and different approaches to change than current and past interventions.

- In the remainder of this introductory chapter, I will establish the relevant historical context of general practice, and policies around access, within the NHS. I will also summarise the current national, regional, and local contexts of access to general practice during the time of this research.
- In chapter 2, I examine the theoretical access to healthcare literature and justify my decision to apply a conceptual framework of patient-centred access to health care (Levesque et al., 2013), and a broad definition of access as the interaction or fit of population needs and healthcare services (Donabedian, 1973; Levesque et al., 2013; McIntyre et al., 2009; Penchansky and Thomas, 1981), within this research. I then utilise this broad conceptualisation of access to critique the existing literature about previous access interventions and their evaluations in general practice. From this review of the literature, I reveal the knowledge gaps that this research seeks to address and articulate my overall aim and specific research questions understanding access from multiple perspectives to inform how population access can be optimised.
- In chapter 3, I describe and justify my overall research approach and methodologies, including my decision to focus on a single area as an in-depth,

instrumental case study, my community-based participatory research approach, and my qualitative methodology using multiple methods and an iterative analysis process to generate and analyse data.

- In chapter 4, I present my research findings of a paradoxical relationship between the demand on general practice and unmet population health needs, which the demand both masks and creates. I describe the reactive, rigid rules that have developed to deal with the real and perceived demand, the undermining of continuity within general practice in response to this demand and through these rules, and the increased work caused by the above, which further fuels the paradox by leaving little room for proactive or flexible care for those who need it.
- In chapter 5, I present further data that demonstrate how current attempts to address access to general practice, namely the seven-day extended access policies, do not address the issues within the access paradox and therefore further fuelled it. I describe how the local service did not address existing demand, included more complicated rules, further decreased continuity, resulted in increased work, and left unmet needs, particularly within certain groups, within the population.
- In chapter 6, I present further data to examine the effect of practice size, and the trend towards larger practices over time, on the issues within the paradox. I demonstrate how at the larger practices, the demand felt greater, the rules were applied more rigidly, continuity was more of a challenge, there was more unnecessary work, and as a result, certain groups were left with greater unmet need. In contrast, in the smaller practices the demand felt more manageable, the rules could be adapted, elements of continuity were preserved, there was less extra work, and there were examples of the proactive approach required to meet the needs of certain population groups.
- In chapter 7, I utilise the findings of the previous three chapters to articulate my theoretical insights stemming from the importance of the *human* fit of access from *both* the service and population sides. Building on the Levesque et al. (2013)

conceptualisation of patient-centred access, I propose ‘people-centred access,’ which focuses on the people on both sides of relevant access interactions, and the human factors—including roles, resources, attitudes, empowerment, knowledge, beliefs, experiences, and expectations—that affect the ability for there to be a fit of population needs and healthcare services. Importantly, this conceptualisation includes considering these human and environmental factors that affect the *abilities* of the people within the workforce to *be* patient-centred. I suggest that focusing on the people on both sides and directly addressing the issues within the paradox reflect a different approach for *how* to address access with the aim of improving the fit for all, and therefore optimising access across the population.

- In chapter 8, I discuss the overall contribution of this thesis and relate its findings to the wider relevant literature and to local, regional, and national developments. I then reflect on the strengths and limitations of my work, and describe implications and future directions for people and practice, policy, and research.

1.2. General practice and the National Health Service: Historical context

In this section, I will establish the relevant historical context of this thesis regarding access[1] to general practice in the UK. First I will describe the organisational infrastructure of the NHS and the role and place of general practice within the NHS since its inception. I will then focus on policies specifically relating to access to general practice, in order to demonstrate how this issue has historically been conceived and addressed within the NHS. For this second portion of the historical review, I will draw on a project I contributed to in 2014-2015 in which a multidisciplinary team, led by an historian and including general practitioners (GPs), historians, and health services researchers, reviewed historical policy documents relating to access to general practice (Simpson et al., 2015a; Simpson et al., 2015b; Simpson et al., 2018). The goal was to provide this historical

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[1] The definition of ‘access’ will be discussed in depth in the next chapter, when I review the conceptual access to healthcare literature. For the purposes of this historical review, policies that referred to general practice ‘access’ specifically were included, as well as those deemed relevant to access, but discussed the issue in other terms, such as geographic distribution of GPs.

context for several pieces of work relating to access to general practice within the National Institute of Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester (GM), my PhD funder.

1.2.1. Organisational infrastructure of the NHS and the role of general practice

In this section I will explain the relative position of general practice within, but in several ways separate from, the NHS, and the implications for the present day context. The NHS was created in 1948 following a movement towards such a system that began with the 1911 National Health Insurance (NHI) Act, and developed through the war years to a consensus for a truly national health service that included both hospital and primary care and was free at the point of care (Klein, 2010; Peckham and Exworthy, 2003). There was precedence for general practice to be considered separately from the rest of the health system in earlier models (for example, under NHI, GPs received capitation income for patients on their panels, but hospital care was not included) (Peckham and Exworthy, 2003).

A tension between central control and local practice has been present since the debates which preceded NHS implementation, when doctors were wary of state control (Klein, 2010). The result is that GPs have remained a separate contracted entity, rather than direct employees of the NHS, leaving the government with the ability to influence, but not direct, general practice. The hospital and general practice divide was, in this way, entrenched by the formation of the NHS as it was negotiated, and still has a lasting impact today as policy efforts strive for integration through shifting organisational boundaries between primary and secondary care (Peckham and Exworthy, 2003).

In the early years of the NHS, there was relatively little policy about general practice and primary care, other than the infrastructure to administer GP contracts, as the hospital component demanded the most consideration. The policy attention to general practice has grown over time as the cost of the NHS has consistently exceeded expectations, and primary care began to be seen as a less costly alternative to secondary care (Peckham and Exworthy, 2003).[2] In this way, access to general practice has adopted an importance in the integration of primary care and secondary care, and in creating the balance of use of resources important for the sustainability of the system. This notion is what underpins some of the current debates about access to general practice and its presumed ramifications for the system as a whole.

Efforts to integrate primary and secondary care have been manifested through organisational rearrangements over decades through various policies, which generally gave GPs increasing influence over other parts of the NHS. GP fundholding schemes were the first of such reforms in the 1990s, continuing with the formation of Primary Care Trusts (PCTs) and the notion of a *Primary Care-led* NHS (Peckham and Exworthy, 2003).[3] The Health and Social Care Act (HSCA) (2012) was a further rearrangement of NHS organisations, culminating in the realisation of a 'Primary Care-led NHS,' and establishing Clinical Commissioning Groups (CCGs) as general practice member organisations, which control commissioning of both secondary and community-based care for a geographic area. One original exception to the commissioning powers of CCGs was primary care, given potential conflicts of interest. However, though this responsibility was originally given to local NHS England area teams, there were almost immediate movements towards a greater CCG role in primary care commissioning, and as of April 2015, primary care can be co-commissioned by NHS England and CCGs with three possible levels of power-sharing (NHS England and NHS Clinical Commissioners, 2014).

Since the inception of the NHS, demand for and delivery of GP services has grown substantially (Peckham and Exworthy, 2003). General practice has become the largest provider of medical care in the UK (Harding et al., 2015). However, over the past two decades, there has been a growing awareness of a developing workforce crisis (Majeed,

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[2] Peckham and Exworthy (2003) trace this pattern through the first 20-30 years of the NHS when primary care was 'detached' from the mainstream of the NHS. They note the Family Doctor Charter of 1965 as a turning point in the development of a policy sphere for primary care. Primary care particularly began to be seen as both an issue/problem to be tackled and a solution to 'difficulties' elsewhere in the NHS in the 1980s and 1990s, due to the rise of manageralisation of the NHS.

[3] The 1990s also saw a further diversification in the organisation of the NHS in the nations of the UK, with 'The New NHS' White Paper for England and parallel white papers for Scotland, Wales, and Northern Ireland (Simpson et al., 2015a). Hence further reform discussed applies to England, unless specifically noted.

2017) as not enough medical trainees are choosing general practice and more GPs are working part-time, retiring, or practicing abroad (Mathie, 1997). New measures were put in place in 2015 to improve recruitment, retain practicing GPs, and encourage GPs to return to practice, in the form of an action plan jointly developed by the Royal College of General Practitioners (RCGP), the British Medical Association (BMA), NHS England, and Health Education England (HEE) (Snow-Miller, 2015). However, understanding of the reasons for the workforce crisis was poor and with workloads continuing to increase, the shortage has continued to worsen (Spooner et al., 2018; Spooner et al., 2019). Despite the coalition government's promise in 2015 of 5000 new GPs by 2020, and a renewal of similar commitments in various ways in the interim, the full-time equivalent of GPs has only decreased since those pledges (Pearce, 2020).

1.2.2. Policies addressing access to general practice

Specific policies around general practice, and especially concerning access, have gradually become a priority focus for the NHS over time. As stated earlier, the government had limited levers to affect change on general practice given the independent contract nature of GPs. Though that remains true today, the organisational changes that have taken place over time have integrated GPs into the NHS through structural responsibilities, and subsequent contract negotiations have been opportunities to shape the delivery of general practice. The review of NHS policies specifically affecting access to general practice highlights the trend of recent policies increasingly emphasising timely access over other issues, such as continuity of care and the geographic distribution of GPs, which had been emphasised in earlier policies (Simpson et al., 2015a; Simpson et al., 2015b).

From its inception, the NHS removed a financial barrier for accessing general practice by making services free at the point of care (Simpson et al., 2015a). This made GP services theoretically accessible to the entire population, not just those who could afford to pay. However, the distribution of GPs was not necessarily aligned with public need, especially considering GPs perhaps had been established where people could pay or where GPs could serve members of their panels through NHI (Peckham and Exworthy, 2003). For this reason, the Medical Practices Committee (MPC) was established with the aim of ensuring the distribution of GPs and geographic variability (Peckham and Exworthy, 2003). The MPC established criteria based on the number of GPs per population and resulting list size to determine whether an area was ‘adequately doctored’ and whether a new application to practice would be encouraged (designated area, list over 2500), normally approved, dependent on local circumstances, or rejected (restricted area, list under 1700) (Peckham and Exworthy, 2003). Despite this and other measures, unequal distribution of GPs has remained a structural issue for the NHS.

The second half of the twentieth century saw increasing attention paid to issues of access within general practice. A series of mid-century governmental reports prioritised the importance of the doctor-patient relationship, including limiting the MPC from being able to assign GPs to certain places, so that they, along with patients, could enter into these relationships freely (Simpson et al., 2015a). These reports expressed the opinion that continuity should be preserved, including in the out-of-hours (OOH) time, in the interests of the patients, yet also recognised the resulting demand and increasing workload on GPs (Simpson et al., 2015a). These views were upheld by the 1979 Royal Commission on the NHS (NHS, 1979). In the 1980s and 1990s, there was a general political trend towards consumerism and managerialism, with the language of the market introduced into the healthcare context, including emphasising choice and competition, and viewing the patient as a consumer (Klein, 2010). Subsequent government reports focused on making services responsive and keeping convenient hours of opening for patients, yet also noted the need for general practice to be seen as an attractive career option for doctors (Simpson et al., 2015a). The tensions within these documents allude to problems that persist to the present where there is little discussion about managing patient demand, and as previously described, there is a shortage of trainee doctors entering general practice (Harding et al., 2015).

New Labour and the new NHS Plan in 2000 (NHS, 2000) were concerned with access to general practice and wanted the ability to measure access to general practice. It was thought that a measure of how long a patient had to wait to see a GP might be more useful than list lengths or the percentage of the population registered with a GP, both traditionally regarded as indicators of access (Simpson et al., 2015a). A target that patients would be able to receive a GP appointment within 48 hours was established, leading to a number of practice changes to meet targets, including adopting Advanced Access, which affected other modalities of accessing general practice.[4] (This target was abolished in 2010, but the effects on the focus of timely access remain, as this thesis will explore.) The NHS Plan made reference to a 'mature doctor-patient relationship,' which was based on mutual rights and responsibilities, and acknowledges the tension between supplying care to the public and managing the supply of GPs. In an effort to make the profession more desirable, OOH responsibilities were taken out of the 2004 GP contract, leading to a restructuring of providing that care by a variety of different mechanisms which persist today. During this time, other changes were made to introduce options for patients accessing primary care including a DES (direct enhanced service) for GPs to provide extended surgery hours, nurse-led walk-in centres, and a nurse-led telephone help line (NHS Direct) with targets to expand capacity to 750 centres and 30 million callers per year respectively (Simpson et al., 2015a). Also during this time, there was an acknowledgement of the continued unequal distribution of GPs. The MPC was abolished and more direct measures were taken in the GP contract through a needs-based formula (Peckham and Exworthy, 2003). New contracting routes were also established including Alternate Provider Medical Services (APMS) and Equitable Access to Primary Medical Care (EAPMC), which encouraged non-traditional providers of primary care to enter the market, including private companies, in under-doctored areas. The success of these policies is mixed, as some failed to recruit enough patients and had to close (Coleman et al., 2013).

1.3. National context of access to general practice

In addition to the major reforms already described through the HSCA (2012), at the start of this project in 2014, the government was consciously focused on access to general

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[4] I will address the evaluation of these various interventions around access to care in chapter 2.

practice, perhaps as a potential lever to control cost and utilisation in other parts of the NHS (NHS England, 2016b). Policy rhetoric at the time assumed a direct link between GP access and Accident and Emergency (A&E) use (Cowling et al., 2015), with one of NHS England's "underlying objectives for general practice…ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances" (NHS England, 2013; quoted in Simpson et al., 2018). In 2013, a £50 million Prime Minister's Challenge Fund (PMCF) was established to pilot extended opening hours in GP surgeries to ensure seven day per week opening with 8am-8pm access (Iacobucci, 2013; NHS England, 2016b). Although there was conflicting evidence about the effectiveness of extended access to general practice reducing A&E usage, (Cowling et al., 2014; Harris et al., 2011; Huntley et al., 2014) a second round of PMCF was rolled out in 2015 with a budget of £125 million (NHS England, 2016b). The notion of timely access to general practice continued to shape national and local access debates.

Over the course of my PhD, access to general practice remained a contentious and relevant issue in England. Multiple political developments continued to reshape the NHS landscape in which primary care is accessed and delivered. Although the Conservative party won the general election in May 2015, a cascade of leadership changes followed the United Kingdom's referendum vote to leave the European Union, in June 2016, affecting the Prime Minister and Chancellor, but notably not the Secretary of State for Health, Jeremy Hunt. Before the leadership change, the PMCF was renamed the Prime Minister's GP Access Fund (NHS England, 2016b), with a strengthened focus on seven-day routine access to general practice (Cowling and Gunning, 2016; NHS England). As I will elaborate in later chapters, this focus has persisted despite survey data from the GP Patient Survey (GPPS) and the government's commissioned evaluation of the PMCF not supporting Sunday opening for routine general practice services (Ford et al., 2015; Mott MacDonald, 2015).

At the time, the notion of seven-day general practice services was part of the government's larger push for a seven-day routine NHS. Hunt's claims for seven-day hospital services were based on contested and contradicted analyses of hospital mortality rates, which show an increase at the ‘weekend’ (defined by the authors as Friday to Monday) (Freemantle et al., 2015; Meacock et al., 2016). Although it is unknown whether these deaths are linked to staffing at weekends, Hunt repeatedly made these claims, which led to a bitter and unprecedented contract dispute with the junior doctors.

Meanwhile, the increase in workload for general practice in the last decade was quantified as 16% (Hobbs et al., 2016), and the general practice workforce shortage grew, with deprived areas particularly affected (Madsen, 2016). In addition, measures of austerity and subsequent cuts to social care have led to what one GP leader has called, ‘a lost decade for tackling health inequalities’ (Chand, 2020).

There were several governmental leadership changes during the time of this study. However, access to general practice, defined in the narrow way of timely access, continued to be a priority, with Boris Johnson in his first speech as prime minister, specifically mentioning access to general practice as a priority issue, citing recent waiting times for routine appointments as an area that needed to be addressed (Bostock, 2019). Notably, as I will explain in this thesis, the Royal College of General Practitioners (RCGP) has long been a proponent of continuity of care, and increasingly over the time of this study, has recognised the need to view access more broadly, and to include aspects of continuity. In this way, the prime minister’s speech was met with a warning from the RCGP chair, Helen Stokes-Lampard, about “‘vote-winning gimmicks’ focused on GP appointment waiting times” that could “set general practice back 20 years” (Bostock, 2019). In addition, there have been conflicting forces at play around the landscape of the NHS between the government and NHS England, with the HSCA (2012) legislating certain aspects of competition within the NHS, yet the NHS Five-Year Forward View (NHS, 2014) and The NHS Long Term Plan (NHS, 2019) emphasising collaboration. In general, the national political scene, including the NHS being used as a political football, has affected the ability for meaningful and sustained attention beyond campaign promises to be paid to the issues affecting access to general practice.

1.4. Regional Greater Manchester context of access to general practice

While access to general practice became a policy priority on the national front, it was also a specific focus of regional policy in Greater Manchester through several developments, which made it a relevant place to research access during this period. Most importantly, in 2015, was the GM Devolution of power over budgets for transport, housing, policing, and health and social care, leading to the GM Health and Social Care Partnership (HCSP) (HM Treasury and Greater Manchester Combined Authority, 2015). However, prior to that development, there had been ongoing efforts in the GM area to integrate care across primary and secondary settings, including an initiative called Healthier Together (Greater Manchester Association of Clinical Commissioning Groups, 2014), which led a primary care demonstrator community pilot and evaluation of extended access services.

Preceding the HSCP, Healthier Together began in 2012 and was a partnership between the ten local authorities—the Greater Manchester Combined Authorities (GMCA) and the Association of Greater Manchester Authorities (AGMA), as well as the Association of Clinical Commissioning Groups, the acute hospital trusts, and the NHS England GM Area Team. It was primarily a programme of hospital redesign across GM involving urgent, emergency, and acute medicine, acute surgery, and women's and children's care. The programme also addressed and described an investment in primary and community care as it aimed to shift care away from the hospital setting. Specifically, around access to general practice, Healthier Together aimed that:

> By the end of 2015, everyone living in Greater Manchester, who needs medical help, will have same-day access to primary care services, supported by diagnostics tests, seven days a week; by the end of 2015, people with long-term, complex or multiple conditions such as diabetes and heart disease will be cared for in the community where possible, supported by a care plan which they own; community-based care will focus on joining up care with social care and hospitals, including sharing electronic records which residents will also have access to; and by the end of 2016, residents will be able to see how well GP practices perform against local and national measurements (Greater Manchester Association of Clinical Commissioning Groups, 2014, p.4).

The GM Area Team's primary care commissioning (PCC) strategy document for 2014-2018, "Our 5 year strategy for improving primary care within Greater Manchester, supporting the development of community-based care", was developed in conjunction with the CCGs and the AGMA (NHS England Greater Manchester Area Team, 2014). It describes how their strategy aligned with Healthier Together and with efforts by AGMA to implement local integrated care models for health and social care (Association of Greater Manchester Authorities, 2012). With a total annual budget of £620 million for primary care in GM when the document was produced, the Area Team was responsible for developing and implementing the strategy across GM in partnership with local authorities, CCG, NHS and Foundation Trusts, community providers, and the voluntary and private sectors.

The PCC strategy contained several specific commitments and aims relating to access to general practice. 'Access and responsiveness' was one of five key primary care commitments made in the strategy, stating, "There will be easy access to high quality, responsive, preventative primary care including a rapid response to urgent needs so that fewer patients reach crisis and need to access hospital emergency care" (NHS England Greater Manchester Area Team, 2014, p.4). It went on to further specify:

> Everyone will have access to professional clinical advice 24 hours a day, 7 days a week; all children under the age of 5 will be able to access general practice the same day; all patients will be assured of access to primary care within 2 hours in case of urgent and within 6 hours in case of less urgent identified health need; patients will experience increased access to and availability of screening, wellness and prevention services; ... patients will be able to access diagnostic tests quickly and closer to home; patients will be more informed about their health and understand their contribution to use of health and social care services; patients will be able to access primary care and subsequent clinical advice through a wider range of contact mediums (NHS England Greater Manchester Area Team, 2014, p.13).

Other commitments in the areas of 'Quality and safety', 'Involvement in care,' 'Multidisciplinary care', 'Increased out of hospital services,' also contained elements related to access to general practice including GPs as coordinators of care and patient access to care records (NHS England Greater Manchester Area Team, 2014, p. 10-12).

In another component of the PCC strategy, the GM Area Team reserved funds to support six demonstrator communities within Greater Manchester (Bolton, Bury, Central Manchester, Heywood, Middleton, and Stockport) to pilot innovative interventions to improve access and integrated care over 2013-2014. The original budget was £2.1 million for 6 months (later extended to £4.1 million for a total of 15 months) (NIHR CLAHRC GM, 2015). The six sites were chosen from 18 applications. The proposals were varied but had to cover a community of at least 30,000 people, support the delivery of integrated services, consider innovative technology, and extend access to primary care. Four of the demonstrators (Bury, Middleton, Central Manchester, and Heywood) offered extended general practice hours on evenings and weekends as a main component of their intervention (NIHR CLAHRC GM, 2015).[5]

When Devolution was announced, seven-day access to primary care was identified as one of the seven ‘early implementation priorities’ that were addressed in the initial year (GMCA, 2015). Despite limited data showing the pilots were successful (NIHR CLAHRC GM, 2015) and national data casting doubt on the PMCF (Mott MacDonald, 2015), this was the case. There were many potential tensions around GM Devolution, including who set the priorities and how. I was able to contribute to a paper for a special issue of the journal, *Representation*, highlighting relevant tensions around public participation, collaboration and competition, and accountability within the early days of GM Devolution (Checkland et al., 2016). As we describe in that paper, the new Devolution structures have added to the complexity created in the aftermath of the HSCA (2012).

1.4.1. Local context in Tameside and Glossop

This project was a case study of access to general practice in Tameside and Glossop (T&G), one of the CCG service areas within GM. As I have mentioned, following the HSCA (2012), the commissioning and delivery of NHS care was done at the CCG level. Therefore, as I will explain further in chapter 3, it was logical to choose one CCG area in which to explore access in depth.

The service area for T&G CCG includes Tameside, which is an area of GM, and Glossop, a town in the High Peak District of Derbyshire. This arrangement serves to align the CCG catchment area with that of Tameside Hospital NHS Foundation Trust, which geographically services the 221,000 people of Tameside and 33,000 people of Glossop. This arrangement is not without complications, though, as other important components,

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[5] I will further discuss the evaluation of these demonstrator pilots in chapter 2.

including commissioning of social care from the local authority, and Healthwatch, the consumer advocacy group, are different for Glossop than the rest of Tameside and GM. At the start of this project, the CCG consisted of 43 member GP surgeries and 128 local GPs across five localities: Ashton, Hyde, Stalybridge, Denton, and Glossop. The population of Tameside was 93% white, 6% Asian and 1% other. English was spoken by 95% of the population (Tameside and Glossop CCG, 2015).

It is useful to compare several public health indicators across the area of T&G with GM and England to understand its overall health status. For most health indicators available for comparison through Public Health England (PHE) Tameside is worse than the England average, whereas the High Peak is similar to the national average, as I have summarised in Table 1. Life expectancy is one indicator that follows this pattern for both males and females. Additionally, across the most to least deprived areas of Tameside, there is a 10.3 year and 9.3 year difference in male and female life expectancy, respectively (Public Health England, 2015b).

As mentioned earlier, T&G CCG was not involved in the demonstrator community pilots funded by the GM Area Team. During the study period it focused on its own plan for integration of health and social care commissioning called, “Care Together” (Tameside and Glossop CCG, 2020). This eventually involved a merger of the CCG and Tameside Council under a single commissioning agreement which pooled their budgets. Under Devolution and the HCCP, T&G, like all CCG areas, had to implement a seven-day access service to general practice. T&G CCG commissioned this service through three primary care ‘hubs,’ which were open evenings and weekends across the area. These were operated by the local Federation, Orbit, in partnership with GTD (previously Go-to Doc), a local urgent and primary care provider. I will return to the specifics of the seven-day access service in T&G in chapter 5.

Table 1: Summary health statistics for Tameside, High Peak, Greater Manchester, and England

Indicator	Tameside	High Peak	Greater Manchester	England
Deprivation[1]	36.7%	4.6%	17.7%	20.4%
Children in Poverty[2]	22.7%	13.1%	23.3%	19.2%
Long term unemployment[3]	8.2	5.5	8.6	7.1
Smoking status of mother at delivery	17.8%	15.8%	14.1%	12.0%
Obese children[4]	19.7%	14.7%	20.7%	19.1%
Alcohol-specific hospital stays (under 18)[5]	62.5	75.1	58.5	40.1
Under 18 conceptions[6]	29.1	24.7	28.2	24.3
Adult smoking prevalence[7]	22.4%	21.2%	*	18.4%
Physically active adults[8]	47.6%	57.4%	*	56.0%
Obese adults[9]	26.7%	20.0%	*	23.0%
Life expectancy at birth (Male)[10]	76.9	79.7	*	79.4
Life expectancy at birth (Female)[10]	80.3	83.2	*	83.1
Infant mortality[11]	3.0	2.8	4.2	4.0
Smoking-related deaths[12]	419.8	291.1	367.7	288.7
Suicide rate[13]	10.2	*	10.4	8.8
Under 75 mortality rate: cardiovascular[14]	121.2	87.3	102.9	78.2
Under 75 mortality rate: cancer[14]	173.3	137.0	164.3	144.4
Killed and seriously injured on roads[15]	24.1	37.7	25.9	39.7

1. % of people living in area in 20% most deprived areas of England
2. % of children under 16 in families receiving benefits and low income
3. Crude rate per 1,000 population aged 16-64
4. % children age 10-11 (year 6)
5. Crude rate per 100,000 population of person under 18 admitted for alcohol-specific conditions
6. Crude rate per 1,000 females aged 15-17
7. % adults aged 18 and over who smoke
8. % adults achieving at least 150 minutes of physical activity per week
9. % adults classified as obese
10. Years
11. Rate per 1,000 live births
12. Directly age-standardized rate per 100,000 population aged 35 and over
13. Directly age-standardized rate from suicide or injury of undetermined intent per 100,000 population
14. Directly age-standardized rate per 100,000 population aged under 75
15. Rate per 100,000 population

* Data not available

Source: Adapted from Public Health England Health Profiles for Tameside and High Peak (Public Health England, 2015a; Public Health England, 2015b)

1.5. Chapter summary

In this introductory chapter, I have provided an overview of this thesis and established the context of access to general practice in the UK during the time of this study. I have given a historical summary, which established the unique position of general practice within the NHS, and the multiple reasons for increasing political and policy attention being paid to access to general practice leading up to and including the period of this research. I have explained the various national, regional, and local contexts around access to general practice, which are relevant to understand my contribution. In the chapters that follow, I will expand on the ideas that I have introduced in this chapter to explain my novel approach to this topic.

In the next chapter, I will provide a review of the existing theoretical literature on access to health care, and establish the broad conceptualisation of access that I applied to critique existing access interventions in general practice and to establish the gaps that this research aimed to address. As will be made clear, my continued application of this broad conceptualisation of access, throughout my qualitative participatory case study, facilitated the description of access problems, critique of current trends, and theoretical advancements that comprise this thesis.

Chapter 2. Literature Review

2.1. Chapter overview

In this chapter, I will synthesise and critique the existing research that is relevant to this thesis, in order to demonstrate the gaps that this work addresses. In section 2.2 I will review multiple theories of access to health care and justify my decision to embrace a broad view of access through the Levesque et al. (2013) framework in this project. I will then apply this theory of access to examine relevant quantitative and qualitative research about perspectives on access to general practice in the UK, including efforts to relate access to other important concepts, such as continuity, care utilisation safety, and health equity. In section 2.3 I apply the theory of access to critique a variety of interventions to 'improve access' to general practice that have been tried over the years, and their evaluations. The application of the broad theory of access reveals the lack of theoretical input in these interventions and evaluations. In section 2.4 I summarise how my review of these different bodies of literature reveals gaps *between* these literatures. I demonstrate how most efforts to understand and intervene on access have rarely taken into account the existing theoretical literature, or other available literature on past evaluations of interventions. Finally, in section 2.5, I set out my research questions and the aims of this work to address the knowledge gaps that I have articulated around understanding access to general practice.

2.1.1. Review strategy

I used a scoping review strategy to identify the relevant literature described above (Arksey and O'Malley, 2005; Levac et al., 2010). This strategy was appropriate because scoping reviews are undertaken to map fields of research and identify gaps. I chose this approach, rather than a systematic review, because of the broad nature of the literature relevant to the topic of access to general practice, including different types of study design and grey literature. The search processes of scoping reviews are iterative and not linear. However transparency is still important. My searches began broadly and narrowed as appropriate to explore specific areas, as I describe below.

I performed initial searches in the autumn of 2014 and early 2015. In addition to keeping abreast of new research and conceptual pieces published during the study period, I repeated the searches in 2019 to incorporate new information relevant to the work in a more comprehensive way. I executed searches in Ovid Medline, ASSIA (Applied Social Sciences Index and Abstracts), CINAHL (Cumulative Index of Nursing & Allied Health Literature), and EMBASE (Excerpta Medica dataBASE), using combinations of the following keywords and Medical Subject Headings (MeSH) terms: “access” or “health services accessibility,”[6] “general practice” or “family practice” or “primary health care” or “primary care”. To narrow searches, I used the terms “general practice” or “primary care” and “access” in title searches. I limited the searches to the English language[7]. Where appropriate, I combined the above terms with those such as “vulnerable populations”. I reviewed titles and abstracts from my search results for relevant articles, which were then downloaded. In addition, I reviewed the reference lists of articles selected for further relevant articles. I searched Prospero for relevant systematic reviews. I searched key journals such as the *British Journal of General Practice* (*BJGP*) using the word “access.” I utilised existing networks of knowledge experts to identify key publications including local experts in Manchester’s Centre for Primary Care, and international experts through the North American Primary Care Research Group (NAPCRG) and the Society for Academic Primary Care (SAPC).

2.2. Theories of access to health care

An important aspect of embarking on a project about access to health care is to clearly define the concept, and to examine and critique previous efforts to do so. As I will demonstrate below, despite ‘access’ being a commonly used word in everyday language, and despite the importance of and attention paid to access to health care within both political rhetoric, and health services research, there is no standard definition nor way to

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[6] Health services accessibility is under MeSH term “Delivery of Health Care” which was also explored, including its other sub-headings: “after-hours care”, “answering services”, “culturally competent care”, “delegation, professional”, “delivery of care, integrated”, ‘health care reform”, “healthcare disparities”, “telemedicine.”

[7] Limits on country were also explored (“Great Britain” or “England” or “United Kingdom”) but were inconsistent in terms of indexing.

measure it. As I will describe, some efforts to understand access have focused on broad and comprehensive models, some aimed to be practical, and some were intent on measuring using proxy concepts such as healthcare utilisation. Perhaps because of this difficulty with defining such an important concept, many efforts to study or improve access to general practice in the UK have not explored its meaning. As I alluded to in chapter 1, most have pursued a narrow definition of access as speed of access, or did not define it at all. This lack of consideration of the concept sets the stage for some of the persistent problems with efforts to address access, which I will later demonstrate. My critique of the theoretical literature that follows is therefore important both for me to establish clearly how I defined access within this project, and to demonstrate the implications when others, either purposely or inadvertently, omit such reflection.

2.2.1. Early conceptual work on access to health care

The conceptual work of several American scholars in the 1970s reflected their recognition of the disparity between the importance of access in policy and the lack of appropriate definitions. In 1974, Aday and Andersen, some of the most widely-cited scholars on the topic, summarised that, “Thus far, access has been more of a political than an operational idea” (Aday and Andersen, 1974, p.208). Aday and Andersen’s multiple models of access were revisions from Andersen’s earlier quantitative sociology doctoral dissertation on patterns of use and utilisation of health care (Goldsmith, 2007; Ricketts and Goldsmith, 2005). Andersen’s original model focused on “predisposing, enabling, and need components” of patients and later revisions incorporated health systems components (Aday and Andersen, 1974; Aday and Andersen, 1981, p.213). Their 1983 model differentiated access from use and utilisation by conceptualising “potential access” and “realised access” (Andersen et al., 1983, p.50). These models were complex, incorporating multiple concepts, with the relationships between them sometimes unclear. Being derived from quantitative data, they did not engage fully with patient and practitioner perspectives and experiences. Also originating from a model of utilisation, it was difficult, even through the multiple iterations, to achieve something that usefully conceptualised access.

During the same period, Donabedian, an epidemiologist and pioneering health services administration researcher, was the first to combine a discussion of the assessment of need and the assessment supply of health care, with the idea of “accessibility” that “comprises those characteristics of the resource that facilitate or obstruct use by potential clients” (Donabedian, 1973, p.419). Penchansky and Thomas, other contemporary public health scholars, built on the work of these scholars, and defined access “as a concept representing the degree of ‘fit’ between the clients and the system,” and further defined five dimensions of access: “availability, accessibility, accommodation, affordability, and acceptability,” concerning various aspects of the relationships between services/providers/supply and clients/patients (Penchansky and Thomas, 1981, p.128).

These conceptualisations represented useful contributions to understand and measure access to health care, and to move from a political idea to something meaningful in the space of health services research and improvement. However, while Penchansky and Thomas (1981) embraced the idea of fit, their focus was on aspects of the system and how accessible it was, rather than on the people trying to access health care. They used survey data to establish and validate the dimensions, and proposed these surveys as the way to measure access through the dimensions. The predetermined questions of the surveys may not have reflected the contextual experiences of patients and practitioners. Some of the limitations of these models, which I have described, have been addressed in more recent efforts to address the continued gap between the importance of access to health care and a useful conceptualisation of it.

2.2.2. Recent models and related conceptual work

Several more recent access models have embraced these concepts, including the notion of access as an ‘interaction or fit’ and the dimensions of accessibility, and have added to and refined them in different ways. For example, in 2009, McIntyre et al., focusing on low and middle-income countries, proposed a framework that included availability, affordability, and acceptability as three dimensions of access (McIntyre et al., 2009). Similar to Penchansky and Thomas (1981), they called for measuring access through these dimensions, rather than relying on utilisation as a proxy, as Aday and Andersen’s

(1974) model had done. Distinctively, McIntyre et al. (2009) included the concept of empowerment in their definition, defining access as “the empowerment of an individual to use health care and as a multidimensional concept based on the interaction (or degree of fit) between health care systems and individuals, households, and communities” (McIntyre et al., 2009, p.179). A strength of their work is how it builds on earlier scholarship. However, it is not derived from or applied to other empirical data. McIntyre et al.’s (2009) emphasis on empowerment brings the individual into the definition and appropriately addresses issues of power and agency, which is another strength. However the utility of the definition is limited by defining access as empowerment *and* as the interaction or fit. Also, the visual framework accompanying the work is complicated and does not depict the individual or the concept of empowerment within it. While this definition embraces empowerment, it may take the issue of need for granted, perhaps because in low and middle-income countries, unmet need is presumed and dominates discussions. Importantly, while McIntrye et al. (2009) called for policies around access to focus on the fit between needs for health care and receipt of care, which is a strong practical redirection, their model failed to depict that interaction or fit in a way that could aid this.

In light of the above limitations, I considered other relevant work that focused on patient experience as it relates to accessing healthcare. This is important because such work engages with questions of need and appropriateness, which are especially relevant to the setting of the UK. Some of this work goes beyond the field of health services research to include behavioural and psychological sciences. Although some of this work relates to specific patient groups, it reveals insights about the larger picture of access. For example, the concept of candidacy, developed through a critical interpretive synthesis of literature around access to care for vulnerable groups, described “the ways in which people’s eligibility for medical attention and intervention is jointly negotiated between individuals and health services” and a “dynamic and contingent process, constantly being defined and redefined through interactions between individuals and professionals” (Dixon-Woods et al., 2006, p.7). This work has several strengths including its methodology, which expanded on conventional systematic review methodology and allowed for inclusion of and critical reflection on multiple qualitative accounts. The grounding in qualitative literature allowed for understanding of people’s experiences in context, including the complexities of these processes. Similarly, by conceptualising a ‘negotiation,’ the authors both move beyond debates around necessary and unnecessary demand, and convey a sense of a changing rather than static reality, which more accurately captures developments over time than earlier models.

In related efforts, UK researchers investigating access to mental health care for hard-to-reach groups performed a secondary analysis of qualitative data to create a model reflecting the reality of experiences while attempting to seek care (Kovandzic et al., 2011). They used the concepts of candidacy, concordance (the match between users’ and practitioners’ narratives and resources for successful access), and recursivity (the interdependency of users’ experiences of health services and future actions in regard to health and help-seeking). This is a valuable study because it applied several relevant theories to empirical qualitative data to derive a model of care seeking experiences, including notions that previous experiences of care seeking have a profound impact on future behaviour. The issues at play are evident in the model, which is reflective of people’s experiences and therefore, more logical to follow than some previous models. The Kovandzic et al. (2011) model, as well as candidacy (Dixon-Woods et al., 2006), provide an alternative way of conceptualising issues of access that focuses more on patient experiences.

As with earlier models, some recent conceptualisations of access are largely based on how access could be measured. One such relevant conceptualisation of access relating to general practice in the UK is from The King’s Fund report, ‘A rapid view of access to care’ which was part of a broader ‘Inquiry into the Quality of General Practice in England’ (Boyle et al., 2010). Reviewing some, but not all, of the above conceptual work, it departed from synthesising previous efforts and came up with its own definition, which described three dimensions for measuring access: physical access (availability of GPs, proximity, design of premises, telephone access, home visits, electronic access), timely access (appointment and booking hours, out-of-hours care, waiting times, prescriptions), and choice (choice of practice, choice of professional) (Boyle et al., 2010, pp.8-9). The report identified existing data, largely quantitative data from the GP Patient Survey (GPPS), which could be mapped onto these dimensions.

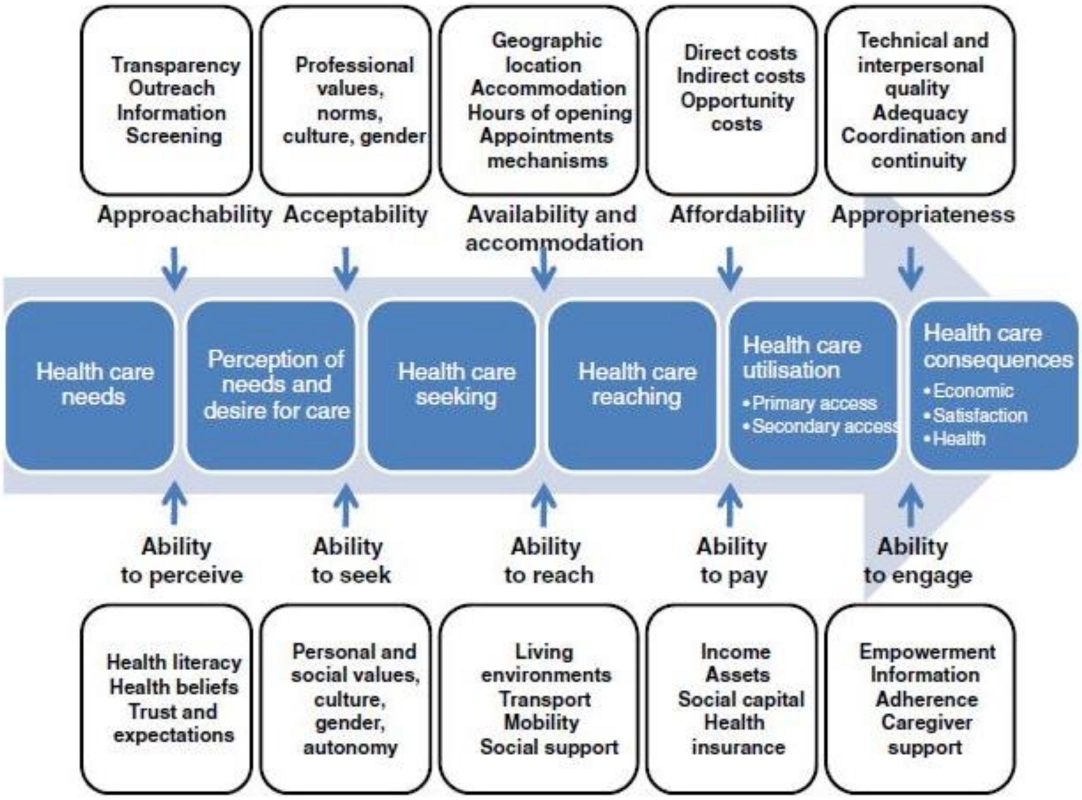
This King's Fund conceptualisation of access has been adopted by some other recent works relevant to UK general practice. However, while convenient for matching with practical measurements from available data, it lacks some of the depth of meaning and nuance about access captured in both lines of conceptual work I described above. For example, it does not capture the aspect of negotiation and implies a static measurable reality. Whilst it may be a useful starting point for providers to consider their own practice, it lacks subtlety in identifying underlying causes and in understanding experiences. Moreover, it is reliant on somewhat unreliable data sources, as The King's Fund's own analysis showed.

The GPPS is a postal questionnaire in the UK that began in 2007 (and was preceded by the General Practice Survey, which started in 1998) as an attempt to allow for systematic comparison of patient experiences over time and between different parts of the country. Although it is frequently used, it has several limitations. The survey has generally achieved a response rate of about 40%, representing about 4% of the population (Boyle et al., 2010). Not only is there a low response rate, but there is evidence of systematic bias of response rates, at both the practice and individual levels. According to The King's Fund analysis of the survey, the categories 'unemployed', 'non-white', 'poor health', 'learning difficulty', 'permanently sick or disabled', 'psychological or emotional condition', and 'fair health' had a negative correlation with response rate. While 'looking after the home', 'aged>65', 'very good health', 'fully retired from work', and 'white British' were positively associated with response rate (Boyle et al., 2010). In light of the limited quality of the available quantitative data on which this conceptualisation depends, while it may be a somewhat more practical conceptualisation of access, it is limited in its own stated purpose to be able to meaningfully 'measure' access. I will further critique this conceptualisation below in comparison to the Levesque et al. (2013) framework, which I ultimately embraced for this project.

2.2.3. The Levesque et al. (2013) conceptual framework of access

As I have demonstrated above, there have been multiple theoretical approaches to access, many of which are useful, but which nevertheless have various limitations. One of the most comprehensive recent models of access, which is both informed by a thorough synthesis of existing literature and grounded in empirical work, is the Levesque et al. (2013) conceptual framework of 'patient-centred access to health care' (see Figure 1).

Figure 1: The Levesque et al. (2013) framework of patient-centred access to health care



Similar to McIntrye et al. (2009), the Levesque et al. (2013) model adopted the concepts, evident in in the work of Donabedian (1973) and Penchansky and Thomas (1981), of interaction or fit and dimensions of accessibility of the healthcare system, However, the Levesque et al. (2013) model manages to depict that interaction or fit by matching aspects of the abilities of patients and people within the population with the dimensions of accessibility of the system, mapped along the different stages of the process of seeking health care. The Levesque et al. (2013) model therefore succeeds in incorporating people and their experiences within the models of accessibility of the system. While the healthcare seeking process is perhaps overly simplified in that it is linear (as opposed to the cyclical and dynamic nature of care seeking conveyed by Kovandzic et al. (2011) and Dixon-Woods et al. (2006)), it makes for a useful, logically arranged model. In addition to the three dimensions of healthcare system accessibility that McIntyre included, approachability, at the start of the care seeking process, and appropriateness at the end, allow the possibility for some of the recursivity and dynamism that Kovandzic et al. (2011) depict and Dixon-Woods et al. (2006) describe. Taking into account the various aspects of the abilities of people included to perceive a health need, seek care, reach care, pay for care, and engage with care, this model appropriately considers patient experience and gives it the visual attention warranted. The issues depicted in the boxes as affecting abilities, such as health literacy and social support, are related to, but are more transparent and specific than ‘enabling, predisposing, and need components’ of Andersen and Aday’s models (Aday and Andersen, 1974).

The breadth and comprehensiveness of this model are its strengths. In listing individual factors related to the five dimensions of accessibility, aspects of care relevant to access, but often left out of narrow definitions of access, are included. For example, continuity is included under appropriateness. As I will elaborate more in the next section, in narrow definitions, access and continuity are often claimed to be at odds with each other. This model depicts the falseness of that dichotomy. The King’s Fund model also included continuity in terms of choice of professional, which is a strength, but it lacked breadth and depth in other aspects, which limited its usefulness to facilitate deeper understanding (Boyle et al., 2010). Similarly, the breadth of the Levesque et al. (2013) model gives context to individual aspects of access that receive much attention in the contemporary policy realm, perhaps because they are measurable or relatively easily changed, like hours of opening or appointment mechanisms. While some might think that those aspects define access, this model demonstrates that access is much more capacious, and they are just two items in one of the many boxes in the model. As I will explain later, this conceptualisation is also useful because it opens up more tangible potential targets for change in efforts to improve the interaction or fit of access.

Another strength of the Levesque et al. (2013) framework is the consideration given to the different levels at which it could be applied. Although it is a comprehensive model and places itself at the “interface of health systems and populations” (Levesque et al., 2013, p.1), it also specifically acknowledges the accessibility of “providers, organisations, institutions, and systems” and the abilities of “populations, communities, households, and individuals” (Levesque et al., 2013, p. 6). This consideration of different levels enhances the practicality of this model, because whether someone is concerned with access at either the individual or the population level, at the provider or health system level, or anywhere in between, they can be assisted in conceptualising access.

Ultimately, I chose the Levesque et al. (2013) framework as the conceptualisation of access during the early stages of this project because I felt it had two core advantages: firstly it included important elements of access, often absent from simple, practical definitions; secondly it was understandable as a logical image. It reflected the early conceptual work as well as the more recent qualitative work on patient experiences. I was able to utilise this understanding of access to critique existing literature and policy efforts around improving access, as I will describe in the next sections, and very practically during my engagement work, data generation, and analysis as I will explain in chapter 3. Crucially, I was also able to advance this theory using my own findings, which I will describe in chapter 7.

During the period of my project, some further efforts were made by leading researchers to conceptualise access in relevant ways, recognising that work on access in the UK was still largely under-informed by theory. For this reason, in 2015, Campbell and Salisbury published a model, which incorporated some of the above conceptual work, though not Levesque et al. (2013) (Campbell and Salisbury, 2015).This model appeared after the tangible work on my project had started, however I would have still chosen the Levesque et al. (2013) model, as I found theirs to exhibit some of the same weaknesses of Andersen’s models (whom they cite), with confusing directionality, and lacking the breadth and depth that Levesque et al. (2013) achieved. Although they cite Penchansky and Thomas (1981) and include some dimensions of access, Campbell and Salisbury did not visually depict the interaction or fit that Levesque et al. (2013) were able to by giving equal and symmetric space to system issues and population issues along the care-seeking pathway.

2.3. Access in relation to other healthcare concepts

Having made clear how and why I embraced the Levesque et al. (2013) conceptualisation of access, I will now begin to apply this theoretical understanding of access to engage with and critique other existing literature about access. I will begin with several bodies of work which relate access to other important concepts in healthcare, including continuity, care utilisation, patient safety, and health equity.

2.3.1. Access and continuity

A major concept, which access is often discussed in relation to, is continuity of care. However, like access, continuity is frequently not clearly defined within work aiming to address it. Therefore, I begin with a brief summary of relevant work conceptualising continuity to clarify how I understand and will use the term. In 2003, a multidisciplinary review of continuity of care published in the *British Medical Journal* (*BMJ*) defined continuity as “the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient’s medical needs and personal context” (Haggerty et al., 2003, p. 1221). Authors defined three types of continuity as relational continuity (“an ongoing therapeutic relationship between a patient and one or more providers”), management continuity (“a consistent and coherent approach to the management of a health condition that is responsive to a patient’s changing needs”), and informational continuity (“the use of information on past events and personal circumstances to make current care appropriate for each individual”) (Haggerty et al., 2003, p. 1220). This work was commissioned by three health services policy and research bodies in Canada and aimed “to develop a common understanding of the concept of continuity as a basis for valid and reliable measurement of practice in different settings” (Haggerty et al., 2003, p.1219) It is a strong contribution in that it included a multi-stage synthesis of over 500 diverse documents, and produced a set of definitions for the overall concept and different types of continuity that are understandable, yet reflect the complexity of these issues within real-life care. Importantly, while they noted the difficulty in measuring these concepts with available data, they did not allow that to limit their articulation of the concept. The RCGP embraced the Haggerty et al. (2003) definitions in their 2011 and 2016 reports on continuity of care, while also stressing the importance of relational continuity in particular in primary care settings (Baker, 2016; Hill, 2011). It is important to note the attention paid to continuity by the RCGP through these two reports, which were published after a period in which policy had undermined continuity in general practice. In addition, as I mentioned above, some conceptualisations of access, including the Levesque et al. (2013) framework and The King's Fund model (Boyle et al., 2010), include continuity as part of access. Levesque et al. (2013) included it under 'appropriateness' and The King's Fund under 'choice' (Boyle et al., 2010). The conceptual work of both access and continuity suggest a complicated relationship or overlapping of these concepts. However, the narrow definitions of both concepts, and the false dichotomy often drawn between them, predominate in policy circles and in the research described below.

In general, when access and continuity are discussed in UK health services policy and research literature, they are seen as potentially opposing concepts. When this is the case, it is usually assumed that access means timely access and continuity is seeing the same provider. For example in 2003, Bower et al., questioning the 48-hour target for GP appointments, re-analysed patient satisfaction data and found that patients had high standards for both access (next day) and continuity (seeing the same GP most of the time), describing these as unresolved conflicts between access and continuity (Bower et al., 2003). As should be clear from my theoretical review, defining both access and continuity in these ways limits the usefulness of the analysis. Also, since this research utilised existing data from the General Practice Assessment Survey (GPAS), which was designed for purposes of evaluation different to this question, it is unclear whether the data appropriately capture the nuance and complexity of these priorities in different situations over time. Nonetheless, this study did provide evidence that speed of access was not necessarily preferred over continuity by patients, despite the strong policy focus through the 48-hour target at the time.

Other research looking to understand patient preferences, at a time when speedy access was assumed to be a patient priority within general practice policy, included a discrete choice experiment where patients had to make trade-offs between different aspects of care, including choice of doctor, and speed and convenience of appointment (Gerard et al., 2008). This was a strong study that utilised qualitative data to inform original survey design and achieved a high response rate of 94%. However, one limitation was that because it was a discrete choice experiment, it was not assessing what patients actually chose or preferred in care when they sought it, but in theory, given the prescribed conditions of the experiment. There could be important differences between preferences in theory and actual behaviour that would affect the usefulness of the data. However, there is no clear reason why preferences would differ from actual behaviour in a systematic way, which would bias the findings. The authors found that although the policy focus was on speedy access, the patients' decision processes tended to be much more complex and dependent on context. Despite this complexity, patients consistently prioritised seeing a doctor of choice and booking at a convenient time of day, over seeing any available doctor or having an appointment sooner rather than later, for both acute low worry conditions and ongoing high worry conditions (Gerard et al., 2008). The authors urged policy makers to consider these findings and patient preferences for continuity, rather than assuming fast access was the top priority.

A qualitative study in Scotland that examined patient and GP perceptions of personal continuity and rapid access found that patients valued "'access to appropriate care' depending on the problem to be dealt with…which is not fully addressed by GPs' focus on personal continuity, nor by performance targets focused only on speed of access" (Guthrie and Wyke, 2006, p. 1). By considering both patient and GP perspectives, this study helped illuminate useful differences in how each valued these concepts. The semi-structured interview design allowed for patient preferences to be articulated in a way that captured the space between the rigidity of rapid access and personal continuity. As I mentioned above, ‘appropriateness’ is the dimension of access in which the Levesque et al. (2013) framework includes continuity. In this way, the findings of this work resonate with the Levesque et al. (2013) broad conceptualisation of access, rather than the narrow assumption of speed of access. This work has implications for how and whose priorities affect policy, as both GP and patient perspectives, while different from each other, were not reflected in the policy focus at the time.

The above research efforts that focused on patient perspectives shed light on the difficulty in determining the relationship between continuity and access. However, they consistently found that continuity was valued, and rarely was speed of access valued more, despite it being the policy priority. In addition to patients, it is important to consider how general practice staff view these issues, as Guthrie and Wyke (2006) have done. A questionnaire study focusing on receptionist views of access and continuity found that 93% of receptionists in one area of the UK favoured same-day appointments with any doctor over relational continuity (Alazri et al., 2007). This study’s strengths include a specifically-designed questionnaire informed by the literature, which should mean a good fit of the data with the research questions. Although survey standards view previously validated surveys as superior, this is not always possible. This survey was not formally validated, but was piloted in three surgeries before being administered in the area. The researchers initially contacted practice managers for permission to contact their receptionists and allowed for two rounds of recruitment. The practice response rate was <50% (50 of 119 practices), which is low, but reflected a substantial number of practice sites across the 148 respondents. Also, although the survey responses were anonymous, each was coded to include a practice identifier and researchers were able to compare consistency across multiple respondents from the same practice. Interestingly, receptionist preferences were quite different from the patient perspectives I discussed above, which generally prioritised continuity or at least ‘appropriateness.’ They were also different from those GPs who valued *personal* continuity. Perhaps this finding is reflective of the receptionists preferring the option that the existing rules systems, made in response to policy targets around speed of access, best facilitated. Another interesting finding is that more receptionists

(94%) felt continuity of care meant “team continuity” in which “care is provided for a patient by a group of healthcare professionals (doctors, nurses) working and communicating with each other at the same premises” rather than “longitudinal continuity” in which care was “provided for a patient by a specific named doctor” (57%) (Alazri et al., 2007, p. 78). This finding may be a sign of receptionists having a more nuanced understanding of continuity than merely personal, relational continuity. Or it may reflect the reality at the time, since named GPs had been replaced with patients being registered to a practice. The researchers did not ask what they thought it should be, or what they preferred, but what continuity meant to them. Regardless, this research raised vital questions about the role receptionists play in influencing continuity of care and demonstrates the importance of considering multiple relevant perspectives around an issue.

My above review of access and continuity work in the first decade of the twenty-first century demonstrates how the policy context set up these concepts to be narrowly defined and seemingly at odds with each other. Expanding how we conceptualise access, and its relationship to continuity helps to recognise the falseness of the customary dichotomy: access or continuity. Although several research efforts called for change, having demonstrated the complexity of the issues and if anything, a preference by patients and GPs for aspects of continuity, the policy and political discourse into the next decade has remained disappointingly consistent. The problem of access is still predominantly framed as one of speed, and continuity has been marginalised for this priority of speed or presumed convenience, as I will elaborate more in section 2.4 on interventions.

Some more recent research efforts have explored the possible effects of efforts to ‘improve access’ on continuity, as continuity has gained some recognition by more groups as important, particularly for the purpose of general practice and various desired health outcomes and effects on care utilisation. For example, a recent report by the Nuffield Trust stated that policies focused on ‘improving access’ may have effects on continuity of care. The report included some practical advice for policy-makers to try to improve both, or at least, to not undermine continuity through ‘access’ policies (Palmer et al., 2018).

While still talking about the two concepts as separate entities, this recent work may indicate that the dichotomy is being questioned by more stakeholders within UK general practice. This work was at least alert to the need to define the concepts of access and continuity and recognised the difficultly in doing so. However, while they embraced a similar definition of continuity to what I have described above, including spending significant space describing the various types, they briefly explain The King's Fund (2010) definition of access without exploring any further conceptualisations (Palmer et al., 2018, pp8-9). Since The King's Fund (2010) conceptualisation of access was the least informed by existing theory and limited by its aim to use existing data to measure access, this choice is a weakness of the report. Since this report is part of a broader effort to evaluate national efforts to improve access, this is worrisome, and is a sign that the core issues with the interventions will not be elucidated, as I will demonstrate further in my critique of interventions in section 2.4 and in this thesis generally.

2.3.2. Access and healthcare utilisation

Another aspect of health care that is often linked to access to general practice in policies is the utilisation of other healthcare resources. For example, there is often a presumed link between improving access to general practice and reducing A&E usage and other secondary services. This was especially pronounced in statements and policy decisions by high-ranking members of the NHS and government officials (O'Dowd, 2013). However, as I will demonstrate, the evidence on the matter is mixed, and a consistent relationship has not been established. This has important implications for understanding the context in which this research takes place, specifically, as I have and will explain, because that logic shaped the policies prior to and during the time of this research. I will try to demonstrate here the extent to which those policy assumptions were grounded in research evidence.

Multiple studies have explored the relationship between access to general practice and A&E use. Two studies based in the UK by the same author have concluded that a significant proportion (26.5%) of unplanned A&E attendances were preceded by unsuccessful attempts to seek care at GP surgeries, and that GP surgeries providing timely access to primary care had fewer self-referred A&E discharges per patient (Cowling et al., 2013; Cowling et al., 2014). The above studies used extrapolations from existing data on utilisation and estimates from GPPS survey responses to calculate their findings. The limitations around using GPPS data, described above, apply here. Additionally neither a temporal, or causal, relationship between the survey response and any care utilisation can be determined, since it is unknown whether those answering the survey were the ones utilising A&E care. Of note, self-referred A&E discharges are only one part of A&E utilisation, and likely not the most expensive part. It is, however, the part most likely to be influenced by access to general practice. The lack of context given the cross-sectional data limits the ability to determine whether this utilisation of care was appropriate or not, and leaves unasked what changes in access to general practice would affect this utilisation.

An international systematic review that examined features of primary care affecting unscheduled use of secondary care (emergency department attendance or emergency hospital admission) found that continuity, or access to the same healthcare professional, was associated with reduced unscheduled secondary care (Huntley et al., 2014). The review found patient factors and proximity to healthcare provision affected use, implying that the issue is more complicated than aspects of primary care availability. This systematic review included 48 papers from 44 individual studies. While the majority were cross-sectional, the limitations of any one design would be mitigated by the systematic review. By suggesting that continuity within access to primary care has the strongest effect on unscheduled secondary care utilisation, these findings raise important questions around the complex issues at play. These findings are consistent with a broad conceptualisation of access that includes continuity. The findings suggest that more work, including qualitative research to better understand patient experience, would help to explain how these factors affect patient behaviour. This seems particularly necessary given the limitations of the observational and cross-sectional nature of the existing data.

Some qualitative efforts have begun to examine the specific issue of why patients seek primary care in emergency departments. One UK-based study combined observation in surgery receptions at six GP surgeries, covering three CCG areas, with interviews of patients who had recently attended A&E and surgery staff (MacKichan et al., 2017). This study found that complicated appointment systems and previous negative experiences recursively informed patients' decisions of where to seek care. These findings reflect an understanding of access similar to the broad conceptualisation that I describe, including awareness of the relevant patient experience literature. By focusing on patients who attended A&E, the findings from this study, more so than the cross-sectional studies above, contribute to understanding what may shape patient behaviour. The authors argue that simply creating more access, or more timely access, to general practice would not address the issues uncovered in this work. This work casts doubt on what might seem like obvious solutions to some of the patterns evident in other work, reminding us of the importance of not only understanding issues in context, but *how* to address those issues in context.

In summary, the evidence around access to general practice and utilisation of other services is complex. While some patterns exist, linking access to general practice with A&E use in cross-sectional data, more compelling evidence from a systematic review suggest it is not timeliness, but continuity, within access, that affects this use. Recent qualitative efforts, which aimed to more deeply understand patients' reasons for their behaviours, help to make sense of the utilisation patterns and begin to suggest how to address the underlying issues.

2.3.3. Access and patient safety

There is some relevant UK-based research on patient perspectives, which relates access to issues of patient safety. In a report commissioned by the Greater Manchester Primary Care Patient Safety Translational Research Centre (PCPSTRC), access to care was identified as a way that patients conceptualised safety in primary care, with sub-themes of timeliness, integrity and professionalism, communication, physical accessibility, and access to a full range of services (The Patients Association, 2014). While this report was not from an academic source, which could raise questions about its integrity, it indicates an interesting shift in power to facilitate a patient organisation to investigate such important issues. The research effort used mixed-methods, with qualitative focus groups based in the community of a city in the north of England and targeting groups seldom heard from in health research, and a quantitative survey of members of the Patient Association. Participants discussed their concerns about having sufficient time with a clinician, as well as frustration with inflexible provision of services. Interestingly, this report presented issues of continuity of care as separate from access, yet acknowledged continuity as being the most commonly cited issue within their survey responses. The broad conceptualisation of access that includes continuity resonates with these findings which suggest both are important for patient safety. The individual participant quotations linked to the access and continuity themes reveal their concerns about quality of care and how that relates to safety, which provide further suggestion that better understanding in this area is needed.

Other related qualitative work carried out by health services researchers at Manchester offered similar findings, in that patient concerns, about access, length of consultation, and relationship continuity, were raised as matters of safety, even though they are often thought of as issues of quality (Rhodes et al., 2015; Rhodes et al., 2014). This qualitative research involved semi-structured interviews with patients from a variety of GP surgeries in the northwest of England and utilised inductive, theme-based analysis. The importance of continuity and its relation to access is once again made visible, through the lenses of safety and quality of care (Rhodes et al., 2014). The authors highlight how in the UK, the common system approaches to both safety and quality of care do not take into account issues of trust and temporality that are inherent to patients' accounts, and call on policymakers to pay greater attention to these issues (Rhodes et al., 2015). Together, the above efforts to understand issues of patient safety in primary care once again suggest a broad conceptualisation of access is integral to fully grasping patient perceptions and system characteristics in order to improve care.

2.3.4. Access and health equity

Before moving on to my review of interventions to improve access, I will take the opportunity to address another relevant aspect of health and health care: the distribution of health in the population. Once again, my purpose in doing this is to clarify my own understanding and use of terminology for the reader, and also to address the confusion around the terminology of these important concepts in both academic literature and in policy. My use of ‘health inequalities’ generally refers to the disparate or unequal health status of people in the population. I refer to ‘equity’ in relation to the process of accessing care. Different disciplines and policy sectors use these terms differently. The European WHO, for example, in the 1980s and 1990s decided to use equity for both concepts, in part because of issues of translation, where some region’s languages did not have two different words for inequality and inequity (Whitehead, 1991). Health economists tend to embrace equity as the term relating to accessing care, but they distinguish between horizontal equity and vertical equity (Goddard and Smith, 2001). In this sense, horizontal means ‘equal access for equal need,’ which is a theoretical construct that to me seems too hypothetical to be useful. However, the majority of health economics work on equity deals only with horizontal equity because of analytical constraints and the complexity of vertical equity (unequal access for unequal need). Because I am interested in equity of access across the entire population, and am sensitive to different people and preferences, I generally mean equity in a way that embraces the complexity of vertical equity.

Regardless of specific terminology to distinguish these issues, they are relevant to primary health care, and it is worthwhile to examine the specific NHS context. Many studies have evidenced the relationship between primary health care and population health. As Starfield and colleagues established in a seminal review of relevant literature, more so than other components of healthcare systems, primary care is internationally recognised as having a health-promoting influence on the population, including prevention of illness and death, and a more equitable distribution of health in populations (Starfield, 2005, p. 457). However, social determinants of health have the most direct effect on health (Marmot, 2005). Some scholars have identified that primary health care that *considers* social determinants of health is the most effective way to address population health inequalities (Rasanathan et al., 2011).

In the NHS, issues of equity are at the core of the system’s founding principles, but scholars have recognised that policy around equity has been largely focused on the provision of services, and not necessarily the accessing of them (Powell and Exworthy, 2003). There are several studies that examine persistent issues within the NHS dealing with equity, especially in relation to certain groups and the social determinants of health (Oliver and Mossialos, 2004; Salway et al., 2016; Whitehead, 1994). The Levesque et al. (2013) conceptualisation of access is once again relevant because ‘interaction or fit’ captures the processes of access that affect equity, and the ‘abilities of people’ and aspects of ‘accessibility of the system’ acknowledge important factors that influence equity of access. The social determinants are visible in affecting various aspects of people’s abilities in the lower half of the model. One can see how this conceptualisation of access is generative for thinking about issues of equity and inequalities of health in the population.

One recent international research collaboration, IMPACT (Innovative Models Promoting Access-to-Care Transformation), has applied the Levesque et al. (2013) framework to a survey of interventions to improve access, focusing on issues of equity (Richard et al., 2016). The authors mapped interventions to the framework to see where existing efforts have tended to focus. They found that the majority of interventions are directed towards the service side, and not the population side. One can begin to see the value in asking what problem of access an intervention is targeting, and importantly, *why* and *how* it is doing so.

2.4. Interventions to improve access to general practice

Over the years, several trends or big ideas about improving access to general practice in the UK have shaped the current situation. In this section, I will apply the Levesque et al. (2013) conceptualisation of access, and the understanding of related issues within health care that I have established, to critique these interventions. My application of theory helps to highlight the general absence of theory and evidence informing these interventions, and resonates with earlier observations made by some scholars about gaps between conceptual literature and policy interventions. Given the nature of the NHS, some of these interventions were dictated by the policy of the time, which, as I explained in chapter 1, often had different and more opaque motivations than addressing existing specific problems. Critically examining the policy discourse brings into view the complex milieu from which these often overly-simplistic ‘solutions’ for improvement emerge. My stance was informed by Taylor’s idea of “critical policy analysis” to understand the “contexts, texts, and consequences” of these policies and subsequent interventions (Taylor, 1997, p. 23). In this section I will also critique the efforts to evaluate the interventions, when they have existed. These critiques are necessary to establish the persistent gaps between understanding access and efforts to improve access to general practice in the UK.

Before focusing on a few of the most relevant interventions in the last two decades, I will present the findings of a systematic review from 2004, which summarises the situation up to that point. Chapman and colleagues reviewed thirty relevant studies from 1980-2003, which focused on “innovative ways of delivering primary care…to facilitate and broaden access” in the UK (Chapman et al., 2004). The authors described the interventions that aimed to improve access during this time: personal medical services (PMS, an alternative to the traditional general medical services contract for GPs), telephone consultations with GPs or nurses, nurse-practitioner-led care, walk-in centres, NHS Direct (a nurse-led advice service, which preceded NHS 111), and pharmacist-led initiatives (Chapman et al., 2004). This was a robust study, which considered a wide range of relevant literature on access to primary care in the UK. Importantly, the authors summarised their understanding of access for the purposes of the review, and distinguished four key aspects: availability, utilisation, relevance and effectiveness, and equity (Chapman et al., 2004, p. 374-375). It is instructive that the authors found that no studies in the review were based on a theoretical model of access. Chapman et al. (2004) explained that this overall lack of conceptualisation of access affected the quality of the available literature and limited their ability to determine whether interventions were successful, as it was not always clear what the specific aim was in terms of improving access. The authors determined that some of these interventions, namely NHS Direct, were used by those “who already make use of pre-existing health services—the white, healthy middle class” (Chapman et al., 2004, p.378). Similarly, walk-in centres attracted largely middle-class patients with minor and self-limiting complaints. They also found evidence that walk-in centres were duplicating, rather than substituting, care, given that one third of users intended to make a GP appointment following their walk-in centre appointment (Chapman et al., 2004). The authors noted that PMS was the only service innovation that began to address inequalities and was based on local need. They concluded that other interventions may in fact have increased inequalities, “by expending resources to ease access for affluent patient groups who are already accessing care” (Chapman et al., 2004, p.379).

Although my conceptualisation of access (Levesque et al., 2013) is slightly different from Chapman et al. (2004), the contribution of having a conceptualisation of access is apparent in their critique of the literature. Because of their focus on relevance and equity as aspects of access, they were able to recognise that few studies looked at service relevance with respect to community health needs and priorities, or service acceptability in terms of the cultural, social and economic needs of the population served (Chapman et al., 2004, p. 379). They called for an awareness of the context and complexity of health-seeking behaviour to inform efforts to address access inequalities. These observations and recommendations resonate with issues of candidacy (Dixon-Woods et al., 2006) and in the dimensions of the Levesque et al. (2013) model. The authors also discussed the tension and potential for compromise when addressing access, in terms of patient expectations and economic feasibility. They noted that while improving access may be politically appealing, demand may have to be managed (Chapman et al., 2004). These insights resonate with awareness of supply-induced demand as well as the political tensions behind some of the policy ideas—which sound good in theory, but seldom clarify or contextualise the problem they intend to address. In summary, this systematic review establishes the critique of previous efforts to address access, with a focus on the gaps between the conceptual literature on the one hand, and the implementation and evaluation literature on the other. In the next sections, I will review other major interventions from the past fifteen years, which largely ignored the advice, warnings, or critiques about such efforts that these authors expressed.

2.4.1. Advanced access

Advanced Access was an appointment scheduling intervention to support same-day access in the UK following the implementation of the 24-hour and 48-hour appointment targets in 2000. It was based on a model originally developed in the US in the 1990s to support continuity, but a version of the model was adopted in the UK, anchored around timely access. It was described by some as “Doing today’s work today by offering a same day appointment to all patients who call” (Murray, 2005; quoted in Salisbury et al., 2007, p. 27). Notably, this system did not take into consideration whether the caller wanted a same-day appointment or not. Advanced Access was widely-implemented after positive experiences were reported from early adopters, but before any sustained evaluation had taken place. Rigid implementation of the idea within surgeries led to restrictions on the booking of advanced appointments, resulting in difficulties for patients trying to obtain appointments that were not on the same day (Salisbury et al., 2007). Although practices chose whether or not to implement this system, its adoption was clearly linked to the policy climate and targets at the time.

A comprehensive mixed-methods evaluation of Advanced Access in the UK was published in 2007, and included 48 practices and 8 in-depth case studies. This evaluation concluded that practices with Advanced Access had more same-day appointments for both routine and urgent issues and that embargoing appointments for same-day access meant patients often had to call back the next day when there were no longer appointments available (Salisbury et al., 2007). Patient satisfaction around the wait time for an appointment was better at Advanced Access practices, but patients were also more likely to have tried, and failed, to make an appointment, or to have not bothered to try, anticipating that they would not be able to book in advance (Salisbury et al., 2007). The evaluation also found that continuity was often the main priority for patients when booking appointments (over convenient timing, seeing a GP rather than a nurse, or fast access), likely because the majority of GP appointments were for chronic conditions. The authors found that continuity was not different between types of practice, with trade-offs being made at each type. Although there was a perception by staff that Advanced Access reduced Did-Not-Attend appointments (DNAs), the data did not reflect that (Salisbury et al., 2007). Because of the way Advanced Access was adopted across the UK, a controlled trial of the model was not possible, and so this study was based on observational data. While the inability to conduct a trial limited the evaluation options, this study provided several useful insights into the effects of the intervention through its mixed-methods approach.

Another study of Advanced Access in the UK, which focused on patient experience, found that hybrid systems tailored to local preference and needs were better received by patients than rigid ones (Pascoe et al., 2004). This finding is notable because Advanced Access was generally implemented in a rigid way. This research complements the Salisbury et al. (2007) evaluation in suggesting how a one-size-fits-all model would not be well received by patients. In a systematic review that included evaluations of Advanced Access scheduling in both the US and UK, authors reviewed 28 articles covering 24 studies (Rose et al., 2011). This systematic review included the above evaluations of Advanced Access in the UK, and is useful because it compares studies in the country where the idea originated and its implementation in a different context. The authors found that studies that evaluated waiting time (defined as time to the third next available appointment) showed a decrease, but only two studies reduced it to less than 48 hours. They found DNAs were reduced only in practices with a baseline DNA rate of >15% (Rose et al., 2011). They also noted the data on patient satisfaction was mixed, and data on health outcomes was limited.

In summary, Advanced Access was an example of a one-size-fits-all intervention with a narrow goal of improving access in a certain way. Applying the Levesque et al. (2013) broad conceptualisation of access helps us to recognise the narrowness of its scope. Further, if we approach access to mean an ‘interaction or fit of services and people’s needs,’ it is unclear how something so rigid on the service side would improve this fit. This intervention demonstrates a lack of understanding of the conceptual literature on access. It is interesting that it was widely adopted prior to rigorous research, which perhaps reflects the policy context at the time, with timeliness of access elevated above all other considerations. Higher patient satisfaction with hybrid models goes some way to suggesting how a system could be designed in collaboration with patients, and locally adopted to meet needs that exist in a certain area. Despite the limited data on the effectiveness of this intervention, and the abolishment of the 48-hour target in 2010, remnants of Advanced Access remain in practices today, as I will describe in my results chapters, which conveys the lasting impact of these changes.

2.4.2. Telephone triage and consultation

Telephone triage and telephone consultations are another type of intervention that has been implemented to improve and control patient access to general practice in the UK. Some versions have targeted same-day requests for appointments, or urgent appointments, while others adopted a universal telephone triage process before any appointment with a GP could be made. Individual pilots of telephone triage showed promising results, including that telephone consultations could replace home visits for patients who could not make it in to surgery but did not need to be seen (Jiwa et al., 2002). However, other studies had found that overall demand increased with implementation of telephone triage (McKinstry et al., 2002). A cluster-randomised controlled trial was carried out before widespread adoption and demonstrated mixed results (Campbell et al., 2014). The trial evaluated primary care workload and cost, and found that telephone triaging of patient requests for same-day face-to-face appointments led to increased contacts (or more work) compared to controls, with no effect on cost at 28 days (Campbell et al., 2014). A randomised controlled trial is rare in this space of access interventions because of logistical difficulty; for example, as I mentioned above, one did not occur with Advanced Access given the way in which that programme was widely adopted. The results of this trial are therefore viewed by some as offering the highest quality of evidence around objectivity of the evaluation of the intervention itself. A more recent observational study comparing practices that had adopted a ‘telephone first’ approach (either ‘Doctor First’ or ‘GP Access’, two commercial providers) for any appointment request found mixed effects (Newbould et al., 2017). There was wide variation across practices in terms of GP workload, with telephone consultations generally increasing, face-to-face consultations decreasing, and the overall time spent consulting likely increasing by an average of 8% compared to prior to the intervention (Newbould et al., 2017). Compared with a random sample of other practices in England, GPPS data showed an improvement in length of time to be seen but negative changes in other aspects of the survey. Utilisation data on secondary care was mixed including admissions, A&E attendance and cost. The authors concluded that it was not a panacea for meeting demand (Newbould et al., 2017).

If one applies the Levesque et al. (2013) framework, one can see that these two types of telephone intervention only deal with a narrow aspect of access, pushing timeliness and a specific mode of contact, when these are not necessarily appropriate. Typically such programmes also lack a theoretical understanding of the many dimensions of access, the role of people's abilities in such situations, and the idea of access as fit (Levesque et al., 2013). Similar to Advanced Access, these interventions would be unlikely to improve fit if rigidly adopted. This understanding provides an explanation for why both resulted in increased work for GPs despite a motivating goal of doing the opposite. Authors of several studies reflected on the fact that telephone calls and consultations have a role to play in UK general practice, and are an important for specific people in specific contexts (Campbell et al., 2014; Jiwa et al., 2002; McKinstry et al., 2002). What did not work, though, was the one-size-fits-all approach to implementing them. This evidence suggests the importance of working more closely with patients to decide which combination of modes of contact fit best with the range of needs that arise across the population, and ensuring they are available and accessible when needed.

2.4.3. Seven-day extended access

As described in chapter 1, seven-day access and extended access became a main focus of improving access to general practice at the start of this study. As I will describe in detail in chapter 5, this allowed me to capture experiences with this policy as part of my research. Here I will briefly review the early evaluations of the seven-day access policies. I will return to more recent evaluations and how they resonate with my findings in chapter 8.

In Greater Manchester, a team of researchers from the NIHR CLAHRC GM was commissioned to evaluate the seven-day access demonstrator pilots using mixed methods, and the final report was released in June 2015 (NIHR CLAHRC GM, 2015). The evaluation included a quantitative outcome evaluation (mainly focusing on uptake of services offered, utilisation rates at A&E, and patient satisfaction using secondary data) and a qualitative process evaluation (consisting of primary data collection interviews with providers and analysis of interview data). The outcome evaluation included a Difference-in-Difference (DiD) analysis, which compared utilisation rates in the demonstrator communities (n=4) to similar (non-demonstrator) communities at the start and end of the evaluation period. This DiD analysis was to control for causes of changes in utilisation pattern trends that were not related to the demonstrator interventions. The additional appointments were booked between 62% (Central Manchester) and 84% (Bury) of the time across the four sites, with the least uptake on weekends, especially Sunday. Of the booked appointments, between 4% (Bury) and 14% (Central Manchester) resulted in a DNA. Total A&E activity was not reduced across the four extended-hour demonstrator sites in DiD analysis. Since the interventions were more likely to have an effect on minor A&E attendances, separate analysis was carried out and found a significant reduction of 8% in Central Manchester only. Only the Bury demonstrator showed a significant decrease in walk-in centre or out-of-hours (OOH) utilisation (14% and 38% respectively). Bury was also the only site to have significant improvements in patient satisfaction scores, regarding opening hours, convenience of appointment, and overall experience of the surgery (NIHR CLAHRC GM, 2015). In summary, this quantitative analysis showed that the pilots were underutilised, and had a negligible impact on decreasing utilisation of other services, which was one of the stated goals.

The process evaluation of the pilots described six factors that had the potential to be either enablers or barriers: federations and alliances, information technology, information governance, workforce and organisational development, engagement and communication, and supporting infrastructure (NIHR CLAHRC GM, 2015). These six factors, and the process evaluation in general, begin to explain the ‘why’ and ‘how’ behind the demonstrator community implementation successes and failures. In addition, the evaluators warned that the demonstrator services may create new demand, rather than divert existing demand from other services, and that the cost implications should be considered of initiating services that may be duplications.

Applying the Levesque et al. (2013) framework, as well as the evaluations of previous interventions, to the extended access intervention, one can see that the idea of extending access over more hours or longer days represents a narrow aspect of access—hours of opening—within one dimension, ‘availability and accommodation.’ One can also see that *extending* access does not necessarily affect the fit with population needs, especially if minimal work was undertaken to establish what needs were already going unmet. As I will explain further in chapter 8, nationally the GPPS survey data did not show a demand for weekend or evening opening (Ford et al., 2015), and the National Audit Office report and the evaluation of the initial wave of the national extended access showed that these services were not an efficient use of resources (Mott MacDonald, 2015; National Audit Office, 2017).

2.4.4. Online and digital consultations

Finally, during the time of this study, online and digital consultations have become the latest idea to ‘improve’ access to general practice in the UK. There is limited data on the effectiveness of such interventions, but perhaps because of the enthusiasm for technology of the current health secretary, they have been embraced. As with extended access, I will return to these ideas again in chapter 8, but for now I will include a brief summary of some of the initial evidence, and once again use the Levesque et al. (2013) conceptualisation to critique the nature of the interventions.

One mixed methods study on the real-world implementation of video consultations (via Skype) within the NHS combined observation, review of video consultation recordings of and face-to-face consultation audio recordings, and interviews with document analysis (Greenhalgh et al., 2018). The authors found that video consultations were possible, though tended to work better when patient and clinician already knew and trusted each other. They were sometimes used to respond to patient requests for care in a way that strengthened self-management. However, there were also logistical barriers which led to low rates of implementation across different clinicians (Greenhalgh et al., 2018). Although this study did not take place in a primary care setting, it goes some way to understanding the potential for this type of consultation. Viewed through the Levesque et al. (2013) framework, this could help with the fit of patients' needs and services, though it is unclear how much advantage there was to telephone calls being used in a similar way. Importantly this was not used as a gateway or triage through which all requests were funnelled, as with some earlier interventions, but an additional option for providers and patients.

In the space of UK general practice, an app-first model through a company called Babylon was launched in 2018. Following the publication of a report on their 'GP at hand' app (Ipsos Mori, 2019), a prominent GP health services researcher criticised the app and the Babylon model, which was more readily adopted by young and healthy users as, "general practice by smartphone," which risked "destabilising care for patients with the greatest need" (Roland, 2019, p. 1). Similar to some of the rigid elements around Advanced Access to same-day, and telephone first to same-day and telephone, applying the Levesque et al. (2013) framework again helps to realise that forcing all consultations through a digital interface, would not result in an appropriate fit for everyone. Once again, this does not mean that digital consultation, or contacts, do not have a role to play in general practice, but that there are important consequences to consider when a mode of contact excludes certain people or does not fit with others' needs.

As mentioned, I will return to the ongoing developments in the digital and online interventions in chapter 8, where I discuss the current state of access to general practice in the UK and the relevance of my findings and insights into this dynamic landscape.

2.5. Summary of gaps in the literature

In the preceding sections, I have examined individual bodies of literature around theories of access to health care, access in relation to other important concepts in health and health care, and interventions to improve access to general practice. Through understanding the theoretical literature and embracing a broad conceptualisation of access, I have shown, along with others before me, that many efforts to address and improve access neither begin with a knowledge of that literature, nor a sufficient grasp of the context to identify which problems of access they were targeting and which they, by definition or default, were not. A persistent gap has long been therefore evident between the theoretical work and the practical interventions, including at times, their evaluations. Prominent researchers in the space of access to UK general practice have called for more theoretically-informed efforts (Campbell and Salisbury, 2015; Chapman et al., 2004), and my review reiterates these calls.

In addition to the conceptual gaps, efforts to understand and address access have often lacked the input of multiple perspectives, though as my review has shown, these are often invaluable. Indeed a variety of perspectives are important to consider in both defining access problems and in deciding how to address them. This insight leads to the final related gap that this review has uncovered. There is a lack of articulation of the problems of access from multiple perspectives, which take into account both the theoretical understanding and past work on access, *and* the input from those providing and seeking care in the contemporary. In the rush to do something to ‘improve access’ many interventions, over generations, have lacked grounding in such understandings, at times for political reasons. The result of this is persistent inequalities of health in the British population that could be alleviated through a better understanding of and more equitable approach to tackling such issues. As I will explain further below and in chapter 3, researchers have opportunities to address these gaps not only in *what* research is done, but *how* it is undertaken.

2.6. Overall research aim and research questions

In light of the above summary, the overall aim of this research was:

> to understand access to general practice from multiple relevant perspectives in order to consider how population access might be optimised.

I have established the need for better understanding through multiple perspectives above. My use of the word ‘optimise’ is in recognition of the dynamic interaction or fit that defines access, which is apparent in the Levesque et al. (2013) framework and is relevant at multiple points along the pathway of having a health need and accessing appropriate care. Optimise also conveys the realities of the context of the current system and resources, including budgetary and other limitations. Efforts to simply provide 'more' access have had unintended consequences, which may in fact have worsened health inequalities, while certainly diverting resources. My attention to the 'population' is in recognition of persistent health inequalities between groups and the need for general practice to provide care for an entire population, with no individual left out. As stated above, my overall research aim therefore captures the practical purpose of this understanding of access: to improve population health equity.

In order to address this aim, I will answer the following research questions:

1. What are the issues relating to access to general practice from patient, community, provider, and commissioner perspectives?
2. To what extent do current approaches to improving access address the issues raised?
3. What could be done differently to optimise access to general practice for the population?
4. How does a broad conceptual understanding of access, through the Levesque et al. (2013) framework, help in understanding and addressing these issues?
5. What role does a participatory research approach have in understanding and addressing these issues?
6. What are the implications of these findings for future policy, practice, and research efforts?

I will address my overall research aim and my specific research questions in the following chapters of this thesis. In chapter 3, I will explain how my participatory approach and qualitative methodology within a case study allowed me to bring together theory, multiple perspectives, and an in-depth understanding of problems and current approaches. In chapters 4-6, I present a rich description of access problems and a critique of the effects of two recent policy trends around access, made possible through my approach and methodology. In chapter 7 I reiterate the usefulness of the theory, including my refinements of it, and fashion an approach to addressing the issues within access to general practice that includes what, how, and why, and is grounded in further relevant literature. Finally in chapter 8, I will reflect on the participatory approach to this research and the overall implications of the contribution of this thesis to practice, policy and research.

2.7. Chapter summary

In this chapter, I have synthesised the access theory literature and applied a theoretical understanding of access to facilitate a critique of existing scholarship on access interventions to general practice in the UK. I have clearly stated the gaps that this research addresses, namely a disconnect between the theoretical literature, people's experiences, and the policy level solutions to access. In the following chapters, I will address my overall aim, and my specific research questions, to bridge these gaps, and will describe my contributions to advance the understanding of access in order to optimise access to general practice in the UK.

Chapter 3. Research approach and methodology

3.1. Chapter overview

In chapters 1 and 2, I established the context of general practice in the NHS and the relevant knowledge gaps that justify my research questions about access. In this chapter, I describe *how* I set about answering those questions through an instrumental case study, which utilised a participatory research approach and qualitative methodology. In section 3.2, I will first explain my 'research ethos,' which is a reflection on how my own identities and values affected the way I went about this research. In section 3.3 I will justify my decision to use a single CCG area as an instrumental case study about access to general practice. In section 3.4, I explain my participatory research approach, namely my application of community-based participatory research (CBPR). Then in sections 3.5-3.7, I describe the qualitative methodology and specific methods I employed to generate and analyse data in partnership with the community-based project team (CBPT) I formed in the early stages of the work.

3.2. My research ethos

I use the term 'research ethos' to encompass my overall orientation to research, including issues of epistemology. I think one's research ethos is affected by general worldview, by personal and professional roles, and by previous experiences. To me, research ethos also concerns the purpose of research (including whom research is for) and issues around conducting the research (including interactions of researchers with collaborators and participants). I am presenting this first because the approach and methodology I used to address knowledge gaps about access are inextricably linked with my research ethos. As demonstrated below, this explanation of my research ethos also relates to my practice of reflexivity as a researcher, in which I have questioned and reflected on issues relating to how I define my identities and how that affects my research (Dean, 2017).

As I explained in the 'About the author' section that precedes the main content of this thesis, I am a physician. I studied history of science and medicine for my undergraduate degree, and I am aware of changing ethics and norms around doctors and patients, and around medical research, over time. I brought this awareness of history to my medical training, and I bring it to my research efforts. I chose to pursue a career as a primary care physician because I recognised that was what the American healthcare system needed most, and I wanted to be a part of that solution. I also found I could not bring myself to view people as one system or organ, but as a whole person. My training in family and community medicine, caring for a largely medically underserved population within Philadelphia, taught me to further value patients as people with full, complex lives, affected by structural inequalities in society, and to meet them where they were to best help them. I learned the value of home visits for homebound patients, some of the most vulnerable people within the population. My clinical experiences have informed my research interests and vice-versa. My experience of qualitative research during my medical school thesis taught me the value of listening to people and reinforced the power of silence. This synergy of my roles continued during my two-year research fellowship, during which I learned about community-based participatory research (Lucas, 2015). In this model, the members of the community were valued for their experiences and knowledge, and I was a part of an effort in which research was conducted for a purpose, and in a way, that included the contribution of those people and their needs. These experiences prior to moving to the UK have shaped the kind of clinician and researcher that I am. My other roles and position since I moved to the UK, as a relative outsider, further affected my approach to this research. I believe in fair access to health care, and I sought to understand what that meant within the NHS as part of this research.

As a result of the above, I am motivated by the pursuit of health and social justice for all. I believe that knowledge is experiential and that experiential knowledge should be valued as potentially shaping a research project, as well as being potential data within a research project. In turn, I believe those people whose knowledge or lives may be the subject of research should have a say in whether and how that research is carried out. While I now understand that my medical training was largely conducted through a positivist epistemology as the default norm within medicine (Walsh and Gillett, 2011), through my further experiences with qualitative research and participatory research, I place myself within a subjectivist epistemology (Dyson and Brown, 2006). Another component of my research ethos is my acknowledgement of significant power differentials between members of society and a desire to redress that. As a researcher with a position of relative privilege to be able to carry out such work, I feel an obligation to try to share that privilege, not just with the research outcomes, but within research processes, consistent with others who practice participatory research (Bourke, 2009; Wallerstein and Duran, 2010) as I will expand on further below.

My own previous experiences as a researcher doing participatory and non-participatory research, and doing qualitative and quantitative research, have shaped my preferences. I have an ability to do all of the above, but I feel most true to my values when I do participatory research, and in particular, qualitative participatory research, which allows others' experiences to inform the work and facilitate understanding in context. There is also an element of pragmatism to my ethos. I believe that research should be useful in the 'real world', and I believe the best way to have it be useful to people is to work with them to decide the nature and shape of the undertaking. This means that as a researcher I am open-minded to the input of others and flexible in my thinking to adapt to their contributions. I am more flexible about the qualitative or quantitative aspect of research, and am willing to rely on the complex negotiations and facilitation involved in participatory research to determine the best methodology to apply to the problem at hand to generate knowledge that is useful to the researcher, the participants, and the collaborators (Minkler and Wallerstein, 2008).

3.3. Instrumental case study

Building upon my research ethos as explained above, I will explain my decision to conduct a single-area case study of access to general practice. Case study research involves examining a particular phenomenon in a particular context. One of the leading scholars on case studies, Robert Stake, has written, "Case study is not a methodological choice but a choice of what is to be studied. By whatever methods, we choose to study the case" (Stake, 2003, p. 134). Stake differentiates between intrinsic and instrumental case studies, where the former is undertaken because of an interest in that particular case, and the latter in order “to provide insight into an issue or redraw a generalization” (Stake, 2003, pp. 136-137). I chose to study access to general practice within one area, so that I could feasibly pursue both breadth and depth of the wide range of relevant perspectives and experiences in that area. I conceptualised this as an instrumental case study, because my aim was to understand *access*, and the area provided a bounded place in which to do that. I actively brought theory to the project with the hope to advance a more general understanding about access. My use of theory within this case study is more consistent with Stake’s constructivist views that researchers can use theory to guide a study, as opposed to Yin’s postpositivist orientation that requires using a formal framework to test hypotheses within the research (Boblin et al., 2013, p.1268). I thought that this work would contribute beyond the intrinsic learning about the case itself (Stake, 2003), that it would generate relevant insights that could reasonably apply to other areas and other parts of the NHS.

I decided, along with my supervisory team, that the area of a single CCG was the logical and feasible size to study access in context, given the NHS infrastructure following the HSCA (2012). I could have chosen to study something smaller such as a single surgery, but that would have likely limited my ability to understand the wider system in which access is realised. The CCG footprint includes all the surgeries within an area, which meant a range of sizes, contractual arrangements, and other factors. I could have chosen to study more than one CCG, in what Stake would call a collective case study (Stake, 2003, p. 138). However, more than one CCG area would have limited my ability to capture the depth of detail required to understand access in its entirety as a single researcher. Also, as I will expand on below, including multiple areas could have undermined the sense of commitment to the community that I tried to convey in my early engagement, consistent with my participatory approach, or the relevance of the work to community members who were considering collaborating with me and participating in the research project.

As I will explain further in the next section, it was important for my participatory approach to make the decisions about the nature and size of my instrumental case study relatively early in the project. The early engagement was necessary for conceptualising the work as a participatory case study, which “involves the participants, local groups, or the community in all phases of the research process, from conceptualising the study to writing up and disseminating the findings” (Reilly, 2010, p. 1). I will fully explain the rationale for my participatory approach, including weighing the potential risks and challenges with the benefits, in section 3.4. In addition, in section 3.5.1, I will expand on the potential ethical issues around taking a participatory approach within a case study, including around the identities of and interactions with the collaborators within the community.

3.3.1. Choosing Tameside and Glossop

Because of my priority to begin the participatory engagement within the community of my case study, along with my PhD supervisory team and the director of the CLAHRC GM, I made the initial decisions about a single CCG area and my preference for Tameside and Glossop (T&G), within the first month of my PhD. The CLAHRC GM had a local focus, and T&G was one of the twelve CCGs in GM at the time. Compared to several of the other CCGs, which had ongoing research partnerships with the university or were being actively studied as demonstrator pilots of extended GP access in 2014, T&G was relatively under-researched. T&G is a varied area, with both urban and rural parts, significant population income and health inequalities (as I explained in chapter 1), and GP surgeries of all sizes and contractual arrangements. I acknowledged that as a resident of Glossop, I would be researching within the area I lived. I hoped that the proximity would facilitate my engagement with the participatory processes and extensive fieldwork necessary for the project, and that this would enhance the richness of my data. I recognised that I would need to continually reflect on how my various identities within the area—as a resident, patient, carer, and eventually practising GP—could affect the project and interact with my role as the lead researcher of this study. As I will explain, I continually reflected on these aspects as part of my reflexivity during the project (Dean, 2017).

Following the decision to approach T&G, from October 2014, I was able to begin engaging with various parts of the community about interest in *partnering* with me to work on a project about access to general practice. I will explain the details of these engagement processes in section 3.4.1. It is worth noting that when I began this engagement, I had not yet fully distilled the literature to identify the gaps, nor formulated my specific research questions, nor chosen my research methods. This meant that I could approach people about partnering on the project, including guiding those formative phases, which is consistent with participatory research principles, as I will elaborate in the next section. While this was an advantage in terms of relationship building, a potential disadvantage was that it precluded the possibility of the literature review and other work of the early phases to *inform* the choice of the case. However, after conducting the review, there were no factors that would have made me chose another area for the research. As I mentioned above, the instrumental nature of this case study was to have a reasonable area in which to study access to general practice in context. The participatory nature of the case study meant I could study access, not just *within* T&G, but *with* those in T&G, as I will elaborate further in the next section.

3.4. Participatory Research Approach

Participatory research is an umbrella term for the diverse array of approaches that prioritise partnership as a necessary precursor to research and seek to maximise the participation of those whose lives or work are the subject of research in all stages of the research (International Collaboration for Participatory Health Research, 2013a, p. 6). The various participatory approaches developed to challenge assumptions on “agency, representation, and power” within “conventional” research during the twentieth century (Cornwall and Jewkes, 1995, p. 1667) and emerged alongside related global movements for equality and civil rights through participatory democracy (Miller, 1987). Internationally, various terminologies exist to describe participatory research approaches, reflecting the diverse contexts in which they emerged and developed, including but not limited to: participatory research, participatory action research, action research, community-based participatory research, community-based research (Kemmis et al., 2014; Koch and Kralik, 2006; Minkler and Wallerstein, 2008; Waterman et al., 2001). While participatory research aims to confront the issues of existing power differentials in conventional research and in society, this can reflect added challenges for the researcher taking this approach (Cargo and Mercer, 2008).

From the milieu of participatory research approaches, I felt that a community-based participatory research (CBPR) approach was the most appropriate fit for this research endeavour. This decision was based on the gaps I identified in the literature around understanding multiple perspectives of access, my own previous experience and research ethos, the social justice aspect of the issue of access to general practice, and the fact that my case study was in a defined geographic area. CBPR is defined as:

> a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change (Viswanathan et al., 2004, p. 22).

CBPR has been recognised as relevant for addressing health disparities, including issues around equality of access to care within communities (Wallerstein and Duran, 2006). While not the only approach to addressing these disparities, through its mechanisms of partnership and empowerment, CBPR is well-placed to directly affect these issues, in addition to studying them. CBPR scholars have developed guiding principles for the approach, which should be adapted to fit the local context and specific research projects (Minkler and Wallerstein, 2008). These include:

> 1. CBPR recognizes community as a unit of identity.
> 2. CBPR builds on strengths and resources within the community.
> 3. CBPR facilitates collaborative, equitable partnership in all research phases and involves an empowering and power-sharing process that attends to social inequalities.
> 4. CBPR promotes co-learning and capacity building among all partners.
> 5. CBPR integrates and achieves a balance between research and action for the mutual benefit of all partners.
> 6. CBPR emphasizes public health problems of local relevance and also ecological perspectives that recognize and attend to the multiple determinants of health.
> 7. CBPR involves systems development through a cyclical and iterative process.
> 8. CBPR disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process.
> 9. CBPR requires a long-term process and commitment to sustainability.
>
> (Israel, 2013, p. 7-9)

In the sections below, I will explain how I applied these principles, recognising T&G as a community, including being open to learning about the multiple facets within the community, and the challenges of its identity as a ‘community’ (defined as a geographic area served by an NHS organisation, but otherwise consisting of two distinct areas, which comprised two different counties, social care systems, and histories). In addition, I wanted to recognise and build on the knowledge, strengths, and resources of those within the community, including patients, clinicians, and voluntary groups. Here it is worth acknowledging that applying these principles within a research effort represents additional work, especially on the part of the researcher in the early stages to establish connections, and throughout the project, to continue to maintain relationships and deal with challenges that arise within this aspect of the approach. While it represents additional work, the potential benefits have been demonstrated. For example, a realist review of participatory research conducted by an international multidisciplinary team concluded that the synergistic research partnerships created through these approaches can:

> (1) ensure culturally and logistically appropriate research,
> (2) enhance recruitment capacity,
> (3) generate professional capacity and competence in stakeholder groups,
> (4) result in productive conflict followed by useful negotiation,
> (5) increase the quality of outputs and outcomes over time,
> (6) increase the sustainability of project goals beyond funded time frames and during gaps in external funding,
> (7) create system changes and new unanticipated projects and activities (Jagosh et al., 2012, p. 312).

These potential benefits are all important in different respects. Some relate to ethical issues within research conduct, such as culturally and logistically appropriate research, which I will address in section 3.5.1. Others reflect practical benefits to the research process, such as enhanced recruitment, which can also affect the quality of the research. Some relate to social impact, such as building capacity within stakeholders. I felt that the variety of the potential benefits from the formation of research partnerships in the community was worth the potential initial and ongoing challenges of this approach. However, as a single researcher undertaking a PhD project, there were potentially even more risks in adopting this approach, in terms of feasibility, as well as relevant issues in ownership, authority, and authorship. In addition, the alternative paradigm of participatory research remains relatively under-recognised in academia, and some might view this approach as compromising either objectivity (Moore, 2004) or the researcher's ability to be critical if too close to the community being studied. I was aware of these potential criticisms, but for the above reasons, felt it was the appropriate approach for the research questions identified.

In some respects, CBPR seems similar to the concept of patient and public involvement (PPI), which is required of NIHR-funded research in the UK, including my PhD funded by the NIHR CLAHRC GM (INVOLVE, 2013). However, PPI largely separates the idea of patients and members of the public from other important stakeholders who could inform research, which limits its potential to confront some of the power issues involved in bringing a diverse stakeholder group together. In general PPI in the UK, as a requirement even of researchers of different epistemologies, without the research ethos I have described above, has generally meant that it has suffered from a chronic problem of tokenism (Ocloo and Matthews, 2016; PiiAF Study Group, 2013). While PPI has some shared roots with participatory research, and some NIHR PPI-related documents cite participatory resources (INVOLVE, 2014) it has largely not embraced the participatory language (INVOLVE, 2013) or acknowledged the above challenges that are necessary to confront in order to realise the benefits. On the other hand, CBPR has been recognised as a way of doing meaningful PPI within health services research in the UK and 'walking the walk' instead of just 'talking the talk' (Boote et al., 2015, p. 44). In this way, I decided to embrace the CBPR approach, along with its challenges, to potentially reap the benefits and be true to my research ethos in addressing the issue of access to general practice within a defined community.

3.4.1. My application of community-based participatory research

My application of CBPR within this thesis reflects my best efforts to enact the principles stated above within the practical constraints of a PhD project. My community engagement activities within T&G throughout the project are summarised in Table 2.

Table 2: Community engagement activities in CBPR approach

<table>
<tr><th>Academic Year</th><th>2014 – 2015</th><th>2015 – 2016</th><th>2016 – 2017</th><th>2017-2018</th><th>2018-2019</th></tr>
<tr><td rowspan="4">Community Engagement Activities</td><td>Initial engagement meetings & CBPT building</td><td colspan="4"></td></tr>
<tr><td colspan="5">CBPT work: team meetings, email communications, & individual meetings regarding project design, data collection, analysis, dissemination planning</td></tr>
<tr><td colspan="2"></td><td colspan="3">Local/community dissemination: updates, emerging & final findings</td></tr>
<tr><td colspan="5">Other miscellaneous: participation in CCG Equality and Diversity Group, visits to PPG meetings, touch base meetings with relevant non-team members, attending relevant meetings</td></tr>
</table>

As I have already stated, my early decision to choose T&G allowed me to begin engagement alongside other formative phases of the PhD, such as reviewing the literature and identifying knowledge gaps. Early on, my engagement activities involved initial introductory meetings, which I sought out with groups such as Healthwatch, local patient groups, and different parts of the CCG. In those meetings I expressed my interest in studying access locally and my desire to do that in a participatory way. Hence, I was looking for general thoughts on the acceptability and possibility of such a project, and specifically for individuals and/or representatives who would be willing to serve on a project team, which I later called my community-based project team (CBPT).

During these initial months, I also joined some relevant committees locally, including the CCG's Equality and Diversity Group, with whom I established a 'critical friendship' (Smith et al., 2008) around my project and the group's work. Over several months, I made 18 email, telephone, and in-person contacts, including receiving general, informal permission from within the leadership of the CCG to partner with individuals for the purpose of collaborating on this research effort in December 2014. The director of the CLAHRC GM accompanied me to my first meeting at the CCG to discuss my project in January 2015.

In March 2015, having identified and engaged with a variety of different people willing to contribute to the project through collaboration, I brought members of the CBPT together for a first project meeting. As the facilitator of that and future meetings, I allowed time for introductions and sharing of motivation for attending, based on people's various roles and identities, and I explained and welcomed discussion about CBPR and my preliminary ideas for studying access in the area based on my engagement and on my review of the literature. From that point on, I endeavoured to share project decisions, including the composition of the team and to discuss 'who else' should be at the table, with the members of CBPT. Figure 2 is a representation of the team around our meeting table at the volunteer centre in Ashton-under-Lyne, within the community of T&G.

Figure 2: Community based project team members

The initial team consisted of myself, a Healthwatch representative, the CCG patient engagement lead, three local GPs, two Lay Advisors to the CCG, one PPG member, and a practice manager. We discussed that it would be useful to have a representative of the regional NHS England team, given their role in primary care commissioning, and I was able to make that link, though the role remained virtual. Over the next few months, I was also able to engage with a local carer who joined the team. Two of my PhD supervisors attended several of the initial meetings to observe, and offer assistance with my facilitation, and then did not attend further. While there may always be unanswered questions around issues of representation in efforts such as this (Harrison and Mort, 1998), my team reflected a mix of gender, class, general life and professional roles, and included individuals possessing a variety of the nine protected characteristics under the UK Equality Act (2010), with further relevant links, including within the responsibilities of professional roles, to address health disparities.

From March 2015 through September 2019, I held 35 CBPT meetings, which were attended by different combinations of the above group as per their availability. Team members preferred that I lead the meetings, along with the research project, with their contributions limited to attending meetings and participating in other project activities when their other responsibilities allowed. As I will detail in the following sections, the CBPT and I co-designed the research protocol and ethics application in 2015, and they contributed to data generation, analysis, and dissemination activities.

3.5. Qualitative Study Design

Having clarified my research ethos, my conceptualisation of an instrumental case study, and my participatory approach, in this section I will discuss the qualitative methodology I used to generate relevant data for the research questions identified. The methodology used to study a problem has to do with the nature of the problem and the questions researchers have about it (Carter and Little, 2007). As I have described, the decision to use qualitative methodology to study access to general practice in T&G was heavily informed by my synthesis of the literature and identification of knowledge gaps. I had been able to share and discuss my evolving understanding of the literature with the people I spoke to about being on the project team, and I continued these conversations during the first team meetings. After discussions about the differences between qualitative and quantitative research, CBPT members agreed that qualitative methodology was preferred because it would allow for an in-depth understanding in the context of people’s experiences (Malterud, 1993). CBPT members felt that an understanding was lacking, not only in the literature, but especially in the real-life policies and practices around access.

In the respective sections below, I will address the specific details around design decisions made in terms of choice of qualitative methods, sampling and recruitment, and analysis. First, I will address how I considered the ethical issues around and within this work, including through discussions with the CBPT members about their own roles in the project, and how that set the scene for subsequent discussions and decisions.

3.5.1. Ethical considerations

This section serves to clarify my overarching ethical orientation in this research, but I will detail how certain ethical considerations were made in the relevant sections below. In addition to the formal ethical procedures around conducting research within the NHS, I adopted an idea of ethics as an ongoing, living concept that infused each step of the research. Similarly, some scholars have distinguished between ‘procedural ethics’ and ‘ethics in practice’ (Guillemin and Gillam, 2004, p. 261), while others have questioned the appropriateness of the biomedical model of ethical regulation in humanities and social science research (Dingwall, 2008). While this research was about health and health care, the participatory approach and qualitative methodology used were more consistent with social science research, and so both conceptualisations of ethics required consideration.

Relevant ethical issues within participatory health research include mutual respect, equality and inclusion, democratic participation, active learning, making a difference, collective action, and personal integrity (International Collaboration for Participatory Health Research, 2013b, pp. 9-10). Relevant ethical issues within qualitative health research include informed and ongoing consent, confidentiality, attention to potentially sensitive issues, and cultural sensitivity (Green and Thorogood, 2009, pp. 72-76). My main ethical considerations spanned these issues regarding my responsibilities to my CBPT members, my research participants, the community of T&G, and the academic research community.

In terms of my participatory approach, the engagement work I have already described was necessarily done before formal NHS ethical approval. The formal procedures account for this by allowing PPI work to be undertaken outside of ethical approval, yet I very much considered the ethics before and throughout my engagement with my CBPT and the community. I led with a respect for the people I was engaging with and was transparent about my intentions. I was clear that I wished to work with potential team members as collaborators, not as participants (unless separately consented, as per below), and as such their experiences would inform the decisions and direction of the project with the goal of democratic participation (International Collaboration for Participatory Health Research, 2013b).

In the first months of the CBPT meetings, based on our group discussions, I drafted and revised a role description and agreement form, which clearly set out these intentions and shared expectations. The role description and agreement form emphasised the voluntary nature of their participation on the team and their ability to change their mind at any time. Lay members were offered compensation for their time at a rate of £15/hour for meeting attendance and other direct project work, and all members were offered a contribution towards their travel costs. Compensating PPI members for their time and expenses was standard practice within the context of NIHR-funded research (INVOLVE, 2010). We agreed that professional members were considered to be contributing to the team as part of their roles. All CBPT members signed the agreement forms following ethical approval of the project (see appendix 1). I signed one as well, considering myself a member. To support my own role as facilitator of this group, including potential ethical dilemmas that could arise, I created links with local, national, and international participatory health researchers through the UK Participatory Research Network and the International Collaboration for Participatory Research, and I set up a local discussion group for participatory researchers. I was also supported by my supervisory team.

Together with the members of the team, we considered the further ethical issues around our shared work, including our responsibilities towards the research participants. Because the area of the project was identified as the T&G community, issues of confidentiality among participants required careful consideration within data generation, analysis, and presentation of findings. Relatedly, we decided that team members would not be excluded from also serving as research participants, but if they did participate it would be anonymous and not related to their CBPT role. We also agreed to offer participant checking (Mays and Pope, 2000) of transcripts for CBPT members if they decided to be interviewed or a focus group research participant, in order that they have extra assurances around the confidentiality of these contributions. CBPT members were bound to preserve confidentiality of the participants as well through their agreement form. I undertook Good Clinical Practice training through the NHS and shared learning with the team. Consistent with the ethical consideration above around active learning in participatory research, given my research knowledge, I was able to explain and discuss relevant concepts within qualitative research with my team members as we developed the research protocol and carried out the research.

In general, the topic of this research was not particularly sensitive. However, sensitive issues certainly could arise during the course of data generation, and I was prepared to deal with that through my training, including my clinical knowledge. I also developed a protocol for dealing with potential disclosure, distress, or poor or unsafe practice (see appendix 2).

A final, overarching aspect of ethics is that the research, using public funds and relying on participants' time and trust, should produce useful information. In CBPR, it is important that the knowledge be relevant locally and be used to improve local conditions, including by the community members themselves. In general, there is an expectation that the research will make a contribution to academic literature. As I will explain below, a commitment to produce research at the highest quality possible within the disciplinary and practical bounds of the researcher's capacity addresses this issue.

In terms of formal ethical approval, the protocol I developed, in partnership with my CBPT from March 2015, gained NHS Research Ethics Committee approval from the Greater Manchester West Research Ethics Committee (reference: 15/NW/0740) and NHS Research Governance Assurance from the Clinical Research Network Greater Manchester (177650) in October 2015.

3.5.2. Quality

I will return to the issue of methodological quality in chapter 8, when I critique my overall research effort. Thus far, I have demonstrated, in section 3.2, how the researcher's awareness of their own influence on the research through reflexivity, contributes to quality (Dean, 2017). In addition, the relevant ethical considerations that I have described above contribute to the quality of the work, including issues of credibility and transparency (Mays and Pope, 2000). Quality is also related to the appropriateness of the choices around the methods of data generation and analysis to the research questions identified. Below, I will detail specific decisions within my qualitative design and will highlight relevant aspects, including my continued transparency and rigour within the execution of this research.

3.6. Data generation

In this section, I will first explain the sampling and recruitment techniques used, in section 3.6.1. I will then describe the different qualitative methods chosen for generating data in context: interviews and focus groups in section 3.6.2 and observation in section 3.6.3. In section 3.6.4, I will expand on my use of theory within data generation, and in section 3.6.5 I will summarise the data generated through all methods. Although my analysis processes were concurrent with and directed data generation, I will explain them in section 3.7. Throughout all I will endeavour to be transparent about my role as the lead researcher, and about my CBPT members' contributions to the work.

3.6.1. Sampling and recruitment

Consistent with the ethical considerations described above and the project research questions, the goal of sampling and recruitment was to be as inclusive as possible to include a variety of experiences from different perspectives. Specifically, my CBPT and I discussed inclusion and exclusion criteria, and agreed that broad inclusion was important in this project. We discussed issues of diversity and health inequalities locally, and how we would make a point of exploring issues for those with protected characteristics (Equality Act 2010). For example, we discussed the need to ensure that those for whom English was not their first language were not excluded, since such groups would perhaps have issues of access relevant to that characteristic.

Following some explanations of the concepts by me to the CBPT, we agreed to use purposive sampling (Green and Thorogood, 2009) to recruit a variety of people with different perspectives on access and to observe in a variety of settings across T&G. Additionally, we agreed to use the snowball technique (Biernacki and Waldorf, 1981; Goodman, 2011) to learn from participants about others who might have different experiences. Initially we utilised the knowledge and contacts of the CBPT, as well as contacts I had made during the initial engagement phase of the project. Notably, the CBPT members also had input to the wording of the information sheets and consent forms (see appendix 3), to assist in the appropriateness of the recruitment efforts by ensuring the material was understandable from their perspectives. I also utilised readability statistics when editing in Word to make the documents as comprehensible as possible.

Below I will discuss specific inclusion and sampling criteria for the individual data generation methods.

3.6.2. Interviews and focus groups

The CBPT and I decided to utilise semi-structured interviews and focus groups (Green and Thorogood, 2009), with individuals or groups, respectively as appropriate. In discussing these methods, team members were pleased to understand that a semi-structured guide would allow for the appropriate flexibility for the respondent to tell their story in context. I created initial guides and CBPT members made further suggestions before the protocol submission for ethical approval. We perceived two main types of participants: 'service users,' which included patients, carers, and members of the public; and 'service providers,' which included commissioners, health professionals, and surgery staff. I created four topic guides, comprising an interview and focus group guide for each participant type (see appendix 4). The service user guides aimed to understand their experiences of accessing general practice care, their ideas for improvement, their understanding of the health system and resources, and their ideas for optimising access. They contained suggested prompts and probes to explore the issues discussed in more detail (McCracken, 1988). I annotated a version of the Levesque et al. (2013) access diagram to use as a visual prompt (see appendix 5) in the latter part of interviews and focus groups, if time permitted. This allowed for direct participant engagement with the theory, including a further prompt around the breadth of related issues, which I will expand on in section 3.6.4.

The broad inclusion criteria for the interviews and focus group participants, as agreed with the CBPT, were people who 1) were resident of T&G, or received care from a T&G

surgery; or 2) provided, received, or commissioned care in T&G. The only exclusion criterion was age less than 16 years. Although we did not directly recruit children, I learned about experiences of accessing care for children through the recruitment of parents and carers.

After I made contact with a potential participant and discussed the project, they would express their preference for an individual interview or participation in a focus group, and receive further information accordingly. Most focus groups consisted of existing groups whose members were interested in sharing their views on access with me, such as Patient Participation Groups (PPGs) at the practice and neighbourhood level, volunteer groups, and carer support groups. Usually I made contact with one group member, who was able to act as a point person to explain the project to the others, share the information sheets, and assess their willingness to have me join one of their future meetings to conduct the focus group.

Interviews occurred at a private place of convenience for the participant, such as their home or place of work, to increase their comfort (McCracken, 1988). Focus groups often occurred in the community location where the existing group usually met, such as a meeting room in a community venue, as long as it was a relatively private place for a potentially sensitive conversation (Kitzinger, 1995). I planned one focus group of new mothers, who usually met in a public place, in a home setting to allow for more comfort and a quiet, confidential atmosphere. I had discussed what arrangements would be necessary with one of the mothers ahead of time, and as agreed several mothers brought their infants to the focus group and were able to feed them as needed during the group. The ability to accommodate and include these mothers as participants outweighed any potential compromising of the quality of the data due to extra noise or interruptions. One service provider focus group occurred in a GP surgery meeting room, following a separate meeting which the providers had attended. My aim was to make the participation experience as accessible as possible, and on the terms of the participants to maximise their comfort, while balancing my own safety. I completed lone worker training at the university and utilised a lone worker protocol to ensure my safety during fieldwork.

In total, I conducted 19 interviews and 7 focus groups, as I will summarise in section 3.6.5 and in Table 4. As mentioned, and as I will explain further in section 3.7, on-going analysis of data generated through the interviews and focus groups, in combination with fieldnotes from observation sessions, directed the purposive sampling, until data saturation (Corbin et al., 2008; Guest et al., 2006) was felt to be reached in discussion with CBPT members. I conducted all of the interviews in-person, alone. My CBPT and I considered having a CBPT member join for some interviews, but decided not to for various reasons including not wanting to intimidate or outnumber the respondent. We also considered having the CBPT members conduct interviews, but decided for several reasons not to, including the potential impact on the data and the balance of my responsibility for the data for my PhD project. However, as I mentioned in section 3.5.1, we decided that team members could be interviewed as participants in the project, in order to gain familiarity with the experience of the interviews, to allow me to trial the topic guides, and to learn more about the member's own views. My CBPT and I decided that while I would lead the focus groups, CBPT members could be co-facilitators in order to contribute directly to data generation. Three different CBPT members joined for between one and three focus groups each. They helped with the pre-group logistics such as handing out the forms, took notes during the group, contributed with questions or prompts, and debriefed with me after the groups. One focus group required an interpreter, since, as I stated above, we decided that it was important to include participants even if English was not their first language. At that focus group, the interpreter, who was also my contact for the group, functioned as the co-facilitator, and I shared the guide with her ahead of time so that she would understand the nature of the conversation I wanted to have. Once again, the ability to include these participants and understand their perspectives was balanced against potentially compromising the quality of data through the use of the interpreter (Plumridge et al., 2012).

I obtained written informed consent from all participants prior to interviews and focus groups, including permission for audio-recording. I did this following the 'Introduction' section of the guide, which reminded the participants of the purpose of the study, the voluntary nature of their participation, and the principles of confidentiality. I treated the next portion of the interview as a ‘warm up’ and a chance to obtain some general background information with the aim to get the participant comfortable and talking about themselves. I made it clear during this time that I was there to listen to them, and I would usually not move on to the content relevant to the project until the respondent had given a long, broad answer to one of the warm up questions. This exercise usually took just a few minutes, but it set the tone for the rest of the interview. In the focus groups, this portion was usually somewhat briefer per person, but it did allow for each participant to have the chance to speak and as appropriate, offer information such as which surgery they were affiliated with and their age. I did not have a separate demographics form for participants to complete, but I captured demographic information opportunistically in these introduction/warm up sections, and during the interviews and focus groups themselves.

Following the warm up, I asked broadly about the respondents’ experiences accessing or providing general practice care. While I always had the relevant topic guide in front of me, I tended not to refer to it much because I had a clear mental picture of it. I made minimal notes during the interviews and focus groups to allow my attention to be on the respondents with eye contact and encouraging non-verbal gestures. Depending on the flow of the conversation, I was generally able to ask about ‘ideas for improvement’ and ‘understanding of the healthcare system’s resources and limitations’. As I mentioned, in most cases I used the Levesque et al. (2013) diagram as a visual prompt in the ‘ideas for optimising access’ section, but only after there had been substantial discussion about the person’s experiences. In some interviews and focus groups I was able to ask about previous access interventions, but if time was short, that was usually what was omitted. Interviews lasted between 46 and 158 minutes, and focus groups between 74 and 142 minutes.

Consistent with my processes for beginning analysis with data generation, after each interview and focus group, and sometimes before, I made fieldnotes about the context of the setting or other factors that may have been relevant to the conversation, such as interruptions or perceived distractions. I also included insights that occurred to me during the interview. As mentioned above, after each focus group, I was able to debrief with my co-facilitator, which helped with our mutual learning and to capture our multiple perspectives on the content of the discussions. We were able to discuss issues that occurred during the group, such as non-verbal behaviours and interactions between group members. These observations and further insights were included in the fieldnotes and were helpful for analysis of the focus group data (Duggleby, 2005; Kitzinger, 1995).

Following the interview or focus group, as per my data management plan, I uploaded the audio file to 1st Class Secretarial Services, an independent, secure transcription company based in the UK. They transcribed the files as ‘intelligent verbatim’, because I determined with my supervisory team that every ‘um’ and ‘ah’ was not necessary for this analysis. Once I received the completed transcript from the company, I listened to the audio recording while checking for accuracy and made corrections as necessary. While I had given instructions not to include identifiers in the transcript, I also ensured the transcript was anonymised at this time. As I will explain further in section 3.7, during this checking activity, I created a memo (Bazeley, 2007) for each interview and focus group that included first impressions of important ideas and themes in each.

3.6.3. Observation

As stated, in addition to the interviews and focus groups, my CBPT and I decided that I would observe in GP surgeries and at meetings and events (Green and Thorogood, 2009; Madison, 2012). The goal of these observation sessions was to provide further contextual data that would complement the more formal interview and focus group data. Surgery observation sessions were limited to the reception and communal areas. For practical and ethical reasons, I did not request to observe clinical encounters between patients and clinicians. The goal was to directly observe the day-to-day activities and practices of the surgeries (Swinglehurst et al., 2011), including things that may not have been mentioned in a more structured interview or focus group, or that I would not have thought to ask about. For the event and meeting observation sessions the aim was to hear about issues of access for the T&G area discussed in ways they may not have been raised or articulated in interviews, focus groups, or in surgeries, and to hear views I may not have captured with the other forms of data collection. During these observations sessions and directly after, I was able to make relatively detailed ‘jottings’ (Emerson et al., 2011) in a notebook. Back at my desk, I then typed up the jottings in longer form, fleshing out details. I used a structured form for these longer fieldnotes, which allowed for the expanded jottings, a reflection on the process, and any insights, themes and ideas that occurred to me during the session or the processing of fieldnotes. All of this work contributed to the first stage of analysis (Emerson et al., 2011), which I will expand on in section 3.7.

As I will summarise in section 3.6.5, in total I performed 45 hours of observation in 13 sessions across 8 surgery sites, and 26 hours of observation at 12 meetings and events. As mentioned above, and as I will describe further in sections 3.6.5 and 3.7, the ongoing analysis of the data generated from all of the methods described, informed my purposive sampling and I ceased generating new data when my CBPT and I felt that data saturation had been reached.

For the GP surgery observation sessions, the goal was to obtain broad coverage to include maximal variation of experiences within the area. I aimed to sample surgeries in each of the five ‘neighbourhoods’ within T&G and with variation of practice size and GP contractual arrangements. I utilised the knowledge and contacts of my CBPT to purposively sample practices. I included the recently created seven-day access hubs as potential sites for observation, and the walk-in centre which was based at an APMS GP surgery.

Prior to the surgery observations, I met with an individual from the practice or attended a surgery meeting to explain the project, answer any questions, and distribute the relevant information sheets (see appendix 6). I made it clear that anyone could decide they did not want me to observe at any time. I also clarified that I would stay in the common areas, such as reception areas, waiting rooms, and common back office areas, and that no clinical patient encounters would be observed. I explained that no identifying information would be recorded about individuals, and no recording devices would be used. Once the surgery members were happy for me to come and observe, I obtained written consent from a surgery representative, usually the practice manager (see appendix 7 for consent form). For the seven-day access sites, I obtained consent from a representative of both the federation and the out-of-hours (OOH) service that jointly provided the service. On the day of the observation session, I brought an A4 poster for the practice to display at the reception desk that described the project and stated that I was observing that day (see appendix 8 for poster). It also stated that patients could inquire with questions. I also had the surgery participant information sheets with me to remind any individual who I was sitting near about the nature of the project and my purpose in being there.

During the surgery observation sessions, I occasionally interacted with patients in the waiting rooms, but my main interactions were with the receptionists who were going about their daily work. I focused on their interactions with each other and with the patients. During the relative downtime, I was able to ask more about the interactions and activities I witnessed to understand the rules and norms of that practice. In addition to the reception staff, I also interacted with GPs and other health professionals, such as practice nurses. Again, it would not have been feasible for many of these individuals to take part in a full interview, but they were able to give brief input about access opportunistically during these sessions. Sometimes I used the annotated Levesque et al. (2013) diagram as a prompt during these sessions, especially if a person seemed interested in the broader approach to access that I was taking. Surgery observation sessions lasted between one and four hours.

For the meeting and event observations, I used the knowledge I gained in early engagement and that of CBPT members to decide which were relevant to attend in order to hear about issues of access for the T&G area. I observed in relevant public meetings, such as at the T&G CCG Governing Body meetings, the T&G Joint Primary Care Committee meetings, and at other public engagement events including two Healthwatch events and two Care Together events. I essentially attended those meetings as a member of the public, so I did not ‘recruit’ prior to going or obtain informed consent. However, the decisions about which to attend were consistent with the purposive sampling used throughout the project.

3.6.4. Using theory as a tool in data generation

As mentioned above, I used an annotated version of the Levesque et al. (2013) access framework as a visual prompt in the latter part of most interviews and focus groups, and occasionally during observation sessions. As shown in appendix 5, I included a definition (access = the interaction or fit between the needs of the population and health services) above the diagram, having learned from early engagement about the project, and in discussions with my CBPT, that it was helpful to have a summary of the concept in addition to the framework itself. As seen in the topics guides in appendix 4, this engagement with the diagram was included in the fourth and final portion of the interviews or focus groups, after I had listened to people's experiences of access. The aim was to see whether the broad concept of access resonated with people, what they thought of the idea of access as interaction or fit, and how that related to their experiences.

There were a variety of responses to the diagram. Many participants were able to engage with it, ranging from validating the relevance of the broad concept of access with their experiences to offering critiques about what was missing. A few examples from several types of participant, shown in Table 3 below, demonstrate how people felt that this idea of access was appropriately comprehensive for what they recognised as a complex problem, and that it offered a way to address issues of access that did not skip to the solution. In addition, the final example reflects a critique of the model: that it did not reflect the importance of the abilities of GPs to engage.

Table 3: Example participant responses to the Levesque et al. (2013) framework

IR01[8], patient	*"It reflects, I think, the discussions we've just had, and it… fits with the way I've been trying to describe things because I can recognise all of those, and I've alluded to them."*
IR04, GP	*How do you feel this idea of access resonates with you? (JV)*[9] *"Really strongly. I think it's very, very useful and tells you- it has just so much more in it than how people are usually seeing access..." (IR04, GP)* *"You mentioned that this isn't necessarily the way access is usually talked about. (JV)* *"No, it's all about whether you can get an appointment within a certain length of time." (IR04)*

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[8] Participant code denoting an individual respondent from an interview (IRx).

[9] My initials to denote myself in an interview exchange.

IR07, commissioner	*"What you can almost come out with is a toolkit to help you in your area look at access seriously. So this could be [pointing to diagram], these could be the ways you could start to look at access. Not 'the answer', it's, 'Before you look at that, think about this in your patch.'"*
IR10, NHS staff	*"I think it's relevant... Especially things like this: 'the ability to reach, the ability to engage'… 'the abilities of people'… I think that's really, really, really important…because I don't think they think about that enough…I also think – and I don't know whether it should be on here – but there's the abilities of GPs to be able to engage... And I think that is massively important…"*

In many instances, the discussion continued following the direct interaction with the diagram, perhaps in directions it otherwise would not have. In this way, the use of the diagram affected the data generated, likely enhancing the breadth of topics covered, in addition to capturing the direct participant interaction with the theory. It was important that I did not lead with this exercise, as I wanted the participants to know that understanding their experiences was my priority. Also, the influence on the data was limited, since the bulk of each interview had already taken place. However, it was a useful aspect of data generation when it was feasible to include, and it had implications for the ongoing analysis of the data and the use of theory within analysis, which I will explain further in section 3.7.

3.6.5. Summary of data generated

Table 4 summarises the data generated through the multiple methods described above. Including all methods used, the data generated spanned experiences at approximately 36 of the total of 45 surgery/hub sites[10] that existed in T&G during the project.

Table 4: Summary of data generated

Method	Number of events	Number of Participants	Approximate Hours
Interviews: service users	9	9	12
Interviews: service providers	10	10 (3 were also patients in area)	12
Focus Groups: service users	6	30	10

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[10] I used my own system for counting the sites, which may differ from the number listed on CCG and other websites, in part because I counted two locations of the same 'surgery' as two different sites. Also, some practices merged during the course of this study. As mentioned, I also included the seven-day access hub sites, one of which was otherwise not a site in the area.

Focus Groups: service providers	1	5	1.5
Observation: Surgeries	13	8 sites (including interactions with approximately 40 receptionists, GPs, practice managers, practice nurses, administrative staff, and patients)	45
Observation: meetings and events	12	(approximately 70 individuals across all meetings/events)	26
Total	51	54+	106.5

I performed 19 interviews: nine with ‘service users’ and 10 with ‘service providers’ as previously defined. Of the 10 service providers, three were also patients in the area. I performed six focus groups with service users, which included a further 30 participants. Five service providers participated in that focus group. Several of the ‘service users’ had relevant voluntary sector roles, which were the primary reason I recruited them. The patient/carer participants ranged in age from 26 to 79 years old, with carers discussing patients ranging from zero to 101 years old. The service provider participants ranged from having four to 26 years of experience in their current or previously relevant roles. The service provider roles included GPs, practice managers, commissioners, other CCG employees, and other relevant NHS staff roles. I heard from people possessing all nine protected characteristics from patients with various degrees of health and illness, from carers of people with chronic diseases including dementia and learning disabilities, from those facing economic deprivation, and from members of voluntary organisations helping various individuals.

I observed at eight different surgery sites, including the three seven-day access hubs, for a total of thirteen sessions (between 1-3 sessions at each site). The surgery sites included both small and large surgeries in all of the five neighbourhoods. I meaningfully interacted with at least 40 people during the surgery observations. I also observed at twelve relevant meetings and events. I estimated from my fieldnotes that I heard from about 70 individuals at these meetings and events.

After nearly a year of fieldwork, having begun generating data in October 2015 and analysing in an ongoing process, I felt, and discussed with my CBPT and supervisors, that we were starting to hear similar patterns and fewer new experiences and ideas within the data. We were also influenced by the idea of ‘information power’ in determining ‘saturation’ where the criteria for a sample to be sufficient depends on how relevant it is to the study (Malterud et al., 2016). We agreed that the data generated was very relevant, and that we had met our goals of a diverse sample, having heard from people on various different sides of the issues around accessing care in a number of distinct environments, consistent with the idea of fair dealing (Mays and Pope, 2000). We felt we had generated a wealth of useful data that clearly related to and could further advance the existing access theory (Tavory and Timmermans, 2014). Following the processing of the final planned purposive sampling, I concluded new data generation in October 2016 and continued with the analysis processes that had already informed the work.

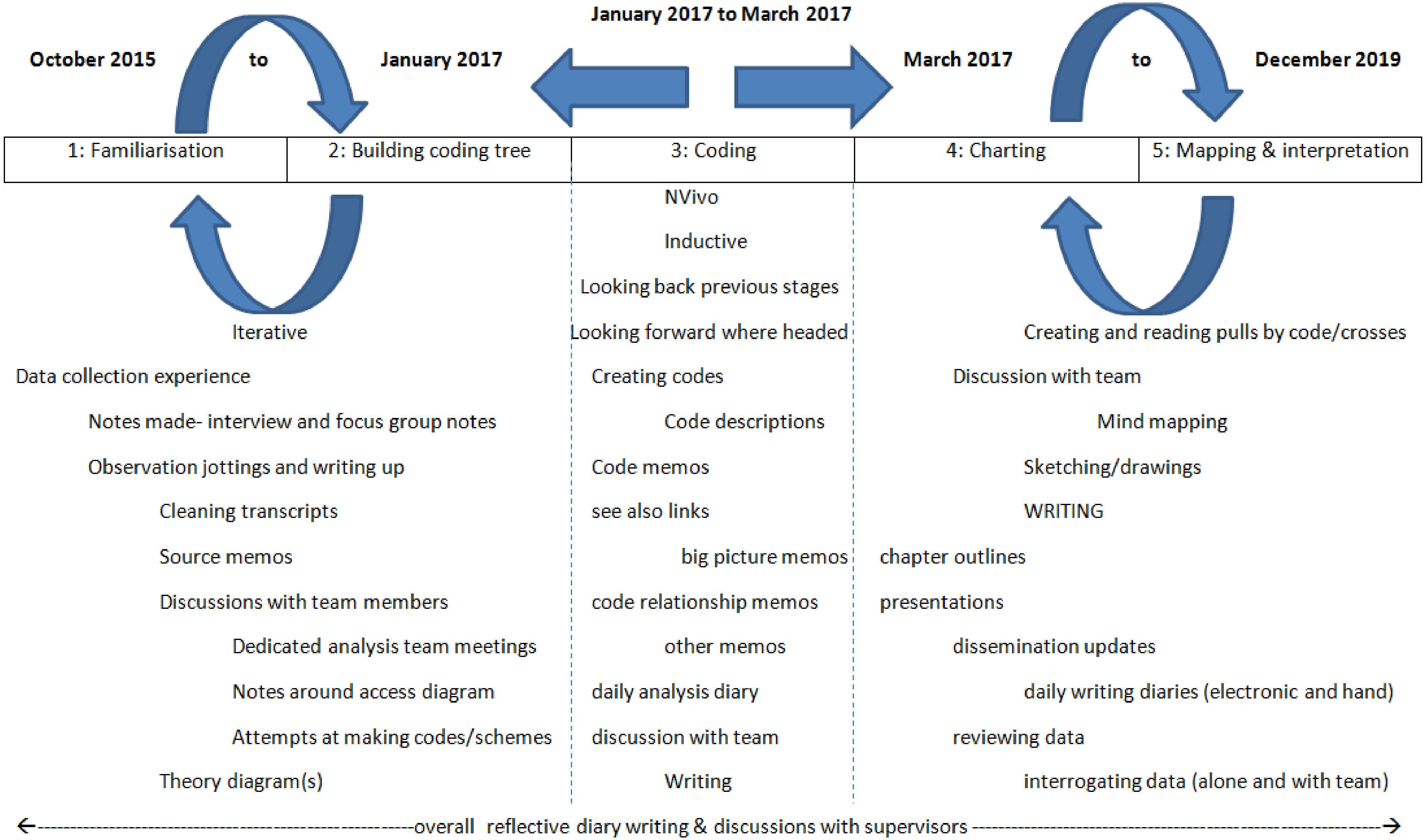
3.7. Data Analysis

In this section I will explain the data analysis processes that I applied, both with my CBPT and independently, during this work. As I have mentioned, analysis began with data generation, and it continued throughout my writing processes. I am influenced by several forms of qualitative data analysis, but from the outset I chose to modify the five-stage framework approach developed by Ritchie and Spencer (Bryman and Burgess, 1994; Pope et al., 2000) to describe the analysis steps I would take in theory and in practice, including with my CBPT. Figure 3 summarises my analysis processes throughout this work using slightly altered names for the stages: familiarisation, building coding tree, coding, charting, mapping & interpretation. While Ritchie and Spencer aimed to make the framework approach more straightforward—and therefore less inductive and less iterative—for applied health research, my processes embrace and incorporate the inductive, iterative nature of grounded theory (Corbin et al., 2008). In figure 3, this is represented by the arrows and the activities listed under the different stages. I also embraced the idea of abductive analysis (Tavory and Timmermans, 2014), in which the researcher actively looks between existing theory and the data generated, to describe my deliberate interaction with the access theory throughout the analysis processes. Together, these different forms of analysis contributed to the process I have depicted in figure 3. Notably, joint analysis in participatory research can be a challenging undertaking (Israel, 2013). By involving the CBPT members in analysis, I aimed to balance the desire to have CBPT members contribute and learn from the process, consistent with CBPR principles, with the realistic limits on others' availability and with my ownership of the PhD. On the whole I devoted significant meeting time with them to the ongoing discussion and analysis of data generated, so that their perspectives were included in the interpretation of the data. However, I did the majority of the analysis independently in order to progress the project and prepare the opportunities for CBPT members to contribute.

3.7.1. Familiarisation

Familiarisation consists of immersion in the raw data to gain a general understanding of the data obtained (Pope et al., 2000). As seen in figure 3, this stage began with my lived experience of the data generation itself, and included notes I made around interviews and focus groups, as well as the observation jottings and full write-ups (Emerson et al., 2011). It also included reviewing the transcripts when I re-listened to check for accuracy, when I made a memo for each item/source about important concepts that arose. CBPT members participated in familiarisation too. Some were present for aspects of data generation as I have described through focus groups and attending some of the same meetings and events. I also shared some de-identified transcripts with team members, on which some made notes and which we discussed at CBPT meetings. Ongoing familiarisation allowed us to check whether we needed to adapt any data generation techniques and directed our continued purposive sampling. Familiarisation was also an iterative process that cyclically fed into the next stage of analysis: building the coding tree.

Figure 3: My five-stage analysis process and associated activities



3.7.2. Building the coding tree

Concurrent with familiarisation of the data as it was collected and processed, I aspired to develop a coding scheme to aid in organising the data and to allow for the articulation of themes and develop new and/or existing theories. This stage was both inductive and deductive, coming from the data itself, yet with an awareness of the relevant literature on access including especially the Levesque et al. (2013) diagram. The CBPT and I discussed this over several months, including two additional analysis meetings with a smaller subset of team members. I drafted an initial tree based on our discussions, which we reviewed over the next few months as new data was collected, and we agreed it was not quite right. We were reluctant to move on to the coding stage with it, unsure if it was comprehensive enough, whether it was too detailed in some parts and too general in others, and whether we had enough breadth of our sample to be sure important ideas were included. Particularly problematic was how or whether to incorporate the specific elements of the Levesque et al. (2013) diagram in the coding tree. While data generation and familiarisation took place, we continued to discuss the idea of coding, but in the end, did not build a coding tree during this phase. Instead, as I will explain below, we progressed to the coding stage once data generation, having been informed by the work of these first two stages, was complete, and the coding tree was built inductively during that immersion process.

3.7.3. Coding

Once data generation and familiarisation were complete, and significant CBPT member and meeting time had been devoted to discussing the emerging ideas within the data, my CBPT and I decided that I would be the sole coder of the data. While we had initially thought that CBPT members might directly contribute to this step, several factors contributed to this decision, including the amount of meaningful discussion that had already taken place, yet not produced a tree, and people’s availability. There were also limitations with multiple users of the NVivo11 qualitative analysis software, which we used to aid in this stage of analysis (Bazeley, 2007). I had attended a training course for an alternative software package that claimed to be better suited for participatory research, along with a CBPT member, but it was inferior to NVivo in other ways. Therefore, we decided that I would inductively build the coding tree in NVivo while re-immersing directly with all the data, and that the process would be informed by the significant discussions and preliminary analysis that had already been completed.

Thus, with all of the rich work of the first two stages to mind and in hand, I uploaded all of the data to NVivo and inductively coded, building the coding tree in the process. I did this with the knowledge of the whole data set, and of what had seemed right or wrong about the previous attempts to build the tree. I purposefully coded the data in an order that varied the type of collection method and the chronology of the data. I created the codes and code descriptions, sometimes creating code memos. I did this with an awareness of what I hoped to do with the coded data in further stages of analysis, as I began to make connections between codes as the work progressed and had moments where a ‘big picture’ began to emerge. I kept a separate analysis diary within NVivo during this time. The CBPT and I discussed the ongoing coding process, and in meetings I displayed NVivo to demonstrate the developing coding tree and interrogate the code definitions with them. In this way, they were able to contribute to the coding stage and ensure it reflected all of the previous months of work with the data.

3.7.4. Charting

Once the data was coded in NVivo, I arranged it by codes (pulls) and performed other queries around the overlapping of certain codes (crosses) (Bazeley, 2007). The CBPT and I further discussed and explored aspects of the data in this way over several meetings as the findings began to take shape. This stage also overlapped with my early attempts to write up the findings. This stage was cyclical with the final stage: mapping and interpretation.

3.7.5. Mapping and interpretation

The final stage of analysis consisted of mapping the emerging concepts and interpreting the big picture of how concepts were related. In this stage I drew mind maps and did other sketches and drawings. I discussed these with my CBPT and my supervisors. This stage overlapped with the process of writing up the findings of the thesis, during which I kept a separate writing diary. It also overlapped with early and final dissemination with local groups. All of this involved a continual interrogation of the data to be sure the points made were justified in the data and were consistent with the work of the earlier stages of analysis. I also continued to look between the access theory and the findings to see how they were interlinked and how the theory could be advanced by this work.

3.8. Chapter summary

In this chapter, I have explained and justified my research approach, methodology, and methods. I have described how an in-depth instrumental case study using an applied theory of access, participatory research, and multiple qualitative methods were the appropriate choice to address the knowledge gaps around access to general practice that I identified in chapter 2. In the following three chapters I will present and discuss the findings of this research which were the result of the above processes: a novel description of access problems, a critique of the main effort to address access during this time, and a critique of a main trend within general practice of increasing practice size. In chapter 7, I present the theoretical advancement and further suggestions to address problems with access, which were generated by the analysis processes described in this chapter. I have endeavoured to be transparent in my description of my research activities, and in chapter 8, I will reflect on the quality of this work, including a final reflection on my identities and roles and how they have shaped the research processes and my overall contribution in this thesis.

Chapter 4. Understanding a Paradox of Access Problems

4.1. Chapter overview

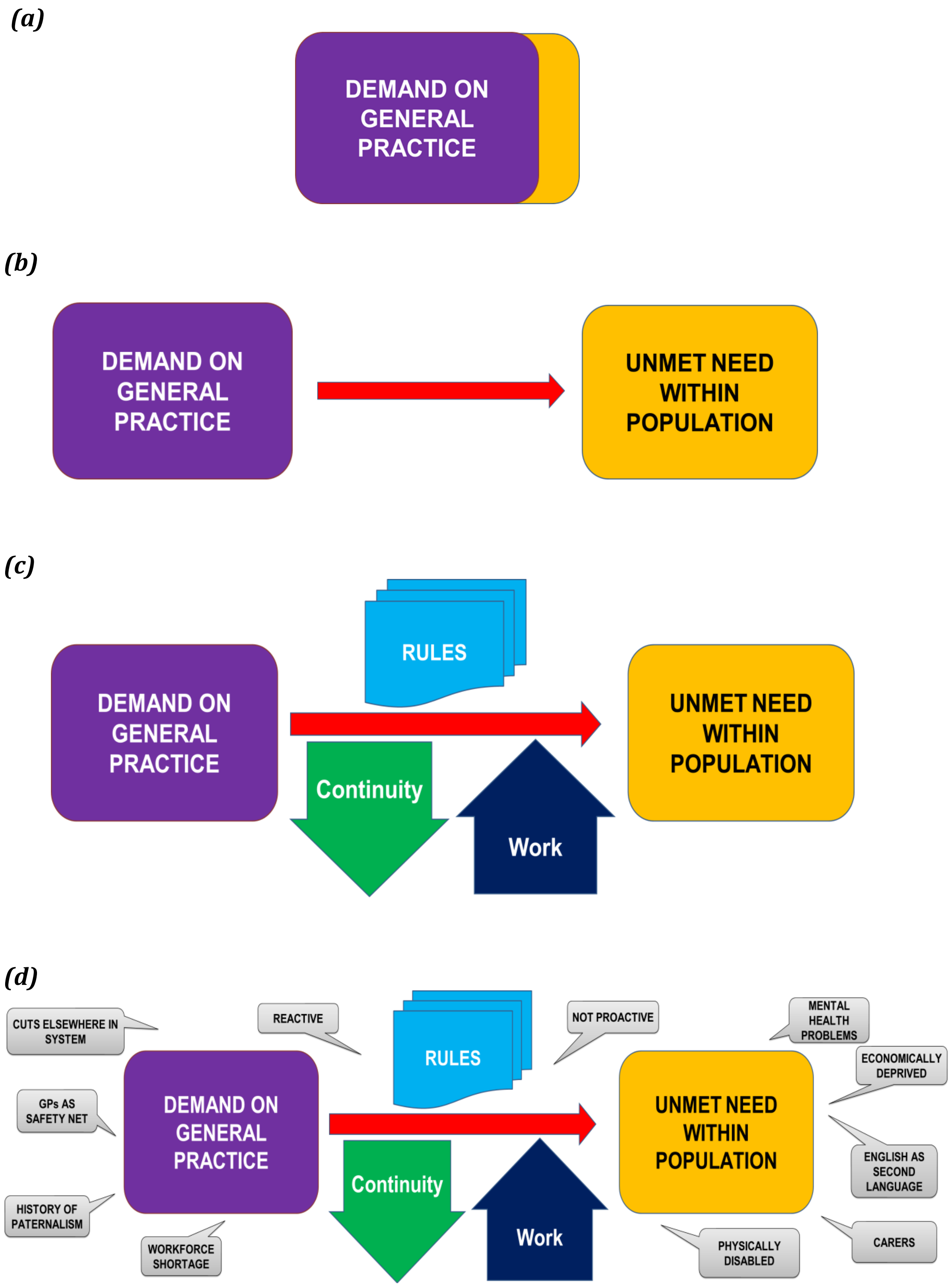
In this chapter, I will present the core of my findings: a novel description of access problems within general practice as a paradox of demand and unmet need. I came to this understanding of the multiple issues relevant to access through the steps I have described already in this thesis: a critique of the existing access literature, an active application of a broad theory of access, a participatory approach with relevant stakeholders, and a qualitative methodology that allowed multiple perspectives to be heard and analysed alongside each other.

Within my description of the access paradox, I will demonstrate how the real and perceived demand on general practice has necessitated a reaction involving rigid rules that undermine continuity and increase work, which in turn cause a different problem of unmet need. This unmet need is largely a result of general practice not having the capacity to be either flexible or proactive for some of the most ill and at-risk people within the population. It is within these groups that the persistent health inequalities lie, hence why this is important—to the aims of my project and the sustainability of the NHS—to identify and understand this unmet need so it can be addressed. As I will explain, the demand problem not only causes the unmet need through the mechanisms described above, but it also obscures it, in turn perpetuating the paradox.

Figure 4, below, depicts the understanding of the paradox of access problems that I have described. Part (a) demonstrates how too much demand on general practice obscures the problem of unmet need. Part (b) depicts that the two are linked causally. Part (c) demonstrates *how* demand creates unmet need through layers of rigid rules, undermining of continuity, and increased work that prevent the service from being proactive were needed to meet the needs of certain groups. Part (d) depicts the multifactorial nature of the demand, the reactive nature of the rules, and the disproportionate distribution of the unmet need in certain groups because care is not proactive.

Figure 4: Understanding a Paradox of Access Problems

(a) Demand obscures unmet need. (b) Demand also causes unmet need…
(c) through reactive rigid rules, undermining of continuity, and increased work.
(d) The demand is multifactorial, and the unmet need disproportionately affects certain groups within the population



In the following sections of this chapter, I will present various forms of my data to demonstrate the intricacies of the access paradox to further explain: the demand on general practice (section 4.2); the resulting rigid rules (section 4.3); the importance, yet undermining, of continuity (section 4.4); the resulting extra work (section 4.5); and the subsequent problem of unmet need (section 4.6). My presentation of this paradox attempts to reflect the multiple existing realities for people both providing and receiving care, and takes into consideration their knowledge, roles, skills, expectations, and individual characteristics, which emerged as important during my analysis.

4.2. Demand on general practice

Consistent with other resources, my data show that demand on general practice is widely perceived as large and increasing, especially by those working within the system such as GPs and practice staff. The multiple causes and effects of this demand will be explored in this and subsequent sections.

Respondents felt that wider societal issues were causing demand for GP services. Cuts in the social care system, brought on by a policy of austerity, were perceived to be a cause of poor health, deprivation, and the need to eventually seek care for health problems (IR16, patient/voluntary sector worker)[11]. Similarly, respondents identified social isolation as a reason that people inappropriately seek care from the GP. In the following quote, a PPG member describes how the GP reported that patients were coming to appointments for non-medical issues related to social isolation.

> *"… [our GP] said he was getting patients coming to him saying, "Can you get someone to come and change my light bulb?" Because they couldn't do it…And there is a lot of stuff like that. They don't know where else to go just for social stuff. And isolation and loneliness is rife." (FG6R3, patient/PPG member)*

In addition, a GP expressed how, within the system, GPs were seen as the safety net who say 'yes' to patients, when others say 'no'. This GP felt that such perceptions were contributing to the overwhelming demand and pressure on general practice.

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[11] When referencing my data, I will use a code that either denotes an individual respondent from an interview (IRx) or focus group (FGxRx) followed by a brief description of the respondent's relevant role(s), or an observation session from a surgery (SxOx) or meeting (Xx). I will visually designate block quotes from observation sessions with a box. Within interview or focus group exchanges, I will use (JV) to denote myself and (CBPTMx) to denote a member of my CBPT. I will also present some vignettes, which include multiple forms of data fused from multiple sources, which I will also designate as above.

> *"As general practice in the UK, we are the safety net for everything, in that we never say 'no'. We always say, 'yes' to everything. And that's great because it provides that safety net and allows other processes to work and frees up resources elsewhere, but actually, as the service that always says 'yes' to every challenge that's presented to it, we are beginning to struggle. We are a creaking gate, and it's not going to take much before we go under." (IR05, GP)*

Similar to the awareness of the effects of GPs saying 'yes' on the growing demand, some GPs identified overmedicalisation as another problem to which the profession had directly contributed. Here a GP explains the doctors' role in generating the existing demand through labelling patients with more and more medical problems and asking them to keep coming back to the surgery.

> *"That's what really pisses me off about medicine today… I did a visit the other day with the [trainee], to a nursing home, and there's 20 people sat there in chairs, non-verbal, slumped over, most of them on 20 medications. And it's: where did we go wrong? When we decide to stop asking people what they wanted, and just start medicalising everyone? I think we need to really push on this fact that we've medicalised people. And in terms of access, I think we're the problem. We're the people that have asked these people to keep coming back. 'You need this. You've got this.' Labelling people. And as soon as you label someone with something, that's it." (IR18, GP)*

The above GP recognised the demand generated by the proliferation of diagnoses and the follow up required once people have these diagnoses, or labels, in the current system. Along these lines, another GP felt that the paternalistic nature of some GPs, historically, meant that patients were used to coming to the GP for every little thing and to have things 'checked out'. While this patient behaviour was not considered inappropriate in the past, it was now contributing to the problem of demand because there was not enough capacity for GPs to respond to such minor concerns. In the quote below, the GP ventured that the profession was in part to blame for these learned patient behaviours.

> *"Some of it generated by the medical profession who, you know, historically likes to be relied on and to know the answers, and they are there. Stories that I hear from - fortunately not from patients at this practice…they are just not really involved in their care because it was a paternalistic approach. Obviously then that's going to come back to bite you when they need you to say whether a cough is okay and whether a temperature is okay, whether their runny nose is okay, and whether this minor muscle ache is okay, because you've taken on the responsibility and taken control on every other consultation." (IR04, GP)*

This GP recognised the importance of the dynamic in the consultation room as affecting future demand. The same GP also felt that the broader health system generated demand for general practice, often through public health messages, which were released without consideration of the consequences on GP workload, for example by encouraging people to be checked by their GP for various common symptoms.

> *"Yes, usually multiple messages, yes. That phrase – "I thought I had better get it checked out" - I mean we hear it so often, and it's the dominant discourse out there, 'Symptoms been going on, better get it*

> *checked out.' …People don't know how else to check it out, apart from to see their trusted GP. Actually yes it probably is the quickest most efficient, most effective way of getting it checked out, but actually there aren't enough of us to do all that checking." (IR04, GP)*

Respondents also mentioned the GP workforce shortage as exacerbating the feeling of demand on general practice, which in turn affected how GPs approached their work. Because of both an actual shortage of doctors and the alternative professional roles available to GPs, there were now fewer clinicians in the workforce to deal with demand and provide clinical care to patients. This GP explained how the national GP shortage was affecting the local area.

> *"But we have a huge issue at the moment… recruitment and retention of general practitioners. Because now I think, the last count, it was mentioned to us by [name GP leader] this week…35 fulltime GPs down in Tameside. Across GM I think it's 260, and that's ridiculous. So if that's our starting, 35 GPs down, our starting point, how the hell are we ever going to get back to a normal way of working?" (IR18, GP)*

Another GP explained how specifically the establishment of CCGs under the HSCA, and the pull of GPs into administrative, non-clinical CCG roles, added to the feeling of demand on the remaining frontline workforce.

> *"I just thought it was a real shame when [PCTs] were pulled down and the CCGs set up in their place… But what that also did, was to take away a whole load of clinical coalface time. Suddenly, like in our practice, we were suddenly having to manage without [GP name] here for two days a week and [other GP name] here for a day a week. And that must have been multiplied up and down the land, with GPs suddenly not seeing patients anymore." (IR13, GP)*

Practice managers and other staff observed the increased workload on GPs, and recognised it could lead to burn out because GPs were working more and more hours. This excerpt from a focus group of practice managers demonstrates the awareness they had for how hard the doctors were working to meet the demand.

> *"And if nine sessions was nine sessions, if they could come in at nine o'clock…and go home at 5.30, every GP on the planet would stick with that. Not an issue. But they're in at half past six, seven o'clock in the morning. They're going home at eight or nine o'clock at night. They've all got remote access to dial in from home to check their bloods and everything… by the time they get holidays, they're practically ready to crack." (FG1R1, practice manager)*
>
> *"Yes, they're burning out, aren't they? And you only have to look at the clinical system at times that administration is processed, and it can be sometimes…I've got one particular GP half one, two o'clock in the morning…" (FG1R4, practice manager)*
>
> *"Doing things, yeah". (FG1R5, practice manager)*
>
> *[others agree]*
>
> *"You know, and because you look at the time stamp that it's come through on the system and you think, 'Oh…'" (FG1R4)*

Some patients were aware of the effects of the overall workload on their doctor, including the effect it could have on their own consultation. For example, as this patient describes, if the doctor were feeling pressured, they might not seem as open to discussion over issues like their treatment recommendations.

> *"… some GPs can be challenging because of their own stress levels or their workload…In one surgery I'll have a GP who is, you know, the kind of person that would talk like you and I, talk and then say, 'Is there anything else that I can help you with?' And, 'how are you?' And will look you in the eye and will go away from their computer screen, and that's how you want them to be. And with others they will sit down and they'll say… 'What do you want?' … And I've certainly had that where, you know, you've made an appointment and somebody is like, "What do you want?" And that's not helpful. And if you were somebody who wasn't feeling very comfortable or wasn't feeling very well or wasn't feeling very in the mood to have a debate, you know, you'd feel, 'Well actually I'll just take the prescription, thanks.'" (IR15 patient/voluntary sector worker)*

This patient, who also worked for a voluntary sector organisation, recognised that people who might feel uncomfortable or unwell might struggle to express themselves depending on the workload or stress level of the GP.

In addition to recognising how the demand on GPs affected their own opportunities for care, several patients made it clear that they understood the demand on GPs and did not want to take up their time unnecessarily. However, sometimes, as I will explain more in the next section, patients were not aware of the rules around appointments, and they did not always know which was the most concerning symptom to prioritise in a consultation. One focus group respondent described how he did not know that doctors only had ten minutes with each patient until an appointment where he mentioned something at the end of it, which turned out to need investigating as a cancer and therefore took time.

> *"The other thing I've come across, which hasn't been mentioned: it's very rarely, but I tend to go with a shopping list, you know, and then write all the things for the doctor. And they don't like that because they're only allowed ten minutes per patient. I didn't know this until on one occasion I mentioned something. I said, "Oh, by the way, I've got this symptom." And he said, "You didn't mention this when you made your appointment." I said, "No, I never thought about it." "Let's have a look." And it turned out I'd got cancer. Now this is pretty important really, I suppose, but he was annoyed. I came out of that session with him, being more concerned about him spending more than ten minutes with me than the actual problem that I'd got." (FG2R4, patient/volunteer)*

The patient was concerned about having used more of the doctor's time than allocated, even for something so important. He sensed that the doctor was annoyed at the time used or the fact that he did not think to mention the symptom sooner. This example demonstrates how patients were concerned about, and aware of, GPs' time and other demands, but that was sometimes in conflict with their own need for care.

I noticed numerous patients who had empathy for the healthcare professionals, were aware of recent cuts in the system adding pressures, and understood based on similar demands they have felt in their own jobs, or those of family members who worked in parts of the system. However, as above, sometimes it was in conflict with the care they needed. One exchange from a focus group of new mothers showed how they tried to make sense of their care experiences, based on their knowledge of the pressures on the system. The initial example below is about a midwife who was covering for a sick colleague, with the appointment taking place in the patient's GP surgery.

> *"The bad attitude that [the midwife] had when I walked into the room and experienced. I mean, obviously I know it's shortages, it's staff cuts." (FG5R3, patient/mother)*
>
> *"But that's not your fault." (FG5R2, patient/mother)*
>
> *"No, and I get all this from my [family member], because she's a family nurse, and she's panicking that they're going to cut the funding for their services and all this, and she says, 'I don't feel like I can give my best care because I've got this many girls to visit, and it's not always half an hour at each visit because sometimes they want to talk more. So the five o'clock visit, it gets pushed back and pushed back, and then I can't go anymore, because it's getting to six o'clock, and I finish. I can't work all day.'" (FG5R3)*

Within that same group, a participant who worked as a healthcare professional empathised with the GP, saying that she did not envy his job. She could see that it could be isolating, that there might not be enough time per appointment for patients, and noting he was running late not that far into the morning, could imagine the stress this created. She was able to compare it to her own experiences, either working out in the community alone, or at the hospital with colleagues.

> *"It's like when you're bobbing around in the community, you see [patients] all day, but it's not the same as when you're in the hospital, and you're working with your friends and your colleagues... I mean, as I said, we've seen one doctor since [daughter's name] was born, and I left it until she was like 14 weeks, and this [problem] wasn't clearing…So I thought, "Right, I need to get this… sorted." So they booked us in to see the doctor who was lovely, but we were waiting for an hour and ten minutes to see this doctor, and our appointment was at like quarter past ten, so it wasn't late in the day where they'd overrun. But I don't envy his job at all, because as a GP you must never know what is going to walk through your door, and for some people, ten minutes is just not going to cut it, is it? (FG5R2, patient/mother)*

This patient had a particular ability to empathise with the doctor because of her own role, but these types of exchanges from the focus groups were not uncommon.

While the above descriptions demonstrate patients considering the demands on the system and the clinicians, from my observations, practice staff under pressure generally did not feel patients had an awareness or understanding of the demand on general practice within the NHS as a whole. Practice staff tended to mention the demanding patients when they were generalising about patients (FG1, S19). When feeling under pressure, they largely attributed the demand to demanding patients, rather than all of the factors mentioned above. Some practice staff had been verbally abused when patients were frustrated with the available options for services, and it seemed like that affected the way some then dealt with future patients (S19). Practice staff attitudes towards patients are important to note because, for example, a conversation with the receptionist is the first step in most care seeking pathways. As I will explain further in the next sections, the increasing demand on general practice, and the conflation of this with demanding patients, affects access because it generally has led to new rules being developed to deal with demand, and a style of enforcement creates further work, often by undermining the continuity that many patients are requesting, because it is difficult to accommodate within the appointment rules systems that have developed.

4.3. Reactive, rigid rules

The sheer number and complexity of rules around care seeking, and the variation across practices, were notable during my observations in surgeries and when listening to patient experiences. The layers of rules seemed to have accrued over time in response to the perception of excessive demand and to handle the increased workload described above. Importantly, some of these rules were explicit and some were implicit. Some rules, which were based on previous efforts to improve access, seemed to have lingered even though the policies that compelled those rules no longer existed. Although there were some patterns, no surgeries had the same rules around appointments or systems for dealing with requests, and interpretations and actions could differ even among staff at the same surgery. As I will explore further, this undermined the potential for patients to share knowledge about accessing general practice, and created significant variations of experience, which frustrated some patients and greatly contributed to inequality of access.

I observed the advantages and disadvantages of different rules within several surgery contexts. I noticed some surgeries enforced certain rules with consequences that other surgeries, without those rules, did not experience. I observed rules that were clearly derived from previous, outdated policy ideas, yet had remained in place. Some rules were practice-specific, and some were regional or national policies. Some rules from those policies were interpreted differently at particular surgeries. It was clear from focus groups of patients across several surgeries that the rules varied at the different surgeries, and some patients were frustrated with that uneven experience (FG2, FG6). In a CCG event that took place during my study to engage patients about general practice, patients expressed that when they tried to access care, it felt like the practices were trying to fit patients into their existing rule boxes, rather than hearing their needs and treating them as individuals first, which was their top priority (IR07, CCG staff member).

A focus group with practice managers revealed the work done on the practice side to try and create an 'offer' of appointments, and rules around them, which matched a surgery's demand (FG1). Often these rules involved creating a division between 'urgent' and 'routine' appointments. Later in this section, I will elaborate on how that division, while used widely, was problematic for many patients, and some staff, to interpret in a consistent way, which led to further issues. Practice managers saw themselves as genuinely trying to make an offer that worked for patients, and were frustrated when it still did not fit with what patients seemed to want.

> *"See, we operate a walk-in three mornings of a week, which on paper sounds wonderful that you've got open access guaranteed for those three mornings. However it creates sometimes more problem than good because the folk that, you know, you can't get them a routine appointment when they want it, which is usually instantaneously or the next day, although you've offered something that we feel is suitable for what they're asking for, they'll just wait, and then they rock up to the walk-in and then all you're doing, you're almost stockpiling your day. The partners are very… 'Oh, my walk-in day is a Wednesday.' Unfortunately the patients kind of learn your new system, and they circumnavigate it, so there's one GP particularly everybody wants to see, so they'll all rock up on a Wednesday. You can guarantee Wednesday they're queuing out the door. In the past as well, try doing more book on the day, which the trouble is then you then haven't got the book ahead. You're sort of balancing, and it's only a finite number of stuff, but whichever way you try and do, you're almost then doing it at the expense of other types of appointments, and you never really quite get that balance right." (FG1R5, practice manager)*
>
> *"You never will, though." (FG1R1, practice manager)*
>
> *"No." (FG1R5)*

The practice manager in the above quote expressed frustration that patients did not accept what was on offer and learned ways to circumnavigate it, often to obtain continuity with a GP. From her description, the GPs might even encourage this behaviour by telling patients what day they will be the doctor on walk-in duty. However the practice managers felt it was undermining what they had tried to set up and were left feeling that it was not possible to get the balance right. The dichotomy of urgent and routine appointments is discussed further in the following focus group exchange.

> *"That's what we get, because we've changed our appointment contact times for urgents and routine. We've split that up, and it still doesn't suit everybody, which we know we're not going to suit everybody, and we do alternates and try…" (FG1R3, practice manager)*
>
> *"We never seem to suit anybody though, do you?" (FG1R2, practice manager) [all laugh and agree]*
>
> *"You know, we have the urgent appointments available at eight o'clock in the morning because if you've been up all night, you want to see a doctor as soon as possible and you want that appointment. For the routines we say, 'Ring after 11 o'clock.' 'Well, I'm in work. Nobody else can ring up, and I don't get an hour, and I work 12 hours a day.' And that's all you get because they want their appointment to be given when they ring up, but the system doesn't allow it." (FG1R3)*
>
> *"I've started putting that back to the patient to say that, you know, we operate this appointment system, and it's based on X, Y and Z along with several other practices, but I appreciate that people come from all walks of life, and if you have seen a system out there in your daily work or from somewhere, I would be more than happy to…" (FG1R4, practice manager)*

One of the practice managers in the above exchange described a rule in which patients were not allowed to book a routine appointment until after 11 o'clock, and that meant the receptionists would ask the patient who had called, and perhaps waited on hold, to call back another time. It was this type of rule that patients expressed frustration with, as the practice manager indicated. This type of rule and the enforcing of it generated extra work for both the reception staff, and the patient or caregiver trying to make the appointment, which I will explain in more detail in section 4.5.

One aspect of these complex rules is the knowledge discrepancy between staff and patients. While practice staff knew the rules, since it was their daily work, many patients did not. This was especially true about new or more complex rules, and for patients who did not use the surgery frequently. Practice managers and staff did not seem to have an awareness of this knowledge discrepancy, yet this contributed to patients requesting the care in the way that did not fit the rules, adding to everyone's frustration and burden. It would take time to explain new or arcane rules to patients around why their request could not be dealt with as asked. On the other hand, as shown in the earlier quote, practice managers were frustrated when the patients learned the rules well enough to be able to circumvent them. Therefore, there was a narrow range of acceptable patient knowledge about the rules that was sufficient to be able to access care efficiently, yet not so advanced or strategic as to be resented by the staff. Below, a patient, who also worked in the voluntary sector regarding healthcare issues, explained that she felt at a disadvantage in knowing the procedures of her surgery because she does not go often.

> *"I'm [name]. I go to [name GP Surgery 12] in [town name]. I don't know a great deal about it because I don't go very often. And I think sometimes that can go against you, you know, because then when I do have to go, I don't know what the procedure is, so I consistently get it wrong. You know, you're like, 'you can't ring up at this time for this, you can't ring up...' So I think sometimes when you don't use a practice very often, you're at a disadvantage." (FG2R6, patient/voluntary sector worker)*

The knowledge discrepancy was evident even in a focus group of a practice's PPG, arguably the most informed patients in a surgery. Yet from the conversation between members, there was confusion and disagreement over intricacies of appointment rules at the surgery (FG7).

Another patient's story, as illustrated in the vignette below, showed how rigid enforcement of these practice rules, and lack of patient knowledge about rule changes, could affect patient care.

Vignette 1: Rigid enforcement of rules and rule changes not communicated

Patient IR12's partner became ill when they were abroad on holiday. The treating hospital wanted the patient to have a follow up appointment with his GP booked in order to discharge him safely. However, their surgery only allowed patients to book on the day, so it was not possible to obtain an appointment ahead of discharge. When they returned home and rang on the next morning to book, they learned that, unbeknownst to them, the surgery had advanced the time that they opened the phone lines in the morning, and therefore all of the available appointments had already been booked.

The vignette demonstrates that the hospital abroad thought it was standard to be able to book an appointment ahead of time with a GP, especially for someone ill enough to be hospitalised. The inability of that to happen demonstrates the inflexibility in how these rules are applied. The fact that the opening times had changed, but patients were not informed, shows the assumption that patients would know the rules had changed. I observed some surgeries that made practice newsletters, which occasionally announced certain rule changes, but those were mainly left in surgery waiting rooms and were not proactively shared with the entire practice population, in part due to expense (S19, S36).

As I mentioned earlier, the division between urgent and routine appointments was one area where patients and staff found the rules difficult and variable to negotiate. Many patients explained that they did not know what their surgery's expectations were for urgent or emergency (as some surgeries called them) appointments. Patients, carers, and voluntary sector workers felt that how a request for an appointment would be dealt with depended on their own personal interpretation, personality, and often assertiveness (IR02, IR14). A focus group of patients and volunteers from different surgeries had different understandings of these terms and several stated they were often not sure how to answer the question of whether it was urgent because often it is within the nature of their query whether something 'is' urgent or something to be concerned about (FG2). Equally although the staff may have understood their rules, several receptionists I observed discussed how they did not have the clinical knowledge to be able to triage patient concerns, but the urgent versus routine dichotomy and other appointment rules sometimes put them in that position (S19). This was something several were uncomfortable with, and that they did not want the responsibility for adjudicating. For this reason, some receptionists preferred when the rules facilitated them connecting the patient with the doctor (such as with certain telephone triage models) because they did not have to make that decision or have that discussion with the patient. They could connect them to the GP who had the clinical expertise and the clinical knowledge of the patient to help make the determination (S19).

In all surgeries, but with varying frequency, I observed receptionists declining patients' requests and often having to state or restate the rule(s) to explain that decision. The morning of my first surgery observation session, I noted how I was hearing phrases communicating this sentiment in my fieldnotes.

> *I am overhearing things like "only have…" and "ring after 12 to book in then" and "only have AM urgent available…" (S0201)*

From the first phone call of the day, the receptionists were responding to requests with versions of 'no' around the limited supply of appointments with specific rules attached to them. In some surgeries, the responses became straight 'no's at some point in the morning when the available appointments that they were 'allowed' to schedule for that day had run out (S19). The following vignette describes such a morning at a large surgery with a complicated set of rules around appointments.

Vignette 2: No, No, No.

As I sat in the receptionists' space, I watched them struggle to enforce some complicated rules around appointments onto the population seeking care. They had slightly different rules on different days of the week with varying amounts of telephone triage appointments, bookable telephone calls, and in-person appointments. Most of the in-person appointments could only be booked 'on the day,' and those that could be booked in advance with a known GP were full for as far out they were scheduled.

At a certain point in the morning, I started to hear the receptionists tell so many people, 'no, call back tomorrow' that I began to count. Between 9:45 and 11:45 AM, I heard them say it to at least 28 people on the phone and 4 in person at the front desk.

One aspect of telling so many people to 'call back tomorrow' was that the receptionists were actually generating more work for themselves tomorrow, adding to tomorrow's demand of any new patient requests that might be made. It was clear that this was standard procedure at this surgery, even though it caused the receptionists stress to have the feeling of having run out of appointments, and to face the response from patients who were not happy with that answer. Some of the patients had already been trying to get an appointment on previous day(s). There was no guarantee there would be enough appointments the next day. In fact, the opposite was probably more likely.

Patients were also frustrated at having to wait on hold, only to get that answer. Receptionists expressed to me that they wished they could put on the message that patients listen to when on hold that there were no more appointments for the day, as that would save them having to tell patients who had waited. Some of the receptionists there, who lived locally, told of being harassed by patients, when they saw them on the bus for example, about not being able to get an appointment at the surgery. The receptionists had little ability to make exceptions to the rules, though occasionally the GPs would. (S1901, S1902)

The above vignette depicts the interactions of receptionists and patients seeking care. This surgery was dealing with workforce shortage issues, but the reliance on limiting appointments to same-day booking in order to control the demand made the role of the receptionists even more difficult. The different, and constantly changing, rules around appointments on different days were complicated for the receptionists to remember and interpret, and that knowledge that had not clearly been shared with the patients who were trying to reach care (S19).

As I mentioned, the receptionists in the vignette, and others, had little ability to make exceptions to the rules. I saw a few examples of individual sticky notes with a patient's name in a reception area saying that if the patient requested an appointment, they should be given one straight away (S0201). I also heard of exceptions for certain patients that were arranged with the GP, but not in ways that supported the receptionists in their roles. One respondent told of a family member's agreement with his GP that he be given an appointment whenever asked, but that because it was not officially written anywhere, it was still an unpleasant interaction with the receptionists to convince them to ask the GP when they would try to tell the patient, 'no' in their normal enforcement of their rules (IR14).

I observed that doctors were more often empowered to override a surgery's rules than the receptionists. This was sometimes due to the relative position of power of the clinician and sometimes because the clinician knew the patient and could consider their individual circumstance. In some ways, receptionists did not want the responsibility of having to make the judgement of how urgent the patient request was or whether they should have an exception made for them, because that decision required clinical knowledge and knowledge of the patient. To different extents across different surgeries, the receptionists may have had the latter, but generally did not have the former. At the surgery from vignette 2, receptionists preferred when they could book in as many triage phone calls as possible, because they did not have to deal with making judgements about the patient and their query, as reflected in my fieldnotes below.

[Receptionist name] is showing me how on Monday they are all telephone calls.
"We like that, don't we [other receptionist name]?"
"yeah"
"because it's easy for us. We just book the call. Because we can't be making these decisions, and people think we are blocking, but when doctors say, 'no,' there is nothing we can do." (S19O1)

The doctors had more clinical knowledge to make exceptions, and more so for the patients they knew, which brings up the issue of relational continuity that I will explore in section 4.4. Some patients, those in the voluntary sector, and those working within the system, were aware that success in having an exception made depended on how well people advocated for themselves and were able to convince the receptionist of their particular needs (IR02, IR14). I will explore this issue more in section 4.6 since that can lead to the inequalities observed around access.

The issues around the complex layers of reactive rules, strictly enforced, with few planned exceptions, set the scene to examine the extent to which continuity is undermined within these rules and what the effects are in terms of accessing care and increasing work.

4.4. Continuity: important yet undermined

As I explained within my introductory chapters, policies that narrowly viewed access as needing to be timely often placed continuity at odds with it, assuming that a choice must be made between the two. Many of the rules that I observed in general practice across T&G seemed to follow that logic, hence undermining continuity for the sake of responding to the demand. As I noted in chapter 2, the Levesque et al. (2013) model of access included continuity as part of access. In this section, I will explore further how continuity was valued by my respondents, how it was undermined by the rules and ways of working, and what effects that had on people’s experiences.

Continuity has been undermined by policy changes over decades. Patients mentioned even when they had been at the same surgery, it had changed from being a single-handed GP to a practice in which you would not necessarily have your own doctor or see the same doctor.

> *“It wasn't a practice when I first came here 30 years ago. You saw your actual doctor. Now it's a group practice of doctors.” (IR12, patient)*

Patients in a focus group discussed how not knowing who your doctor was anymore could cause anxiety. They discussed that it was relevant because of the standard registration with a practice, rather than a doctor, but was further compounded by the increasing number of locums, the changes from multiple practice mergers, and the number of known doctors retiring.

> *“Oh, I'm not criticising the locums, I'm just saying that people can be anxious if they've had a system where they've been able…they've known the doctors and the surgery for a long time, and then everything sort of disintegrates.” (FG2R8, patient/volunteer)*

> *“I don't see how it's only the locum though, is it. I mean, I had this problem. My GP that I'd been seeing for years, he went. This is just before [name GP surgery 45] took over the one I go to [name GP surgery 7]. And since then, I've never had one doctor, I have a practice. If I'm now asked who my doctor is, I say it's the [name GP surgery 7] full stop, you know.” (FG2R4, patient/volunteer)*

> *"Yeah." (FG2R5, patient/volunteer)*
>
> *"Well, you're allocated a name, but you don't see that person." (FG2R8)*
>
> *"You're right. And I've seen bits of paper from the hospital that says GP's name, and it's got this person, I think, 'Who the hell's he?'" [laughs] (FG2R4)*

These patients, some of whom were old enough to be allocated a named GP under the more recent policies aimed at improving continuity for older patients, pointed out that the process of assigning of a doctor for that policy purpose had often been arbitrary, not considering the GP who they had a relationship with, so did not reinforce the continuity that they had already built up (FG2). They sensed the superficial nature of assigning a GP, and contrasted it to a time when continuity was more naturally a part of primary care because of the infrastructure.

As I mentioned, patient requests for continuity were often not able to be accommodated for by practice systems. Below, a quote from the focus group of practice managers demonstrates how patients' requests for continuity were not able to be met by the practices' appointments rules. The rationale was usually about having an alternative offer that they felt the patient should have been happy with, such as an appointment with another doctor. It was often said, 'if you are sick enough, you'll see anyone.'

> *"We had an example just this morning, a patient came in, and admittedly she'd come down because she said she couldn't get through on the phone, and she's known to us, quite bad asthmatic, she was having a flare-up of her asthma, but only wanted to see one of two particular GPs. One was actually off on long-term sick, don't know when he's coming back, the other one was fully booked, but we had an appointment with a locum and another GP. We could have given her an appointment within 40 minutes of her turning up at the window, and it wasn't good enough for her, and she went away saying that she was going to complain. Now to me, if you're really ill…you'll see anybody who's qualified to see you, and you don't refuse an appointment within 40 minutes. I actually think that that's quite good to be offered something so quick, but it wasn't good enough, and I'm fully expecting, when I'm back in on Thursday, that she'll have written in and complained, and this is the kind of thing that you're up against all the time." (FG1R2, practice manager)*

In the next section, I talk about the work that this clashing of values created, but it is worth noting that this practice manager anticipated this episode could become a complaint, which would certainly generate significant additional work for the practice. Similarly, this exchange suggested that the practice manager and staff had not considered how long that person had been trying to see a familiar doctor, who would know about their long-term condition. This appeared to be very difficult given that practice's rules around appointments.

I noticed a similar undervaluing of patient preference for continuity from other patients who were 'closer' to those within the system. The following statement was made in a focus group of PPG members of different surgeries in the area. This PPG member deemed it 'not a problem' not to be able to have an appointment with a certain doctor for several weeks, even though that being the case made some people feel like they could not get an appointment.

> *"But to put it in perspective, well, from this surgery, from [name GP surgery 23], I don't feel we have a problem. Because there are 3—1,2,3,--yeah, 3 partners who are well established, they've become the favourites. So they are more in demand. So when someone automatically…well, when someone brings up the fact that they can't get an appointment with a doctor for how many weeks, in actual fact they can get an appointment with a doctor, they just can't get an appointment with that particular doctor at that particular time. So to me that isn't a problem." (FG6R1, patient/PPG member)*

My data demonstrate that the issue of continuity was not only relevant to the relationship between doctors and patients, but also was valued by patients when dealing with the wider practice staff (S27, IR11). One commissioner recognised that relational continuity with the other healthcare staff beyond the doctor was valued by patients.

> *"Yeah. But is that part of, going back to this team and longevity in the practice, having a stable team of somebody saying, 'I always go to [name], the healthcare assistant. He's great. I've been going for five years.'" (IR07, CCG staff member)*
>
> *"So then not any random healthcare assistant, but someone…" (JV)*
>
> *"'It's [name]. So therefore I trust him. I don't have to bother the doctor about having my ears syringed' or…'We have a chat and blah-blah-blah.' So I guess that's a factor. This is why it's all very complicated." (IR07)*

This commissioner noted that patients appreciate not having to 'bother' the doctor, and that having knowledge of and trust in the wider staff eased that.

I observed continuity being valued not just with other clinical staff, but with reception staff as well. This was especially true in some of the smaller surgeries (S20), as I will explain further in chapter 5. In the following interview quote, this GP explained that they relied on reception staff to know the practice's patients, and that it was a similar experience to the GPs.

> *"And they also build up a knowledge of the individual characters who are ringing us up and how to handle them. So yeah, they're on the same journey as us, in that respect." (IR13, GP)*

This GP worked in a small/medium size practice and felt that relational continuity between the practice population and the reception staff was important. I did not observe that mentioned in the larger surgeries, as I will explore further in chapter 5.

Despite seeing various ways continuity was valued, when it came to the rules of the practice or around accessing appointments in light of high demand, continuity was consistently deprioritised. As I will explain further in the next section, the undermining of continuity that was largely accepted within the service delivery side, created numerous situations that resulted in extra work. This work further fuels the paradox by adding to the feeling of demand and increased workload for general practice.

4.5. Increased work for all

I observed work created, for patients, for those caring and advocating for patients, and for the practice staff, through the enforcement and constant justification of practice rules, and by the undermining of continuity because of those rules. A lot of that work, especially on the part of the patients, was unseen and perhaps unnoticed by those in the system. Similarly, the staff were somewhat unaware that they were contributing to their own work through these rules.

The variation in rules between practices meant there was also variation in the extra work generated. Some of the surgeries that were the most overwhelmed by certain aspects of demand had further rules that generated even more work than others. For example, unlike some surgeries which had a protocol for reception staff to deal with a patient query about a urinary tract infection without having to make an appointment with the doctor, a surgery struggling with a shortage of appointments seemingly did not have one. I observed a reception staff ask another if a patient who thought they had a bladder infection should be booked in with a doctor. The other receptionist said yes, and that patient was booked into one of the few appointment slots left for that morning (S19O1). Using that appointment meant that the crisis moment in which there were no appointments left hit sooner, which made the receptionists' job harder.

One area in which practice policies generated hidden extra work was the relaying of blood results. Many patients had to do work to chase their results by calling the surgery. In several surgeries, the policy was for the receptionists to relay the result, regardless of the finding, and convey what the doctor wanted to do because of it. However, the receptionists did not have the knowledge or authority to interpret further or help the patient to understand such results. This could lead to poor examples of delayed care and excessive effort on the part of patients.

In the following example, the respondent describes an inappropriate amount of work on her part to receive, and essentially a delay in communicating, important clinical information because of the limitations of this practice.

> *"I'd had the test done, the blood test done about the Wednesday. So I phoned up a couple of days later for the results. She went, 'Oh, the doctor wants to speak to you.' No, I phoned up on the Thursday. So I said, 'Right, well, can I speak to him?' So she went, 'Oh, he's not here now. You'll have to phone tomorrow.' I phoned tomorrow, and he wasn't there, 'You'll have to phone on Monday.' So I phoned on the Monday morning at eight o'clock, and it was about 12 o'clock before he phoned me up and said, 'You've got gout, but I'm not bothered about that. What I am bothered about, your calcium and your magnesium levels are dangerously low, and you could die! You need to be admitted into hospital immediately.' And I went, 'Oh!' as you do, and…I had to come down to the surgery, pick up a letter and take it straight to Tameside, and I was admitted. I was only overnight because I had to go on a drip to get the calcium and the magnesium levels right." (FG4R, patient/former carer)*

In the above example, it seems the GP could have contacted the patient directly if he was that concerned about the result. However that is not what happened. Even though a clinically-trained member of staff would seem best able to convey information about results, I even observed a patient leave a nurse appointment at a surgery and ask the receptionist about his blood results on the way out. I asked the receptionist why she thought the patient had not asked the nurse, and she thought that the patient was aware that the nurse was busy and thought he could just ask at reception (S20O2).

Another example of patient and carer work generated by such policies around is depicted in the vignette below. The work was caused by the practice policy of having someone, who did not understand the significance of blood results, conveying the relative's results. This work was largely hidden to the practice staff, though it also generated work for them and additional GPs.

Vignette 3: Lab work

Patient IR12's 89-year-old mother had a blood test as requested by the surgery as routine for her condition/medication. When she rang for the results she was told by the receptionist that they 'weren't happy with them' and that she needed a repeat blood test and a urine sample. Following that she called into the surgery to learn of those results, and the receptionist told her that she 'needed to see a doctor' but that her own doctor was away. The patient logically asked whether it could wait until that doctor was back and also a little longer because she herself was then going away. The receptionist did not know.

The patient waited while she tried to find out, called back in later in the day, and still had no answer because the receptionist had not yet been able to ask one of the GPs the question. The patient informed her daughter of the situation and planned to follow up the next day to make the appointment. The daughter, who owns her own small business, told her mother of times she could attend the appointment with her within the next week if needed. She would hold those potential slots open until she heard back from her mother.

The next day the reception staff rang the daughter to schedule the appointment for the patient. The daughter assumed her mother had been in and been told it could not wait. She was able to arrange it on the weekday that her business is closed, which she appreciated. Later that morning, the patient contacted her daughter to say the appointment was scheduled in several weeks, when both the doctor and patient were back. The patient had had a different conversation with a different receptionist that morning and scheduled a different appointment. So now they had two appointments scheduled and two different answers on the urgency of the result. They decided to keep the first and go to it to get some information about the result sooner rather than later.

When they arrived for the appointment, the check in screen told them it was with a locum who was running nearly a half hour late. When they get into the appointment, the locum asked how he could help, unaware that they had been asked to make the appointment to discuss an abnormal result. He checked her records and seemed confused. He did not see an abnormal test result that he would ‘lose sleep over’ and suggested that the patient go out to reception to ask for a telephone consultation with the person who asked for the test. He mentioned that they should try and have continuity in these cases when they could.

The patient and her daughter eventually have a face-to-face appointment (patient is hard of hearing so telephone appointment would have been a challenge) with the patient’s own GP, who is largely unaware of the events that have happened since the first blood result, which it turns out was only mildly abnormal. It is not possible to inform the GP of all they have been through in the short time of the appointment, nor is it how the daughter wants to spend the time when the main task is to understand the result. The daughter tries to convey some of it to the GP including that they did not know whether to be worried. This was met with an inquiry by the GP to the patient about why she would worry, in a way that felt to the patient and carer like the patient was being judged as a worrier, rather than acknowledging the knowledge gap that existed around understanding the significance of the result. (IR12, patient/carer)

The above vignette demonstrates how this work further fuels the access paradox by creating more demand. Most likely the policy is in place because of the feeling of such a large demand on general practice that the clinician does not have the time to convey the result. This perceived demand on GPs was such that in this situation, even an abnormal result was twice conveyed to a patient by a person who did not have the knowledge to explain the significance or make a decision about the urgency of the issue. With a lot of time and effort spent, an appointment was made with a locum doctor who did not give an explanation and referred back to the regular surgery doctors. The rules of the practice around conveying results, rather than the doctor directly communicating, created a lot of work. This work was fuelled by the fact that the receptionist does not have the clinical knowledge to explain the result to the patient or even to judge the urgency of the follow up request which the clinician did not indicate. Another element to highlight from this vignette was the role that the lack of continuity played. Ironically the locum was the one who suggested continuity back to the patient and carer. The unmet knowledge need of the patient was created by the system working, or not working, as usual. It created a lot more work including reception staff time and GP time. It was also an unpleasant experience for the patient and her daughter.

Further attention should be given to what capacity is lost when unnecessary work fills the time of patients or staff. With the time and effort involved in chasing the results and worrying, the patient and daughter in Vignette 3 could have done something positive for the patient’s health. Similarly, with the reception staff busy and appointments limited, the unnecessary appointment with the locum and the numerous contacts with reception represent resources that could have been spent on other work, helping other patients. While there were examples of results being conveyed more effectively than this, the scenario was not unique or wildly atypical. Its details convey the frustration people feel when trying to get their health needs met. This situation was largely created by the practice, and despite several people trying to do their job the best they could, it was not a patient-centred way of delivering care.

The lack of relational continuity within general practice, which was an element in Vignette 3, is explored further in Vignette 4 below. This patient described the amount of work involved in dealing with multiple doctors at the surgery as she sought follow up care over time. She explained that it could also be a safety issue if the doctors did not have the opportunity to understand her health issues as a whole person and could miss something as a result.

Vignette 4: Pot luck

> Patient IR17 described waiting 3.5 to 4 weeks to have continuity with the doctor at her surgery, and still not getting it. She was unhappy with this experience.
>
> She previously had a doctor that she went to, but who had now retired. Then another doctor at the surgery retired, and she described from then it was a ‘pot luck’ situation around who you could see. She described that she saw a third doctor for an appointment who decided to send her for some tests for her pain. She made a follow up appointment coming out of that appointment for three weeks later. She was already unhappy to wait three weeks, but then, because the doctor’s schedule changed, the follow up appointment ended up being with a different (fourth) doctor. When she tried to make a follow up from that appointment, only a fifth doctor had an appointment available. That fifth doctor reviewed something from the original tests that had been passed over. The fifth doctor was not happy with it and took it to the doctors meeting to discuss. She then sent the patient a letter saying that they are going to investigate with further tests, which the patient was not happy to learn by letter, since it had been several months since the original test, and she was worried about the delay. The patient then saw the fourth doctor in a follow up appointment about the whole thing, but the relaying of information largely consisted of that doctor trying to guess what one or the other doctors had been thinking based on what they had, or had not, written in the notes. (IR17, patient/retired voluntary sector worker)

These vignettes demonstrate how counterproductive rules and the associated lack of continuity can be. In particular, patients found themselves taking responsibility for follow ups and ended up making repeated visits to the surgery, while doctors often faced patients whose backgrounds they did not know.

The elements of the paradox so far have painted a picture of general practice under much demand, with some counterproductive rules around accessing that care undermining continuity and increasing work for everyone. In the final section, I will examine the unmet need, which remains relatively hidden and is a result of what I have explained so far. Some patients do not have the ability or knowledge to perform the work required to obtain the care they require. I will detail some examples of patients that were not being adequately served by the healthcare service precisely because of this situation.

4.6. Unmet population need

The final element of the paradox of access problems is the unmet population need, which was both caused and obscured by the other elements I have described. By unmet need, I mean the various groups of people who are not having their access needs met by the standard and regimented protocols of general practice. This tended to stem from an inability of some patients to advocate for themselves, combined with a system that does not have the capacity to proactively help identify and meet their needs. These groups, as I will describe below, include those for whom English is not their first language, those with mental health problems, carers, some working people, the economically deprived, and those with physical disabilities. Some of this unmet need was recognised by the professionals, though many felt that because of the current workload and perceived demand, there was little that could be done to change things. The quote below from a general practitioner demonstrates the difference between those who ‘bang on your door’ and get your attention, and those who would suffer in silence.

> *“Quite a lot of end of life and severely frail elderly people are not banging on your doors, tapping you emails, or ringing you up. They’re suffering in silence. So you absolutely have to create that space for someone, somewhere to look after them.” (IR13, GP)*

This practitioner recognised that a different approach was needed for those patients, even though it was not happening routinely in general practice because their attention was taken up by the existing demand within their day-to-day work. Similarly, a commissioner realised the demand on general practice contributed to the difficulty in changing ways of working, even when GPs were aware of the unmet need (IR19). While some practitioners and commissioners acknowledged the kinds of unmet need I describe, much of the data generated about this need arose from patients, their carers, and voluntary sector workers whose role it was to advocate for them.

Sometimes, the unmet need took the form of an information gap. In a focus group of carers, most of whom, and those they were caring for, had less than fluent English, it became clear that there were several issues with communication, including a knowledge gap around the use of an interpreter within general practice. The carers and patients did not seem to know that interpreters were possible to use in general practice, even when the same patient used one for hospital appointments.

> *"Do you ever use an interpreter service? An interpreter for the appointments with your doctor? Anybody?" (JV)*
>
> *"No." (FG3R1, patient/carer)*
>
> *"No, not with the GP. The hospital, like urgent check-ups and things like that." (FG3R3, patient/carer)*
>
> *"Okay, at the hospital they provide an interpreter, but at the GP what happens?" (JV)*
>
> *"No one." (FG3R1)*
>
> *"No." [collective agreement from group]*
>
> *"I don't think they…There's nothing on the wall to say that, 'We offer you an interpreter.' I've not seen anything. Whereas when you get a hospital letter you do, don't you, it says, 'If you require…"' (FG3R9, interpreter/patient/carer)*

This exchange demonstrates one of the consequences of the lack of proactive communication of information to those who need it. Respondents explained the difficulty in trying to explain something in detail to the GP if they had to do it in broken English. This affects the quality of the care received, and it also likely adds to the work of both the GP and the patient, or family members who might need to act as interpreters in place of those provided. Respondents also mentioned the difficulty in interacting with the receptionists on the phone around making an appointment. They struggled with the questions about why they wanted an appointment and felt like the receptionists were trying to stop them from having one. No one in the group had been offered the use of a telephone interpreter to help either with the requests for care or for communicating with the GP directly (FG3).

Patients with mental health problems were another group in which unmet needs stemmed, in part, from difficulties in navigating the interactions with receptionists. While patients and advocates also discussed the need for improved access to specialised mental health care, the GP was still the first point of call. A member of the voluntary sector described how the nature of the interaction with a receptionist at the GP surgery can be difficult specifically for someone with mental health problems.

> *"If you have a mental health issue…and you're having to wait two weeks, that can make the difference between you going into crisis and ending up in A&E, or actually even taking an overdose or something worse…Most of the time we will phone somebody… we'll pick a phone up and say, 'We're from the [name charity]…and I've got a lady with me who's not very well. You can't see her for two weeks, and that's not good enough. She can't wait. She needs help now.' And we've never been refused an appointment on that day. So that's normally what happens. It's quite frustrating that the person making the phone call in the first place can't get that success. And not everybody who hasn't had that success would come to us. So I know personally that there are quite a few people who would just go, 'Oh, it doesn't matter.' And it can add to their low self-esteem." (IR14, voluntary sector worker/patient/carer)*

This respondent would have preferred if the patients could advocate for themselves to achieve the more favourable outcomes, but felt the rules and the nature of the role of the receptionist, with a general inability to make exceptions, hindered it. In addition, the experience of not being able to successfully obtain the care such patients needed had a negative influence on their overall wellbeing. This respondent also described the sheer difficulty of articulating certain mental health needs, such as feeling suicidal, and how important it was for the receptionist to be aware of such conditions or the potential for someone to be feeling that way. She did not think that many were, and felt that the lack of continuity or knowledge of the individual receptionists by patients because of the way things were within practices did not help this situation for people with mental health problems (IR14).

In a focus group of family caregivers, respondents described a lack of effective coordination of their family members' care by their GPs. These carers had difficulty navigating through care transitions through hospital or rehabilitation and back home. They did not feel helped by the GP in much of their care work, and they did not feel supported in caring for their own health alongside their carer role. The exchange below demonstrates how their previous experiences making requests for care from the GP made them less likely to request help in the future.

> *"The things you've had to do…do you think you could have expected more support from your GP than you got?" (CBPTM1)*
>
> *"Yes." (FG4R3, carer/patient)*
>
> *"Yes." (FG4R1, carer/patient)*
>
> *"Yes, definitely." (FG4R3)*

> *"Yes." (FG4R6, carer/patient)*
>
> *"Okay so you feel even though the problems are related often to hospitals, that the GP could have been more supportive, and if you've approached the GP, or have you approached the GP to ask for more support? And if you have done, what's been the reaction?" (CBPTM1)*
>
> *"Well, it's a waste of time doing that. You ring up for an appointment at the doctor's, right, and the receptionist will say, 'Oh, the doctor will ring you back.' So then you've got to wait. You've got to stop in and wait for the doctor to ring you back, which is exactly what happened to me yesterday…So then you're waiting for a doctor to ring you back, and he decides then whether you're not well enough to come and see him. So you've got no chance of asking for support for looking after somebody." (FG4R6)*

It is important to note that these carers were generally not looking to complain about general practice during this focus group. They were used to getting on with their caring duties without much outside support. It was only when my CBPT member specifically asked about the GP role that the group collectively answered in this way. The fact that carers, who themselves were patients and who were also caring for some of the sickest patients within the area's population, felt this way about the nature of GP care is doubly revealing. The carers also described that getting a GP to come for a visit was a particular issue.

> *"They try to keep the visiting down as low as possible, I think, which they work hard, I know that." (FG4R1, former carer/patient)*
>
> *"You can understand." (FG4R6, carer/patient)*
>
> *"You can understand, but when you're there, and you've been up all night for months, not just a week or a few days. It's day in, day out, that's how I was with [husband's name]. You need some help, it's hard." (FG4R1)*
>
> *"Didn't you feel you'd got that? …you might have been really…I can well imagine worn down with the things that had happened. If you'd have gone to the doctor and just said, "Doctor, this is the problem," the doctor would have somehow been able to support or assist you? Do you think that was possible?" (CBPTM1)*
>
> *"No, I don't." (FG4R3, carer/patient)*
>
> *"No." (FG4R1)*
>
> *"No". (FG4R2)*
>
> *"It sounds like it doesn't feel like that's the kind of request that you could…" (JV)*
>
> *"No." (FG4Rs)*
>
> *…*
>
> *"So it isn't the case you've actually made to have been rebuffed, you just don't feel confident about going in the first place, [Rs: no] because of the experiences you've had?" (CBPTM1)*
>
> *"Yes, yeah." (FG4R3)*
>
> *"Yeah." (FG4R1)*

This further exchange from the carers' group demonstrates some of the recursivity of previous experiences affecting future decisions about where or how to seek support. In addition, one can see from the exchange that the carers did try to empathise with the GPs and their workload, but also had needs which were not being met.

During the years of this project, working people were a group often referenced in political rhetoric, particularly around routine seven-day access to general practice (Cowling et al., 2015), which I will explore further in the next chapter. My data show that the difficulties working people experienced were largely around their interactions in making an appointment because of the practice rules. Several people expressed that it was not about when the appointment was offered, because they could plan around work, but that the times you could call and the rules around the availability of booking those appointments were complex and varied, as I previously described. Below, a patient who had worked as a manager in a factory, explained the problems caused when workers needed to schedule any kind of care with general practice.

> *"But even the making appointments was firstly stressful for them, but also it was very disruptive to work. Because they only phone between eight and half past. So they had to leave their machine. Well, a four person [type of machine], that means the machine stops. And then they're on the phone for quarter of an hour trying to get an answer, and that would go on for many days' time… And so there were issues like that around appointments, as well as their ability to get one in a timely manner. It's the arranging that has to be done in a timely manner as well." (FG6R2, patient/retired factory manager)*

The work required on the patient's part to try to obtain an appointment, which was largely unseen by the service delivery side, was less possible for some workers. Others mentioned the inability to call and make an appointment during their morning commutes, particularly if it meant communicating sensitive information if on public transport, or because of an inability to call while driving.

One issue, which is often mentioned when certain groups, such as PPGs and practice managers, discuss access, is Did-Not-Attend appointments (DNAs). I will interrogate the issue further in Vignette 5 below, highlighting how DNAs were often mentioned by certain groups as a problem, or even 'the' problem with access and appointment availability. However, for various reasons, my data show that they were not the problem they were generally assumed to be, but that they did reveal a gap in the fit of appointment offers and the abilities of certain people to attend those appointments, hence a sign of where there may be unmet need in the population.

Vignette 5: DNAs: not the problem they are purported to be

How DNAs were often discussed as a 'problem'	How they were not that problem A: they served a purpose	How they were not that problem B: they were more varied than assumed	How they were not that problem C: they were a sign of the system not working for some
People viewed DNAs as an example of other people wasting precious NHS resources/clinician time because they did not care enough to attend or cancel their appointments. This was calculated into time and money wasted, discussed at length in certain groups, and posted in surgery for all to see. Missing was the denominator of the equation: how many appointments DNA'd out of total appointments. The scale of the problem was often seemingly exaggerated in a large surgery where the number of DNAs seemed big but was not given in context. Discussing DNAs seemed to fuel certain groups talking in terms of 'us' and 'them.'	DNAs served a purpose in overworked system where GPs/clinicians could use time for the toilet, to catch up if behind, to make a phone call, or to do the other numerous tasks that require attention daily besides face to face appointments. While not necessarily an ideal scenario to have a DNA, to say they were wasted time was incorrect. Even if that was not how that time was intended to be used, it served a purpose. One would only see it as this problem because shortages on appointments for the reasons described made that issue seem more important.	Many people DNA'd either because they forgot, they had a genuine emergency, they were in hospital, or through an administrative error or miscommunication, including older people. However, it was often discussed by older patients or staff members as an 'us' and 'them' issue with the them being either the younger generation or other references to people who do not value the NHS or who feel entitled. Aside from the issues of scale mentioned in the first column, the who and the reasons for DNAing were often different than assumed, with a range of people doing it occasionally for unavoidable/justified reasons.	For those who were repeat DNAers, the pattern was often a sign of the access paradox: the system was too inflexible for the needs of certain patients, and those patients did not receive the care they needed. Examples include those who were homeless, those with care responsibilities or other burdens that made transportation or communication difficult. There were issues with technology: text reminders did not work for people who did not use a mobile phone. Rather than totalling up DNAs to display in the waiting room, the response could be to think of an alternative approach to the patients who were not successfully accessing care.

While myself and some respondents (IR11, IR15) noted the lack of signposting of useful information about health in GP waiting rooms for patients, I observed that several waiting rooms had a message posted clearly about the number of DNAs over a certain period of time, intended to convey the issue as a problem as I describe in the first column of Vignette 5 (S19, S02). That information, as presented, could be misleading for a number of reasons when taken out of context, and it was unclear whether posting that information alleviated the issue or further fuelled certain beliefs about patients. In being one of the few things that surgeries actively provided information on, rather than their rules for seeking care or other health information, it perhaps gave that information a false sense of importance. The effort to total up and update that information regularly, and the decision to display it prominently, could be seen as extra work generated, taking time which could have been spent differently. Given what was described in the last column of vignette 5, DNAs could instead have been seen as an opportunity to identify some patients who needed a more accommodating, alternative approach. Some GPs did see the issue this way (IR04), yet they were not the one controlling or directing these messages, and as stated felt relatively powerless to act differently given the other substantial demands on them.

Similar to the GP who I quoted at the start of the section, who recognised that a more proactive approach was needed for those who suffer in silence, another GP described the need to find the things and people who were not seen in the waiting room to make a difference in people's health. He called for a different approach as this excerpt from my fieldnotes conveys.

GP: "If you want to make a difference…look for the things you can't see and at what makes us poorly in the first place.

"Mix of people in reception who will be seen in a given morning- x colds, x administrative help-like letter, 1 chest infection, few UTIs etc.

"But- we need to do less for those people and more for those not there.

"Housing estate across street. Wouldn't want to walk there alone at night.

"Over past decade: 3 suicides, 1 accidental child drowning, many premature deaths, lots of fights and fractures, horrific scene of a man who fell and died at home and some time later [GP] and police broke down door to find partially decomposing body." [Became visibly bothered remembering that and stated

he hopes he never has to do anything like it again]. "Numerous cases of child protective services. One woman they didn't know about with a child with learning disabilities.

"We need a different response than what we are doing for better health in Tameside" (HW1)

This GP called for more proactive care to address issues related to health, including reaching the people who were not sitting in the waiting room, who had not successfully navigated the care seeking pathway for various reasons. This was recognition of the unmet need within the population and within the area of this study, where the persistent health inequalities were. Some GPs had recognised these unmet needs, but little had been done to address them. Reflecting on the paradox of access problems, I have demonstrated that the demand on general practice, the rigid rules around access, the undermining of continuity, and the extra work, all contributed to creating, obscuring, and perpetuating this need. In this section I have explored some of what the unmet need consists of in order to better understand the complexities of existing issues.

4.7. Chapter summary

In this chapter, I have utilised my data from multiple perspectives to present the access problems within general practice, which I observed as a paradox of demand and unmet need. Many respondents agreed with the overall approach to broadly understand the complexities of existing issues of access, as opposed to the way they had seen it often approached by national politicians, for example.

> *I don't think the politicians appreciate any of that. I think they just see it as: if you've… got the flu, how quickly can you get to see your GP? Not that you need to see your GP with the flu, but that's their own direct experience of doctors, and they don't give any thought to the opportunistic stuff, the preventative stuff, the vulnerable people who don't actually ask for appointments, but need probably more care than most voting adults. And so yeah, there is just an impoverished debate around it. There's a lack of imagination about the true nature of the problem. (IR13, GP)*

By listening to and partnering with those closest to these issues, I have used my imagination to inform the debate around access by unpicking the complexities of these interrelated problems. I have demonstrated the multiple causes and effects of the increasing demand on general practice. I have displayed the resulting complex and rigid rules, and I have explored the importance of continuity and demonstrated how it was undermined by those rules. I have provided examples of otherwise hidden work, created by such protocols, which affected patients and their carers and added to the feeling of demand on general practice. Finally, I have shown that the unmet need, which resulted from the inability of general practice to be proactive, has affected some of the most ill people within the area's population. Along with some respondents, I hope that this novel description will allow for a different approach to addressing issues of access within general practice. In the following two chapters, I will use this understanding of the paradox to critique the main politically-driven intervention around access during the period of this study, extended access, and the general trend towards larger practices. In chapter 7, I will use the theoretical insights made during this work to discuss *how* to address the issues within the paradox that I have demonstrated here.

Chapter 5. Understanding efforts to extend access

5.1. Chapter overview

In this chapter, I will apply the understanding of the access paradox, which I established in chapter 4, and use further data to present a novel critique of seven-day extended access. As I will demonstrate, the idea of seven-day extended access dominated the national and local policy context of access to general practice during the period of the study, with both direct and indirect consequences for access. The ability to critique this intervention in this way stems from my approach to the topic of access, as I have previously described in this thesis: an active application of a broad access theory, a critical understanding of previous access interventions and policies, and a participatory approach and qualitative methodology that allowed for in-depth consideration of multiple perspectives at several stages. Below, I will utilise the access paradox to structure the critique of this intervention, to demonstrate how it largely ignored the issues within the paradox and therefore further fuelled it as a result.

5.2. Seven-day extended access

The seven-day extended access policies were dominant both nationally and locally during this study. As I described in chapter 1, the PMCF/GP Access Fund had a large focus on extended access (NHS England, 2016b), and the health secretary at the time was keen on creating a seven-day NHS. In Greater Manchester, the Healthier Together initiative (Greater Manchester Association of Clinical Commissioning Groups, 2014), the GM NHS England primary care strategy (NHS England Greater Manchester Area Team, 2014), and Devolution of Health and Social Care (later GM Health and Social Care Partnership) all focused on the idea of seven-day access to general practice. The logic of this focus was often unstated but, in the early iterations of the policies, was linked to the idea that it would reduce A&E use and pressure elsewhere in the NHS (NHS England Greater Manchester Area Team, 2014). While T&G was not a local or national pilot site, it was mandated, along with the rest of GM, to commission a service for seven-day access to ‘routine’ general practice from January 2016. As I will explain later, there was reluctance from many GPs in the area, including on the CCG Governing Body, who did not think the service was necessary or the best use of money. In T&G the service was commissioned as a hub model, which operated out of three sites across the area, with six fifteen-minute GP appointment slots available every weekday evening, and ten on Saturday and Sunday.

In this section, I will present data to convey how the idea of seven-day access dominated attempts to improve access, with access beyond the usual hours becoming a proxy for ‘access’ more generally. Several of the quotes demonstrate that the goal of the service and its intended consequences were unclear, even to those commissioning and providing the service, and that there was conflation of purpose with the out-of-hours (OOH) service, which was already providing seven-day access to general practice care for urgent issues. One regional policy manger commented that ‘access’ was ‘front and centre’ for them, by which they meant the seven-day extended routine access service provision.

> *“And obviously access is front and centre for us, absolutely at the moment, and we launch in a few weeks’ time…” (IR06, regional policy manager)*

The work around ensuring that this extended hours service would be in place across GM consumed a lot of effort, and by delivering on the ‘commitment given to patients,’ it was felt that access was a major focus. This respondent did not question the service or the logic of it, because they accepted it was a commitment made to patients through previous consultation efforts, as well as a directive from their manager.

> *“It sounds like the operationalising of the seven-day access, kind of, promise or idea is really, at the moment, consuming a lot of your time and energy… It’s a simple idea but it’s a complicated thing to accomplish.” (JV)*
>
> *“Absolutely. But it was a commitment given to patients, so we have to deliver on it. Have to do it, and should.” (IR06, regional policy manager)*

However, even though the focus of the service was routine general practice, the respondent mentioned challenges around behaviours of going to A&E when it was not needed.

> *“…We can put the seven-day access in place, but changing culture and behaviours around going to primary care first, to think about it first, rather than just bob off to A&E when people don’t need to go to A&E. That’s probably the next big challenge, on the whole comms and things.” (IR06, regional policy manager)*

There were specific communication materials produced about this new service. However the quote above demonstrates the confused logic of the service and its conflation with OOH care for urgent issues. Arguably, to solve the issue of patients going to A&E inappropriately, if that were a problem, there should have been a communication campaign about the continued existence of the OOH GP service and the ability of GPs to see patients urgently within their own surgeries, or support to improve the OOH service if that was needed. Instead, an entire new service was created and promoted with a focus on routine care, yet with commissioners voicing an intended logic around behaviour change for urgent issues. I will detail the confusion around this service in subsequent sections, but it is worth noting here that this lack of clarity existed even among those commissioning it regionally.

Within T&G, the service was provided by the federation of GP surgeries, which included over half of the area's surgeries as members, in partnership with the local OOH provider. The large task of creating the service and staffing it consumed the work roles of several people, as described in the quote below.

> *"One of the big things that I've done is the seven-day access, and my work has just predominantly been… I mean that's just taken over everything really. [laughs] It's just been so consuming." (IR08, seven-day access service provider staff member)*

The above respondent had other responsibilities as well, but these were neglected in order to prioritise the seven-day access service. As was the case regionally, this person noted that there were no other projects or issues about 'access' being discussed.

> *"And of course the seven-day access project has been one of the main ways you've been thinking about access in your current role. Have other issues of access to general practice come up so far in your general role? Are people thinking of access in any different ways or other projects around that?" (JV)*
>
> *"No, not that I'm aware of. Well no, I'm not aware of anything else." (IR08, seven-day access service provider staff member)*

Notably, this person did not question or judge why there was an absence of a wider discussion. As a staff member of the provider service, they felt they were in a position to bid for things that were commissioned, and seemed to trust that the service must be needed if it was commissioned. Similarly, as shown in the quote below, they did not naturally question the goal of the service beyond simply providing the service.

> *"So what is the goal of the service?" (JV)*

> *"To provide seven-day GP services." (IR08, seven-day access service provider staff member)*

> *"But in order to…? What does it get linked to in terms of what people think that will make a difference for a change?" (JV)*

> *"I kind of think that they're maybe hoping it will have some impact on A&E. I don't think the scheme was set up to have a direct impact on A&E, but I think they are hoping that they will see some reduction in A&E attendances and costs, I suspect. I think it's probably too early to tell whether that is the case. But I'm kind of thinking that's the hope." (IR08)*

The respondent indicated that the unstated goal may have been to reduce A&E use. However, because the pilot evaluations had not shown that A&E use was reduced, that could not be the official goal.

At the end of chapter 4, the GP (IR13) summarised how politicians misunderstood the problems within general practice, including the complexity of it. This service, or the idea that having access to a GP, though not necessarily your own GP, in evenings and weekends, was seen by some as an overly simple solution to a complex problem. In fact, it was described as a solution without a problem by several respondents. It is worth noting that a local commissioner did question the solutions that were being put in place, including the seven-day access service.

> *"…Are we putting solutions in place, and we don't actually know what the problem is?… I think there's lots of solutions about. I sometimes wonder if—this is a general point, not specific to [area name]—if we put the solution in place first and then narrow it down to fit what we think then becomes the problem." (IR07, CCG manager)*

This local commissioner, who had also worked elsewhere the NHS, both geographically and in various roles, called for a greater understanding of the problems before designing solutions. They did not feel that opening hours were patients' main concern, since the engagement work the CCG had already done during the time of the study had revealed that people most valued being treated as an individual first.

> *"When I read back what people said and summarised it…people put at the top that they really liked being treated as an individual first. That was their ultimate priority…Appointments was important but people didn't sit there and all say 'I can't get an appointment. They thought the topic needed looking at but they had mixed experiences." (IR07, CCG manager)*

However, despite several people with this view, the CCG did not have the choice of whether to commission the seven-day access service, as this decision had been made at a higher level. Commissioners had some control over the details of the local provision, but not in the overall decision or idea.

Having established that seven-day access had come to dominate the policy wider context in regard to access, and explored the effects on several people's roles around commissioning and providing primary care, below I will further examine how this policy was not a solution to the paradox of access problems in general practice.

5.3. Demand and seven-day extended access

I will present data related to two aspects of the issue of demand in general practice in relation to the seven-day access. The first is that while there was a large demand for general practice, as explained in chapter 4, there was not actually a demand for this particular type of service. The second is that this service largely did not address the existing problem of demand on general practice, at least in the area of T&G.

The issue of whether there was a demand or need for this service is important. One interview respondent, who was a retired public servant, considered this issue within a broader understanding of access.

> *"Well, alright, let's just deal with the question of access, and opening hours and accessibility. My own personal view is this seven-day-a-week opening is a red herring, regardless of whether the NHS can service it. If there is a strong case, a good case to provide that, if you can say, 'Yes, that is a need and, therefore, you should fulfil the need,' then arguably, the question of whether you can support it in the short term is neither here nor there, because you should move to a position where you can support it. It's the principle that's more important.*
>
> *"But I don't believe that there's a vast clambering for that. Even when I was working—and I had a very responsible job; I just couldn't drop things at the drop of a hat, you know—if I needed healthcare, I would go and get it. And I think that's the way most people view it...*
>
> *"So I'm not convinced the opening hours are a particular issue. They aren't for me personally, and I don't believe they are for people generally, but I'm not sure." (IR01, patient/retired public servant)*

The opinion articulated above deals directly with the idea that seven-day access is needed for working people. Another participant, who was a small business owner, voiced similar doubt over that as a reason for the service because, like her, many people work at the weekends and so have another day off in the week, during which, if they were able to schedule an appointment ahead of time, they could plan care.

> *"I mean, the thing is, some people work Saturdays. Usually if you work Saturdays, you get a different day off…and I am a bit funny about Sunday working…but if you work Saturdays or Sundays, you generally, I would think people would get another day off in the week." (IR12, patient/small business owner)*

Besides the issue of working people, the issue of whether there was demand for the service can be examined by how it was used, or in this case, underused. The following vignette describes my first experience observing at one of the area's three seven-day access hub sites, after the service had been running for several months.

Vignette 6: Sunday morning at the hub

> I arrive as the receptionist is setting up for the session. She tells me that Sundays are 'a bit hit or miss' as she goes into the clinical room to turn on and log onto the computer for the GP who will be arriving shortly. When she returns, she shows me what she means on her computer screen: out of a possible 10 appointments, none are booked.
>
> However, because they recently added the option for the OOH provider to book into the appointments via a 111 call, the receptionist and GP have to stay (and will be paid for their time). She is not allowed to do surgery work while she is here because it is not permitted. She has brought a book.
>
> In the end, I spent the full three hours talking with both the receptionist and the GP. They spoke about access generally, about this service and how it is not what people want, and the existing issues around access at some surgeries more than others in the area.
>
> Over the course of the morning, no patients were booked in through the OOH service /111. It was unclear if that arrangement was functional yet or just an idea to help the service be utilised. (S44O1)

The fact that there were no patients booked into those appointment slots was surprising because during other surgery observation sessions around that time, I had heard receptionists frequently telling patients 'no' to requests for appointments, as detailed in the previous chapter. There are several reasons why the hub sites were not being utilised, which I will explore in further sections including the complicated rules and processes around them and the lack of continuity for patients.

In addition to the appointments not being booked at the hub, there were a high number of DNAs. One GP, who had worked at one of the hub sites for a few months, described what his experience had been in a conversation after a meeting at the CCG, as shown in the excerpt from my fieldnotes below.

> *[GP name] said: seeing what comes in to the [hub site name] every [weekday evening] for the past couple months, it is 'stuff that didn't need to be seen.' Urgent things, which is not what the service was designed for. Last [week]—4 DNA of 6. Nice day/weather. He said that it is weird because he cannot do repeat prescriptions, cannot do referrals, so it cannot really be routine stuff.*
>
> *[Other name] asked why the high number of DNAs.*

[GP name]: probably 'urgent things that got better in the meantime.' Like a rash that 2 days later is better, etc. (CCGGB2)

The above fieldnote excerpt demonstrates how the confused logic around the service was leading to an ill-fit around needs. While intended for routine care, it was an easier fit for minor, urgent issues. When the appointments were being booked, they were booked with those minor things, which were often self-limiting, and therefore had a resulting high DNA rate. It also shows how some surgeries were using it to help with their own overflow of urgent demand. However one could argue that self-care could have been recommended for some of those appointment requests if they had been handled differently.

The issue of DNAs is important to revisit here. Unlike in the practice setting, DNAs at the hub could be viewed as more of a 'waste' because likely the GP was not in their own surgery, and like the receptionist, was not supposed to be doing surgery work anyway, according to the rules of the service. Therefore, unlike at the surgery, there were no other tasks to usefully fill the space if there was a DNA. There were no routine prescriptions to sign or letters to read or patients to call back or trainees to supervise or colleagues to chat with. Also the hub appointments were fifteen minutes long, rather than the relatively standard ten-minute appointments. This was to take into consideration that the lack of continuity would require more time on the patient's part and the GP's part to explain and assess. Therefore it was potentially a bigger block of wasted time per appointment than a DNA in the surgery. Also, the seven-day access service had a fixed cost, so one could put a price on the time wasted with a DNA.

Having established how the service was not fully utilised and had a high DNA rate, it is useful to explore the extent to which it intended to or did help practices with their existing demand. Several GPs expressed frustration that the service did not aim to help them with their demand which, because of distinctions between GP work in normal/core hours and OOH from the 2004 GP contract, was their in-hours demand. The GP working during my first hub observation explained this to me, as shown in my fieldnotes below.

The GP explained how the Local Medical Council has said that any extra funding should be put towards helping practices during normal hours.

He feels that of the £1.2 million invested in this, half is being wasted. If £1 million could have been invested to help during the week, in hours, it could have been much more efficient and effective. But *the seven days per week was a political promise. In the larger picture, they want the hospital to be seven days per week. The hospitals then turn it around and say that primary care then also needs to be seven days per week…*

He said that within the federation they knew there was no demand, BUT this was centrally funded and demanded so they had to do it.

He continued to say that they have suggested increasing the current £130 per patient per year to £150 to improve access during the week. He said that because of the shortage of GPs, there is a choice of where and when people work, and how money is invested, because you can't do it all.

He concluded by reiterating that the issue exists and should be solved IN HOURS, which is what GPs have been 'saying for years.' (S44O1)

As I stated above, several of the local GPs did not think there was a demand for such a service. However, in various ways and for various reasons, they had to go along with commissioning and/or providing the service. The CCG commissioner noted, from reading the evaluation report from the GM NHS England access pilots, that the effect of the pilots on general practice was not assessed.

> *"I understood, at that point in time that that research had been released [they] hadn't quite got that handle on how it addressed access in practices in their normal hours. Had there been an impact? I don't know. Perhaps I missed it. So that bit I didn't see." (IR07, CCG staff member)*

From the point of view of those within general practice, it was strange that the effects on general practice were not considered in the evaluation, as this was a known issue within an important part of the NHS that was already under strain.

One of the ways that the seven-day access service did address the existing demand on general practice was when it was not used as intended. In some places, particularly where demand was a bigger problem because of other reasons—local staff shortage or inefficient appointment rule systems—it was being used as an overflow from practices' in-hours demand. Some surgeries that had issues with demand because of workforce issues, or their own rules systems, were able to use it as another offer rather than 'call back tomorrow' or a several-week long wait to book a routine appointment. This is not what the service was intended for, yet helping those practices with their in-hours demand at least meant they received some help from somewhere. One of the receptionists at a hub site explained to me the variation in use of the hub appointments based on surgeries' own availability of appointments.

The receptionist mentioned that at their surgery, they do have to turn some people away, but it is less than at other surgeries. She said that other surgeries are currently saying to patients: three weeks until a routine appointment.

She showed from when the appointments were being scheduled, how they were being used as urgent overflow, and not routine, mainly because they were being scheduled for the same day and next day, and not more than a few days in advance. (S44O2)

The surgeries that did not have as much of an issue with waiting times were not necessarily using the service, because as I will explore in the continuity section below, continuity was valued and many people preferred to be seen at their own surgery, by their own or at least a known doctor, rather than in extended hours service with an unfamiliar doctor. However, GPs at those surgeries who were still largely accommodating their own patients, because they were working harder, were disappointed that the service had not provided them any relief (S44O2).

Hearing from people who had the experience of using the service, it was used as an overflow especially on a Friday, if it felt like the issue could not wait until Monday. This was the case of two individuals in a focus group of new mothers who had experience being offered appointments for themselves and their family members.

> *"I had a Saturday appointment as well, which was very good, actually. They managed to get me in on a Saturday at [name site 43]…" (FG5R1, patient/mother of baby)*
>
> *"Oh, was that through the emergency thing?" (FG5R2, patient/mother of baby)*
>
> *"No, she just said, 'Can you wait until Monday or do you want to go…do you feel like…' And I said, 'Well, I do…I am getting really dizzy, and I need to work out what it is,' and so she got me in on the Saturday. (FG5R1)*
>
> *"They did that with my other half, and he rang and they said…he's at [name GP surgery 24] as well, and she said, 'Oh, well, I've got such and such a time on Friday, or you can go to [name site 43] to the clinic on Saturday. Which is best? The only thing is, if you go on Saturday, we don't know which GP it's going to be that's going to be covering.' But yeah, he went to the surgery there." (FG5R2)*
>
> *"The only thing I'd say about that is when I saw him he was lovely, and he seemed really very caring, the doctor, but he didn't update any notes on the file, so when I went back to…she looked to see what he'd written on, and he hadn't put anything on, so we were sort of still…" (FG5R1)*
>
> *"A bit of an appointments journey." (FG5R3, patient/mother of baby)*

It is worth noting the relational and informational continuity issues, when the service was utilised that were discussed in that exchange, which are inherent in offering routine care outside of the patient's own surgery, and which I will elaborate on later.

An exchange from a focus group of practice managers also indicates how they saw the investment of money in the seven-day access service as missing out on helping them with their demand.

> *And the sad thing is, it's a £1 million box, and maybe if you'd have said the PCT, or the CCG, sorry, invest into ten salaried GPs who spend their time gap-filling across the area on normal working patterns rather than this, I would have said that that money was much better spent doing that, but the government want seven-day access. (FG1R4, practice manager)*
>
> *But we did have those GPs, what happened to that? (FG1R1, practice manager)*
>
> *It fell by the wayside. When the CCG was a PCT, and possibly even a PCG, they used to have PCT-employed locums, and the idea originally was to get doctors into the area, so that they could then hopefully get to know the area, get to know practices and take up posts, wasn't it? (FG1R2, practice manager)*
>
> *Yes. (FG1R1)*
>
> *And I think it did work for some of them. It was also a great resource for the practices because if you had a problem and you knew that you've got two GPs off, your first port of call was the PCT locums, and it was brilliant. It was so good, and that would be much more useful than a hub that nobody really wants to go to. (FG1R2)*

These practice managers had other ideas for how the money could have helped them—some of which were things that had previously existed but had been eliminated by previous policy changes and restructuring—but that was not the intention of this new service. The fact that the intention of the service was somewhat unclear only added to the general frustration with it. As I will explore further in the next section, the service may have even added to their demand by creating a supply-induced demand, as there were ongoing efforts, across GM and in T&G, to try and promote the seven-day access sites to have them be better utilised. As I will show, the service certainly added to regular surgery work by creating further rules and complicated tasks, with certain work having to be duplicated by the practice regardless, as has happened with previous interventions to add primary care services outside of general practice surgeries (Chapman et al., 2004). In summary, the logic and implementation of the extended access service showed a lack of understanding around the existing demand within general practice, and in that way, did little to address it.

5.4. Rules and seven-day extended access

While I established the complex and varied rules around accessing general practice in the last chapter, here I will demonstrate that seven-day access, like other policies before it, brought with it an additional set of rules. That the service was implemented onto an already complex and varied landscape added to the existing confusion, for both receptionists and patients, which appeared to contribute to the underutilisation of the service.

The process for booking patients in the hub appointments was complicated. There were also logistical barriers in some surgeries more than others, if for example, the electronic record system used was not the one that the service shared with most of the surgeries, the process was more complicated for the receptionists. The following vignette demonstrates the complicated set of processes the receptionists had to juggle to consider whether the patient was appropriate for a hub appointment and check availability, alongside the other offers of appointments within the surgery and across the wider health service. This was the case even when using the electronic platform with the shared service.

Vignette 7: Where can this patient get care on a Wednesday?

While learning from one receptionist about some back office tasks at a surgery, the other receptionist called me back to the front of reception because she knew I wanted to observe a hub appointment being booked.

There was a woman at the front desk who wanted an appointment for her husband, and they were discussing the possibilities for him to be seen. He had gone to work that day but had started to feel ill with a stomach pain, and was on his way home. This surgery has a walk-in option for urgent issues with no limit every morning, but this was the afternoon, and he would not be able to get there before they closed. The receptionist was loading up the separate system to book at the hub while they discussed.

The receptionist showed me how she has to copy over several components of the patient's details from his records and list him as an unregistered patient at the hub. Once she had done that, she could see the available appointment slots and discovered there were none available that day at the nearest hub, and there were none available for several days until Saturday when there were two available. She was surprised that they were booked up because in general there had usually been spare slots at the hub site. (We later learned that they were not booked, but that there were no appointments available because there were issues staffing the sessions at that site. At the time, however, it falsely gave the impression that the appointments were booked and perhaps being more utilised than previously.)

The receptionist explained to the patient's wife that there was one appointment at a different hub site, which was co-located with the walk-in-centre for the area, for the following day and six appointments each on the next two days there, but none that evening either.

The receptionist gave the wife the information to either contact the OOH service or go to the walk-in-centre.

The receptionist turned to me and said: "That wasn't a good one, was it?" (S20O2)

Despite all the work of inputting the patient's details, the lack of availability of a hub appointment for that evening meant it was not the right fit for this patient's need. This vignette about attempting to use the hub also shows how the hub was used as the urgent overflow from the day, demonstrating how the confusion around purpose of the service, evident in its planning, carried through to its operation.

To avoid technical redundancy with other services, there were rules around the seven-day access service in terms of how it was booked, and who or what it was for. It was not a walk-in service, and it was intended for routine—not urgent—issues, so that it did not overlap with the OOH service. Some of these rules were open to further interpretation by different surgeries, or even different receptionists within the same surgery. At the same surgery as above I returned for another observation session several months later. As the following vignette shows, I overheard one of the receptionists tell a patient on the phone that they were not open on Saturday, so they could come and sit and wait or else their next option was Monday. I commented after the morning observation to the two receptionists that they did not book any appointments into the hub. My questions, about how the seven-day access service fit in with the requests they received from patients, prompted the receptionists to reflect on the purpose of the service and who they should be offering it to. This revealed that they had different impressions and interpretations of the purpose of the hub and their role of booking patients in terms of urgent and routine issues.

Vignette 8: What is the seven-day service actually for?

During a Friday morning session, I listened to the receptionist tell a caller that they are not open on Saturday. The caller was given the option of coming at 10:30 that morning to 'sit and wait' at the surgery or next would be Monday. She asked the patient a bit more about what was the matter, and put the patient down to come to the surgery that morning. Wondering why that patient, who seemed to request a Saturday appointment, was not offered a hub appointment, I ask the receptionist about the hub at the next opportunity.

She said patients ask about seven-day access, but she has to keep telling them ‘Yeah, but you want urgent. It is for routine.’ She said some people do not want to ‘come and sit,’ which is their urgent option at this surgery. They want to go to the hubs. But she tells them if it is urgent they should ‘come and sit and wait.’

She showed me that there were two appointments available for the local hub on Saturday. For the same night, there were two appointments available at one of the other hubs and multiple more for Saturday.

During the morning, they receive a call from a staff member of the seven-day access service to tell them that there are now two more appointments available for the next day (Saturday) at the local hub and that they have opened up Sunday.

Also during the morning, I do hear some people request evening appointments on the known ‘late’ evening for the surgery. Two patients requested asthma checks with the nurse for the evening and both were accommodated by the surgery’s availability the following week.

I comment at the end of the morning to the two receptionists that they did not book any patients into the hubs. They discussed the urgent or routine nature of them, with the one reiterating that she thinks they are not supposed to be used for urgent things. The other asked, ‘Can it not just be for any appointment then?’ The first responded that the practice manager said they were for ‘routine.’ She said that patients think it is like a walk-in centre, and it is not. Since there are leaflets about the hub there, the other receptionist brings one over and reads that is says ‘new concern or existing condition.’

(S20O3)

The above vignette demonstrates the persistent confusion around the purpose of the hub by some receptionists six months after the service was launched. The one receptionist took the idea of ‘routine’ literally and would not schedule urgent requests. The other thought it could be for any GP appointment needed, especially if requested for that time, and it seems clear that the patient who phoned would have been scheduled for a hub appointment if they had spoken to the other receptionist. The way that surgery handled urgent and routine requests differently meant that the one receptionist interpreted the purpose of the hub with the same dichotomy, while it likely meant a different division between routine and urgent. The vignette further showed that the hub had capacity, and yet it was not used. During the session, the staff member called to alert the receptionists to the availability of the hub appointments, including for Sunday. Yet I did not witness them book any hub appointments on the Friday, which, because of the rules of how people were supposed to be booked in, was the last day the appointments could have been utilised.

Although national rhetoric for this service was around ‘working people,’ there was no rule that the person needed an appointment necessarily during those hours, whether because of working commitments or for any other reason. As I mentioned, it was often used as an overflow for some surgeries’ minor, urgent requests and was not even reserved for patients who requested appointments for those days and times, as few did. Only on one occasion, when I was observing at a hub site on an evening, did I witness someone state that they needed an evening appointment (S01O1). The woman had actually arrived for her scheduled hub appointment, but the service had been cancelled that night due to clinician unavailability, unbeknownst to her. The patient was a patient at the host surgery site, so the receptionist was able to reschedule the appointment for her, by having the surgery’s electronic records open alongside the hub’s, and the patient said that she still needed it to be in an evening. This occurrence was also notable because the host surgery receptionist was not supposed to do surgery work during the hub session, as I mentioned in the previous section. At other sites, I had even been that receptionists that were not allowed to wear the uniform of the host surgery (S44O2). If a patient from the host surgery came in to ask about a routine task for the host surgery, like scheduling an appointment or requesting a prescription refill, the receptionist was supposed to respond that the surgery was closed, and this was a separate service (S44O2).

One of the most confusing aspects of the rules around the service on all sides was the limitation of scheduling patients during routine opening hours even though it was an extended-hours service. Not only did that inherently contribute to the work of the receptionists at the surgeries, it meant that for anyone who had a limited ability to schedule their care during daytime hours, the barrier was not removed. Some people who had heard of the service thought it was a walk-in service. When I observed at one hub site, there was an example of a young woman who walked in and asked to be seen (S43O1). She stated that she needed the morning after pill. Although the service had not been booked to capacity, it was not possible for the receptionist to book her in. The receptionist explained that only option for the patient was to call 111 and see if the OOH service was able to book her into one of the available hub appointments. The GP working that session had been in the reception area speaking with me about my project, as many GPs working the hub sessions were able to do, because there was usually spare time. He had overheard this patient’s request, even though he had said that as a rule when people walk in, he usually walked away to let the receptionist deal with it. He told her there were some pharmacies that were able to provide the morning after pill, and that she could access it via that scheme. After she left, he explained that his malpractice insurance specified that this service was for routine GP care, rather than if it were OOH or walk-in care, so that he really cannot see those patients without being in violation of that. Previously in the session, the receptionist had shown me the amount paid to the GP for the session. The GP explained that even though the amount is large, by the time tax is taken out and the indemnity cover is accounted for, it is not that much for money for him. He was not working at the hubs for the extra money, but as a local doctor in the area it was something he felt he could contribute to, and it fit in with his family life to work the weekend morning sessions occasionally (S43O1).

The complexity of the rules around the seven-day access service, and the confusion around the purpose of it, made it particularly hard for patients to understand. More communication materials were created to explain the new service than for most rule changes within general practice previously, yet most patients still did not know about it or how to access it. If patients did not know about a service on the evening or weekend, and opening hours were a true barrier, they might not even make the request to the surgery for an appointment. Even after six months of the service existing in their area, members of a practice PPG, arguably the most informed patients in terms of knowing the rules and accessing care, tended not to know about the service or to conflate it with the existing

OOH service. This long exchange from a focus group in the following vignette demonstrates this.

Vignette 9: Where is the hub? What is it?

On my way into have a focus group at a practice surgery with their PPG, I sign in at reception and notice one of the official posters advertising the seven-day access service at the reception desk.

During the focus group, my CBPT member (CBPTM2) asked if they knew about the hub and whether they thought others patients were aware of it. These PPG members had all spent time volunteering in the surgery waiting room to help with various issues within the surgery.

The lead PPG member said they knew what it was but wanted to hear what the others said.

Their response: ‘Where is the hub? What is it?’

As had happened in several other focus groups, my CBPT member and I proceeded to explain the service. It took several minutes and the lead PPG member contributed to the explanation as well.

However the lead PPG member conveyed some of the details incorrectly, reinforcing the complexity of the service. The PPG lead told a story of using OOH as an example, which demonstrated the confusion around the overlap of the services and their function. The PPG lead also said the service had only been running for several weeks, when it had been several months. The PPG lead also said that it was not important if patients knew but that the receptionists knew because they were the ones booking people into it. However, at this surgery, it was not possible to call and book ahead for other routine appointments, as they mainly did telephone triage on the day, so even that logic was against the rules of the surgery itself.

The persistent confusion around the service on both the patients’ and receptionists’ part, demonstrates the effect of the lack of clarity around this service and how it contributed to the already confusing and varied landscape of rules in the larger context of the services available. In general the seven-day access service represented overly complicated rules, which were poorly communicated and variably interpreted. They do not reflect a recognition of the existing problems around rules within general practice, so likely only served to worsen this aspect of the paradox.

5.5. Continuity and seven-day extended access

In chapter 4, I established the role and importance of continuity as well as the fact that it was undermined by previous policies. Here I will demonstrate how the seven-day access service further undermined continuity, how the lack of continuity proved to be a barrier for patients to use it, and how some patients and providers managed to maintain some continuity by not using the service as it was intended.

By definition this service took routine care out of the GP surgery where the patients were registered and encouraged it elsewhere. Surgery staff mentioned the lack of continuity as one of the key reasons the hub appointments were not being booked, even when they were being offered to patients. This was the case specifically because of the intended routine nature of the service, yet that was where people wanted continuity with their provider.

> *The receptionist showed me the schedule for the future. Three are booked at this hub site for tomorrow, but then none. She explained that people are not using them to book routine appointments and that is because they don't know who the appointment would be with. (S44O2)*

The practice managers also identified continuity as one of the reasons the hubs were not being used. In a larger discussion during their focus group, they considered the complexity of all the options for patients and the issue of supply-induced demand. They mentioned the emails about appointments at the hubs that were not being used.

> *"But do you not think, though, in terms of the walk-ins, the seven day access, access for patients has actually never been better. There are so many options, and I don't know if this is what's actually garnering the problem, that we have put so many methods and choices, which is all very well and good, it looks again wonderful on paper but that then becomes…it drives, it feeds the demands and that again, I worry where that's going to end because it's like a snowball, it's getting bigger and bigger, and it's now about to knock you all over so…" (FG1R5, practice manager)*
>
> *"But how many times do we get emails saying that there are appointments available at the hubs, and it's because the patients don't want them." (FG1R2, practice manager)*
>
> *"But if you were really poorly, you would surely." (FG1R5)*
>
> *"They want to see…their own GP." (FG1R2)*

Despite acknowledging that patients did not want the appointments because they wanted to see their own GP, the practice managers were consistent here in their dismissal of patient preferences for continuity, restating the logic that if you were really poorly you would want whatever appointment was offered to you. This exchange once again reveals the confusion around the purpose of the service and the questionable utility of a GP service that lacks inherently in continuity. It shows how the extended access service was not designed to correct the undermining of continuity that already existed within general practice.

Despite the inherent lack of continuity in the purpose of the service, within the utilisation of the service, there were notable exceptions of continuity-by-chance and continuity-by-design when either the GP, patient, or receptionist utilised the fact that the GP working a hub shift was a known local GP and their own patients scheduled in the appointments (IR08). This ability to maintain relational continuity at the hub was more possible at certain surgeries where receptionists, because they also worked sessions as hub receptionists, or GPs, knew which GPs were working at the hubs on which days. I was told of one occasion of this happening on a bank holiday, when one of the GPs in the area worked the session and all of the patients scheduled were his own patients, having been booked in by the surgery reception with the knowledge that the GP was working that session, which they shared with the patients when offering the appointments (IR08). As I demonstrated in the previous chapter, the fact that this occurred reveals that continuity was valued and sought after by patients and clinicians, and accommodated by receptionists if the system allowed. However because that was not how the service was designed to be used, it was viewed by some as a misuse. Yet, while it was not the intended use of the service, it was an occasion when the appointments were fully utilised, rather than not. It was another example of the exception to the rule working better for patients, clinicians, and the receptionists. The CCG governing body members discussed the potential inequity such practices created around accessing the service, especially if the surgeries whose GPs worked regularly at the hubs were able to accommodate requests for appointments with them sooner than their otherwise available appointments with those GPs (CCGGB2).

In contrast, at a different hub site, another GP expressed disappointment in the service, primarily for the reason that it did not help relieve the demand on their day job. Their surgery’s appointment system was able to accommodate continuity and could absorb increases in demand, yet largely by the GPs doing more work on the day. Their patients were not choosing to use the hub appointments, preferring the appointments during the normal daytime opening with their own GP. This GP expressed his frustration as shown in my observation notes from a hub session below.

When I asked the GP directly what he thought of this hub service, he said it was a 'rubbish service. Not cracked up to much.'

He said how he and his partners thought it could be good service for their patients, and it would reduce pressure in their day job. They thought that their patients would use the service, especially since they were hosting it at their surgery. But that has not been the case.

The partners have asked the receptionists, 'Why aren't you booking our own patients into the hub? We are working our butts off during the day.' The answer was 'the patients don't want it.' 'No one wants to see just anybody.'

He explained that 5% of the patients that have come to the hub are their patients. He explained that other surgeries in the area have something like a two-week wait for appointments 'because they haven't changed their appointment system' and that they were using the appointments. (S44O2)

Continuity was valued by the patients within that surgery, so they were not utilising the hub where it was not guaranteed. In summary, the seven-day access service was an example of continuity being undermined by design. The lack of recognition of the degree to which patients in the area valued continuity likely contributed to the underutilisation of the service, which limited its effectiveness in improving experiences of access.

5.6. Work and seven-day extended access

As I mentioned in the rules section above, the process to book people into the seven-day access hub appointments was cumbersome for the receptionists, perhaps a barrier to using them. In addition to the cumbersome process of checking hub availability, booking the patient including copying their details across, and explaining the location and nature of the service to them, there was work required on the receptionist's part to prepare a patient to attend a hub appointment. Because of the limitations in the informational continuity of the electronic records system, the service had access to patient's consultation notes in general practice, but not to any letters from consultants, scan reports, or other documents filed in a different software programme. If those documents were required for the hub appointment, they would need to be printed out for the patient to bring to the appointment. There was a chance that if this did not happen ahead of time, because it was not anticipated by the patient or the receptionist, the hub consultation would be limited in function, and the work would possibly need to be repeated within the patient’s own surgery.

Similarly, there were limitations to what could be done during the hub consultation. For example, they could not take blood for tests because there was not a system in place to pick up and deliver the samples to the appropriate place. The service staff member explained to me the limitations of what could be done at a hub consultation.

> *“No. They can request x-rays, [but] any tests that need to be done have to be done by the practice. So the patients would have to go back into the practice. But the reception staff know at the time of booking we can't do tests. So if you know a patient wants… I mean chaperoning is another one we can't offer at the moment. So if you know you've got a patient that requires a chaperone or is wanting a test to be done, a blood test for example or a smear, then they won't get booked into the hub. So we're trying to keep the reception staff updated and educated about what we can and can't see. And we're finding generally speaking that that's okay.*
>
> *“So I think as well in the booking notes the reception staff will put obviously the patient details and why they're coming. We then…before the patient arrives we have to register the patients on the system. So we've got two ladies now working on registering those patients. So if they see in the notes that the patient requires a blood test, they'll intervene at that point and get back to the practice and say, ‘We can't do the blood tests, so you'll have to rearrange the appointment.’ So hopefully there's not going to be too many patients turning up for tests that we can't do.” (IR08, seven-day access service staff member)*

Other than requesting x-rays, any other test that the hub clinician thought the patient needed would have to be done by the patient’s own surgery, also requiring further work by the patient to attend their own surgery again. This was the same if it was determined that the patient needed a referral. A GP at the patients’ own surgery would have to do it, and if they were making the referral in their name, they would likely need to consider whether they agreed with that decision, causing more work and perhaps even more if there was a difference in opinion that would need to be conveyed to the patient. This limitation in what could be done at the appointment also made the job of deciding who to offer it to, or book into it, harder for the receptionist. Receptionists would have had to ask the patient what the appointment was for, which was met with varying amounts of animosity from patients across different practices. All of these limitations weakened how helpful the hub could be and inherently meant additional work for many of the area’s surgeries.

The above quote also reveals the behind-the-scenes work of the service-provider staff to hand-register the patients ahead of their hub appointment, using the information that the receptionist had already manually entered when making the booking. This process was fraught with errors, and one of the service staff members whose role it was told me of several surgeries repeatedly not inputting enough patient information for her to register the patients, or forgetting to indicate that the patient had consented to their records being ‘shared.’ If either happened, then they had to wait until the person arrived for their appointment at the hub to complete the registration process (S43O1). Similarly, it was cumbersome to cancel the hub appointments. The patient had to communicate through their own surgery, and then the surgery staff had to communicate it to the service-provider staff, who could then cancel it. Therefore, there were often delays, which meant some appointments had been ‘cancelled,’ but had not been able to be re-opened for booking by anyone else (S43O1). This situation created more work for the surgery staff and potentially added to the underutilisation of the service.

In terms of all of this additional work, it is worth considering the efficiency of the service itself. As described in the last chapter, there is work created by the loss of continuity, especially relational continuity, within most hub consultations. This service allowed for fifteen minute appointments in recognition of that work. However, an alternative would be to avoid creating a service that conspicuously ignored continuity, so that there did not have to be time factored in to compensate for that loss. Relatedly, on the occasions when patients and clinicians did manage to preserve continuity within the service, by using it not how it was designed, the effort of explaining and getting to know the person within the consultation was likely saved, allowing the need to be addressed more directly.

Finally, it is also useful to think about the GP workforce overall in the area and how this service affected it. It was mostly staffed by GPs who worked in the area. Some were curious about the service, and even if sceptical, wanted to work in it to see if it was useful and who it was serving (S44O2). However, it did mean more work for those GPs, who were taking these shifts in addition to their regular work. If they already felt overworked, this could have added to it. It was difficult for the service provider to fully staff the sessions, with some sites not able to have sessions on all intended the days because of staff availability (IR08, S43O1). Also, some GPs, if given the option, may have substituted working at the hub for a typical session in core general practice. It is clear from the previous data displayed that a GP would likely do more work during a regular session in the surgery, because there are more tasks than just seeing the scheduled patients, and possibly more patients scheduled in the same amount of time. If working the hub sessions meant that any GP worked fewer regular sessions, that would worsen the reality of the workforce shortage of the stable, known population of doctors within the area's surgeries. In general, the seven-day access service represented several types of unnecessary work through inefficiencies in the processes for booking and using the appointments. This additional work likely contributed to the underutilisation of the service, which limited its ability to help an already overworked general practice service.

5.7. Unmet need and seven-day extended access

Both because the seven-day access programme reinforced the problems within the access paradox and because it did not specifically consider groups that may be left out from the service, such policies directly and indirectly fuelled the problem of unmet need.

The one group that the seven-day access rhetoric claimed to target were working people, as I have previously explained. As a group, working people are generally healthier than non-working people, so it was already an interesting group to target as helping them might further increase health inequities. However, it was unclear that the people using the hub were doing so because work prevented them from using routine core general practice. Most of the evidence I have shown demonstrates that the hub appointments were being used as overflow and not because of a desire for evening or weekends from a working population. Indeed, the one time I heard someone specify that they needed an evening appointment when rescheduling their appointment at the hub was an exception (S01O1).

Perhaps even more so than within routine general practice, the groups that needed certain nuanced care were not able to utilise the hub, because they were generally not considered. The complexity of communicating about the hub, the idea of going somewhere unfamiliar or farther away, and the lack of continuity affected certain groups more than others. One example was patients who needed interpreters. Several months after the service's creation, a provision and work process had not been thought out for this group. One of the service provider staff described the lack of consideration when I asked about issues of equality and diversity around the service provision.

> *"So in terms of wearing your various equality and diversity hats and your equitable access hats, do you see this ticking some of those sort of boxes for the area?" (JV)*
>
> *"Um. Well certainly in terms of access, physical access, the buildings are all compliant. In terms of interpretation, so if somebody was requiring an interpreter, I think that's perhaps an area where we don't do so well. There's been one request for interpretation services, and we've said, 'If that's the case, then they need to go back to their GP practice and arrange it through the practice, because that's not something we're able to offer.' And I don't understand the rationale behind that. I'm trying to understand that myself. I don't know. I don't know." (IR08, seven-day access service provider staff member)*
>
> *"So currently it's not part of the contract or it's not something that the service is providing at the moment?" (JV)*
>
> *"It's not something the service is providing, but what I would like to understand is what interpretation services does normal general practice have access to? Who pays for it? How do patients book it? Is that service available in the evenings and at weekends? And I don't know any of those answers at this stage.*
>
> *"… But in terms of access generally for the wider community there's no… I can't see that it would be an issue because it's just about them accessing a GP appointment as they would do normally. It's just that it's potentially in a different location." (IR08)*

This exchange revealed how certain considerations around equality and diversity were clearly after thoughts in the service's design. It certainly was not the priority of the service to consider those with unmet needs and try to meet them. Since the route to being scheduled for these appointments was the same as a normal GP appointment, through an exchange with the receptionist, the factors about that process, which might make it difficult for certain patients, are relevant in accessing this service. The quote above also reveals yet more work that would be required on behalf of the surgery to book the interpreter, because that had previously not been considered by those providing or commissioning the service.

Similar logic applies to a patient who might need a chaperone, which was mentioned in the last section. The logistical reason that there could not be a chaperone was that the only staff working besides the GP was the receptionist, and they could not leave the reception area unattended. Depending on the gender of the clinician and the nature of the patient's health concern, a chaperone may have been appropriate for some or all of a consultation. If a patient, or the clinician, had felt they wanted a chaperone during the consultation, they either would have been declined, and would then have had to decide whether to proceed anyway, potentially causing unease. Or the necessary care would not have been completed, again putting the work back on the patient's own surgery to provide the care.

In general, the seven-day access service did not prioritise understanding the existing unmet needs in the population. It also did not address other issues within the paradox, so it did not free up capacity within general practice for the proactive, flexible service that some population groups within the area needed. For these reasons, the service was a missed opportunity within a new resource. Indeed, as I have shown in this section, due to the lack of consideration of the needs of certain population groups, there were, ironically, actually more exclusions around who could utilise this service than for core general practice.

5.8. Chapter summary

In this chapter I have built upon my understanding of the paradox of access problems to critique the dominant policy intervention around access during the time of this study. The broad understanding of access that I applied to this research, along with my inclusion of multiple perspectives, has facilitated this critique by contrasting the narrow view of access, and simplistic assessment of the problems that the political idea of seven-day access assumed, with the paradox of problems presented in the last chapter. I have demonstrated that the seven-day access policies did not reflect an understanding of the complex issues of access explored in the paradox, and such a crude policy, which did not take those nuances into consideration, only served to potentially worsen the area's health inequalities further. For reasons that the paradox elucidates, the seven-day access service did not help practices with their demand, represented more complicated rules for patients and receptionists, further undermined continuity, created more work, and continued to ignore those with unmet needs. In the following chapter, I will use the paradox to critique the effects of another trend within general practice during this study: the trend towards larger practices.

Chapter 6. Understanding the effects of practice size on access

6.1. Chapter overview

In this chapter, I will build on the understanding of access that I have established in this thesis to critique the ongoing trend within general practice of increasing practice size. Once again, my application of a broad theory of access, along with my participatory approach and qualitative methodology, facilitated my understanding of people's experiences in context. Practice size emerged as an important environmental and contextual difference between surgeries that allowed me to observe nuances within the paradox of access problems. In particular, as I will demonstrate in the sections below, the larger practices seemed to struggle more with issues of demand, rules, continuity, work, and unmet need. In contrast, in the smaller surgeries, the demand felt more manageable, the rules be flexed, continuity somewhat sustained, less extra work, and examples of a proactive approach for those with that need. These findings are relevant, as various national policies during the time of this study encouraged general practice to 'work at scale,' (NHS England, 2016a) and mergers and larger practices were becoming more common (Lind, 2016). This chapter provides evidence to counter some of the presumed efficiencies with increasing size. While I am not arguing that size inherently matters in terms of these issues, the differences observed give an indication of some of the challenges related to access that need to be understood within the current context of the delivery of general practice, including practice size.

6.2. Increasing practice size

In this section, I will demonstrate how this trend of increasing practice size was recognised by my respondents, with mixed opinions about it. A former regional policy manager, agreeing with the broader notions around working at scale that were popular in policy circles, felt that the small surgery, as a concept, was out of date and that small practices being in decline was not necessarily a bad thing.

> *"My personal view is that small practices can't deliver modern effective primary care or it would be very challenging for them to continue to do that. I think there needs to be colocation of general practice. I think partnerships probably need to merge. We need to find a way of being able to employ far more skilled specialist nurses who can support general practice more, the pharmacy example I've already given you. You can't do that on a small practice with three or 4000 patients on the list." (IR19, former regional policy manager)*

Notably, this respondent felt that GPs were in denial about this in trying to preserve the small practice. The respondent later reiterated this view of small practices.

> *"So I think my personal view is small practice is doomed, and the sooner everybody wakes up and smells the coffee and works out a different way of coordinating and working the better." (IR19, former regional policy manager)*

This respondent's views, even though noted as personal views, are relevant given the respondent's role. In addition to the respondent above, on the policy level, occasionally, patients would mention a similar idea that small surgeries were limited in terms of certain services they could offer and certain efficiencies as an organisation (FG6). However, in general while there were several proponents of small surgeries, there were no proponents of large surgeries among frontline service staff or clinicians. As I will describe below, the large surgeries were very much struggling with demand and other issues within the paradox, and were not touting their size as a strength. Even when they were undergoing mergers, it was often out of necessity, not because they thought that bigger was better. In contrast to the above policy maker viewpoint, at a public meeting that I observed early on in my data collection, a GP from a small surgery spoke about the function of general practice and cautioned about what was being lost with some of the ongoing changes.

The GP clarified that they are speaking from their position as a small practice.

Spoke of the increasing size of the average practice in the UK: 10 years ago it was 5,400, now 7,100. The biggest practice is 66,000. NHS England is looking for practices to be 30-50,000.

They said there is international evidence that smaller is better. "Fewer referrals, fewer prescriptions, fewer commissioning costs". They link this to "people knowing their doctor and the doctor knowing the patient."

They mentioned studies from the 1990s saying "most people wanted a doctor who would listen." And that as people get older and sicker, a doctor who knows them becomes more important to them...

Described the catchment area of their practice and their system for dealing with demand. They have a morning walk-in model for urgent appointments on the day. Stated: sometimes it takes longer than I would like to see them all, but the need "is not indefinite, as some people say."

Stated that 8-8, seven days per week is code for fewer smaller practices.

Talked about how the relative number of GPs per population has fallen. The number of GPs has increased, but not enough to keep up with population.

Stated that they think that people say "we don't know who our doctor is, so we may as well go to A&E."

Stated that in the "bigging up" business, "general practice has given away its USP/unique selling point."

(HW1)

This GP articulated their views as a small practice and the service that they felt able to provide, yet indicated that this was under threat with the goals of NHS England and also potentially the idea of seven-day access to general practice. As I will explain in the sections of this chapter, many patients described valuing the things mentioned by this GP, and mentioned the changes over time, especially how increasing practice size and practice mergers had made their experience worse.

Throughout this chapter, I will use data from my observations in and discussions about large and small surgeries, and discussions of people's experiences with mergers that had occurred. The following vignette sets the scene for some of the issues that I will explore in this chapter. I have composed it as a hybrid of experiences from nine observation sessions across three large and two small surgeries, as noted below. It gives a sense of how it felt to be in the different spaces of large or small surgeries.

Vignette 10: Practice size

Large surgery	Small surgery
When I arrived, there was a queue of people waiting outside the door before the surgery opened. The reception staff braced for the day and the onslaught of calls when the phones started ringing. It felt as though there were always more calls and people at reception wanting more than the receptionists were able to offer. There was almost constantly a queue at the reception desk. The waiting room was big, and there was another waiting room elsewhere. Patients were called back for their appointments through a combination of an incredibly loud	There was a calm atmosphere as there were few people in the space. It was even quiet sometimes. The receptionist seemed to know who was arriving for their appointment, greeting them by name, and checking them in. When patients were called or told to go in for their appointment, it did not have to be shouted, it was spoken. There was no display screen or beeping. Though they were busy, the staff did not seem overwhelmed by the work or the patients. As people waited or were checked in, the reception staff occasionally proactively offered

beeping, a number or name display system, or loud shouting. Patients checked in at the electronic check- in screen, but came to the desk if that did not work for some reason. Some patients were at the desk to make an appointment because they could not get through on the phone. The receptionists were enforcing strict and elaborate rules to try to handle the patient demand that always felt like too much. The exceptions were few. There was a lot of noise from the sheer number of people working and waiting in the space. It felt somewhat chaotic and unrelenting as the time passed. (S27, S19, S02)	something to address another element of their care. It was obvious that the patients knew the reception staff and vice versa. The receptionists were able to make exceptions in line with what the clinician on duty would want because of their knowledge of the clinician and of the patients. It did not feel chaotic. I actually had the sense that healing could take place there. (S20, S38)

The above vignette is a composite of experiences and feelings I had as an observer in the different spaces. The large surgeries were characterised by demand that felt overwhelming, and the issues of the paradox including reactive, rigidly enforced rules, undermining of continuity, increasing work, and unmet need were also dominant. The small surgeries felt different, and I was able to observe a different context of delivering care, which I explored in subsequent generation and analysis of my data. In the sections below, I will use the elements of the paradox to expand on these observations and illustrate my critique of the trend towards larger practices.

6.3. Demand and practice size

The demand on general practice that I described in the previous chapter was an issue for practices of all sizes. However, I observed that the scale of the patient population at the larger surgeries magnified the demand in those places. The large number of patient calls and contacts at the larger surgeries was something the staff were very aware of, and some displayed these numbers and referenced them when discussing the large demand on them (S27). Respondents in a focus group of volunteers also referenced large patient population size as a factor for why some surgeries, either their own or the ones they volunteered in, had worse problems with access than others as shown below.

> *“[Name GP surgery 27] …we are still getting complaints about people ringing up and not being able to get through. And you're saying, ‘What can they do about it?’ Well, maybe we need to look at [name GP surgery 36], why…” (FG2R6, patient/volunteer)*
>
> *“Yeah. And ours is not bad.” (FG2R5, patient/volunteer)*
>
> *“…why are some surgeries not getting the level of complaints that others are?” (FG2R6)*
>
> *“I don't know because…” (FG2R0, patient/volunteer)*
>
> *“Because they don't have 10,000 patients.” (FG2R1, patient/volunteer)*

In the above exchange, the large list size was suggested as the reason a particular surgery struggled with access issues, which had generated complaints to the volunteer group. Some suggested looking at what another surgery was doing that did not have such an issue of complaints, yet others noted that the second practice was not as large, suggesting that as a factor.

That particular large practice (S27) had the known issue of patients not being able to get through on the phone, and one volunteer suggested putting in more phone lines, as shown below. However, another reported that the practice manager had said even if they put the additional phones lines in, it is an issue of not having enough staff.

> *“Yeah, well, it's like [name], the practice manager said, ‘It's always a big, big complaint about that.’ You want more phone lines. It's like she said, ‘If I put 100 phone lines in, who's going to manage them? I've only so many staff.’” (FG2R1, patient/volunteer)*
>
> *“Maybe they need to change their system.” (FG2R6, patient/volunteer)*
>
> *“Well, to what? This is the big one. This is the big one. To what? So what you get is: if you turn up on the doorstep at 8 o'clock in the morning, you'll definitely get an appointment before dinnertime.” (FG2R1)*
>
> *“That's what we do.” (FG2R5, patient/volunteer)*

That the practice manager mentioned not having the staff even if they opened more phone lines brings up another issue within the larger practices. The larger practices, while they had a lot of staff, did not seem to have the proportionate number of staff on duty for the size of the surgery compared to the smaller surgeries. I observed, for example, in a small practice there might be two receptionists on duty, but for a practice five times the size, there might be five on duty (S20, S02). That difference made the demand feel bigger in the larger surgeries because it was more for the number of people working.

When observing in a smaller surgery, a receptionist told me the size of their patient population and said it was a ‘manageable amount’ (S20). That was the first time anything had been described as manageable, since I had previously observed in several larger surgeries where that did not feel it was the case. This receptionist also mentioned that they ‘do a lot of chasing’ meaning they are able to seek patients out proactively, something I will explore further under work and unmet need below.

Besides the staff numbers, the patients at the larger surgeries were aware that despite the large patient population, there may not be enough GPs in adequate ratios. The members of a PPG from one of the larger surgeries reflected on this as shown below.

> *“I suppose, you don't see the relative practice numbers. I know the numbers for this practice are relatively high, really.” (FG7R2, patient)*
>
> *“They are. Do you know what they are, [name FG7R3]?” (FG7R1, patient)*
>
> *“What figures did they have last time, it was something horrendous?” (FG7R2)*
>
> *“I think it was in the range of 20,000….patients. I mean, if you divide that with the number of doctors, you know, you get an idea of what the patient-doctor…” (FG7R3, patient)*
>
> *“Well, I mean, how many full time doctors are there, here?” (FG7R1)*
>
> *“Five, isn't it?” (FG7R2)*
>
> *“Because [doctor name]....isn't, is he?” (FG7R1)*
>
> *“No.” (FG7R2)*
>
> *“And [doctor name] has just decided to slack it down. So I think you're looking at, maybe, four.” (FG7R3)*
>
> *“I mean, it's not a lot of doctors for 20,000 odd people, is it?” (FG7R1)*

It seemed to be generally agreed by multiple respondents in different roles that a larger practice list size led to feeling more frazzled in terms of the ability of doctors to know patients, which can affect how the demand felt. The quote below from a commissioner who had also worked in general practice demonstrates this.

> *“I think…I mean it'd probably be useful if you spoke to a very long-standing GP and had a newer GP, and contrast how they look at it. I mean yes, again, it depends how huge your list size is and how frazzled you are. But I wonder if there's something about that relationship with your doctor.” (IR07, CCG commissioner)*

The final aspect of my data that sheds light on the issue of demand and practice size, is the extent to which the different-sized practices seemed to use the seven-day access service. In one observation session at a hub site, the GP showed me the appointments at other hub sites and who was using them.

> *The GP showed me the appointments at the other hub sites on his computer screen to give me a sense of how they were being used.*
>
> *At one site, of the ten appointments, five were booked each for patients from the two larger surgeries in the area. There were no appointments booked from the three smaller surgeries in the area.*
>
> *He explained that he thought that the large size of those surgeries, and the fact that they were both struggling with recruitment, was the reason the patients were mainly from them, because they had issues with their own appointment availability as a result. (S44O1)*

This GP explained his insight from his experience of working in the hub site and observing these patterns over time. He felt there was a difference in the use of the hub appointments based on the different sized practices, with greater use by the larger practices because of their overflow demand.

While I have demonstrated that the demand on larger surgeries felt bigger because of the large practice size and questionable staff and GP ratios, the complexity and rigidity of the rules with which the larger practices tried to handle the demand compounded it even more. I will explore this further in the next section.

6.4. Rules and practice size

Because of the feeling that the demand was overwhelming, and because of the complexity resulting from multiple members of staff and clinicians working in a large practice, there seemed to be less capacity for receptionists to be flexible in the enforcement of the rules, and the rules themselves were more complex. This amplified the feeling of the demand as the fit of the patient need and the service offering matched less often, which only perpetuated the work to another day as I described in chapter 4.

It seemed that the larger practices had taken more complicated measures to control demand with elaborate and strict rules. There was less room for flexibility because in general the process was less personal. The use of the check-in screen, rather than speaking with a receptionist was more common in the larger surgeries. To make an exception to a rule, it would often require GP input, but at the larger surgeries, it was more difficult for receptionists to opportunistically ask a GP a question. The large space contributed to this with the GPs being quite far away and in their own rooms, and because the larger surgeries more often used systems to call patients back, the GP was not coming to the waiting room or reception area. Also, with multiple clinicians working at the same time, each with different styles and preferences, it was difficult for receptionists to make an exception because they were aware that not all would agree with it. Even if one clinician would have agreed to something, it may have been another clinician who would have to do the extra work, and they might not agree. That would often come back to the receptionists as negative feedback from clinicians. They were caught in the middle. It was easier to stick with the rules and not make exceptions. On the other hand, in a smaller surgery, with fewer, perhaps sometimes only one, GP working, the receptionists were able to anticipate what that GP preferred because they understood their style, and because of space and scale, it was easier to ask the GP a question in the interpretation of or an exception to a rule. The issue of scheduling urgent appointments demonstrated this to me at a small surgery as seen in my fieldnotes excerpt below.

> *The receptionist tells me there are ‘urgents’ everyday, but the different doctors who work here like to handle them differently.*
>
> *The partner GP preferred to triage the urgent ones first, rather than the receptionists scheduling them into the urgent slot automatically. There is a form for reception to fill with some basic questions and when there is an opportunity, they will take it in to discuss with the GP.*
>
> *The partner is working today, and there have been eight requests. So far, three have been booked into the six potential appointment slots saved for ‘urgents.’ The others were dealt with in other ways by the GP or by the receptionist after conferring with the GP.*
>
> *The receptionist tells me that some of the other doctors do not want to triage first and say that the receptionists can just book them in. (S38O1)*

The fact that the GP partner wanted to triage requests was possible in this small surgery because the receptionists were able go and discuss the patients. It was not a problem for the receptionists that the other doctors had a different preference because there usually were not multiple preferences simultaneously to deal with. They could adapt to who they were working with. It is also worth noting that the partner’s preference to triage the urgent requests, rather than them just be given a face-to-face appointment automatically, meant that fewer appointment slots were used. Because that was harder to do at larger surgeries, appointments were more likely to be booked, which likely contributed to the overall shortage of appointments at several of them (S19).

Supporting this point further, a receptionist who worked at a large surgery explained to me how it was difficult to work with many different clinicians with different preferences and the effects of that on the receptionists' interactions with patients, as shown in my fieldnotes excerpt below.

The receptionist and I discussed whether they ask patients the reason for their request for an appointment. She said that they only ask for the urgent/on the day requests and otherwise they do not. She said that 'people don't want to tell' the receptionists and that the receptionists 'get abuse' from the patients: 'Why would I tell you? You're not a doctor.'

I ask if they have thought of asking all of the time in case patients reply that way because they are worried you will say that their issue is not urgent. She mentioned she recently spoke with a receptionist at a smaller surgery, where they ask about the reason all the time, and it is fine for them.

She tells me that [name surgery S24] is large and not all the doctors are on the same page. So if the receptionists are asking, the doctors need to be open to that too and be able to respond if the receptionists are not sure. She is not sure all the doctors would be open to that.

She mentioned that currently there were no appointments available to book for three weeks in advance and the rest were being dealt with by patients calling on the day. (S43O1)

This receptionist's explanation for why they do not ask more patients about the reason for their request demonstrates the difficulty of having multiple doctors at a large surgery. Because the GPs approached things in slightly different ways, and not all were willing to help the receptionists deal with the further information they obtained, they did not ask. This left them with a large gap between a three-week wait for a routine appointment to book in advance and the alternative of a same-day appointment for an urgent problem. There was likely an ill fit between many patients' needs and the available appointments at the surgery, but it was not possible for the GPs and the receptionists to work together to get the fit right, as in the above example, because there were so many different GPs with different approaches. This example shows how the complexity of the size of the practice locked the receptionists into the existing rules, no matter how ill-fitting they were.

Mergers had the potential to amplify the issues with rules because there likely would be differences in the rules from the two previous surgeries. This would mean an adjustment for staff, and this would likely not be clearly communicated to patients, since most rules changes were not, as I explained in chapter 4. I will explore some of the extra work around the confusion of rules with mergers in section 6.5.

6.5. Continuity and practice size

Continuity was the issue within the access paradox that was most undermined by this trend towards larger practices and mergers. Multiple aspects of relational continuity between patient and clinician, patient and other staff, and between staff and clinicians were affected as I will demonstrate below.

At the large practices, with appointment system rules that did not prioritise continuity, it was difficult for patients to have relational continuity with clinicians. One patient, who was a new mother, listed this as the main reason she changed from being registered with a large GP surgery to a smaller one.

> *"I used to be at [name GP surgery 24], but I did move, but that was more because I saw a different doctor every time." (FG5R1, patient/mother of baby)*
>
> *"It's so big, isn't it?" (FG5R2, patient/mother of baby)*
>
> *"It's so big, and I think that's quite a personal thing. I didn't really like seeing… I wanted to build a relationship with my doctor. That's important to me. But like you two have said, I'm not one for going to the doctor's at all, which I've really struggled with since having him, and it's that whole, 'Oh, is this how it is?' feeling like you've suddenly got to…you are there more than usual, but yeah." (FG5R1)*

Prior to becoming a mother, that patient had not sought much care, but had several times for the baby and for herself following birth. During that time, she would have preferred to have continuity to build a relationship with a GP, but that did not seem possible at the large surgery. She went on to say that it was not only the lack of continuity for herself and the clinician, but also that she felt that the communication between the staff members was poor at the large surgery, contributing to her decision to change.

> *"I just wanted to add as well, when I was at [name GP surgery 24], one of the biggest reasons that I did move was that I felt like the communication there between staff wasn't particularly as good as it should be, and I know that they're so busy, and sometimes things do get missed. But I had a miscarriage, and I was okay about it, and managed to deal with it, but it obviously hadn't been updated on the system. So I continued to receive midwife appointments for quite some time, which was obviously quite difficult to deal with, and I kind of…I phoned them in the end and said, 'Look, you really need to go onto the system and update my file, because this, I'm trying to move on and get over it,' which I had, but then you get a letter saying, 'You've got a midwife appointment.' (FG5R1, patient/mother of baby)*
>
> *"It's not nice to have little reminders through the post, is it?" (FG5R3, patient/mother of baby)*
>
> *"Really like…and then when I did go in to see [doctor name], I think she's called, she was very sort of matter of fact about it all, and that's one of the reasons I moved to [name GP surgery 22], really, so yeah, just sort of communication." (FG5R1)*
>
> *"So it sounds like for that one: communication, but also with the different people, and then not trusting that the communication was there, you can't know…" (JV)*

> *"Yeah, well, I think that's another part of seeing lots of different people, isn't it, because obviously no one really knows where you're up to, and then mistakes like that can happen which could… Thankfully I was fine, but if it was someone who was really struggling with it, then it's not good." (FG5R1)*

This patient described going through a sensitive experience and because of the lack of continuity, did not feel well cared for as a person. The group went on to discuss the different feeling when there is continuity, for example, with the reception staff at the smaller surgery the patient had changed to.

> *"The reception staff are amazing to the point where…and I suppose it doesn't really matter, things like this, to some people, but to me it really does, that you go in, and they know your name, and they're like, "How are you? How's [name baby]?" And that to me is really important and just…they couldn't be more helpful, and like I said, well, her ringing upstairs to [practice manager name], that was just really…I don't know, they just seem to do…really sort of care and really work very hard. So yeah, no, I think the staff there are really fantastic. (FG5R1, patient/mother of baby)*
>
> *"You said knowing your name and [baby's name] name was important. Tell me why." (CBPTM2)*
>
> *"I think it's just to…it's that confidence thing again. So confident that they…you're not just a name and a number. You're not just another patient. It's that personal, the more personal aspect, really. Makes me feel more confident. I don't really know why." (FG5R1)*
>
> *"It's almost the same though as saying about having the same midwife, isn't it? It's that knowing who…you put a lot of trust in your carers, whether it's a midwife or a doctor or a nurse, and you're more likely to trust somebody that actually knows who you are than it's a stranger, and I would say that is the difference with [name GP surgery 24], because it is a big surgery. It is a bit of a machine, really, a bit of a factory of patients going through." (FG5R2, patient/mother of baby)*

The women articulated the link between the different types of continuity and the trust that comes with feeling like you are recognised and known as a person. They clearly linked this, or the lack of this, to practice size, and they also articulated the value of it to them.

While the above example was one where the patient actually changed surgeries because of the large size, most patients who I heard from did not change surgeries. There was a sense of continuity with the surgery for some patients, even when the surgery had changed dramatically over the years.

> *"I am [name FG7R3], I'm 69, nearly 70. I've been with this practice, getting on now, for 68 years. There's only one year that I wasn't in this practice, and that's when I was overseas. I've said, 'this practice.' It has been the practices that have led onto this practice, over the period, from one amalgamation to another. (FG7R3, patient)*

The above patient demonstrated loyalty to the practice. Some patients described it slightly differently. With the past and recent mergers, while they were still technically with the same surgery—because they had not registered anywhere else—they had seen a lot of changes, which had negatively affected the experience of being a patient, largely because of undermining different aspects of relational continuity. Equally, they did not feel informed or empowered to change surgeries, because they were not sure that it would be any better anywhere else. The vignette below describes one patient's experience.

Vignette 11: Trend towards depersonalisation

A patient (IR11) with a long-term condition that has caused physical disability told me her experience at what was technically the same surgery, which had worsened in her opinion in terms of continuity and patient experience as the result of several mergers over time.

She explained that she had been with the surgery for thirty years. However, it used to be at a different location, which the name still reflected, despite it having moved.

She described how it used to be a small surgery: "I knew all the receptionists. I knew the doctors and everything, and they knew me. And it was more of a community-based environment."

She went on to describe that she did not feel it was patient-focused any more. Before she felt more community involvement. She mentioned that receptionists would greet you with your first name (not with everyone necessarily, but with someone like her). She explained, "They knew me. They knew who I was."

She described that now the receptionists "are not as approachable as they used to be." She said that it puts her off them, but that she does not want to change surgeries because she has been with them so long. She reflected that it seemed to be the way things had evolved, and she said maybe it had to be that way. But from her other experiences, she would have thought they would/should be more patient-focused now than before.

She mentioned the issue that the staff had changed, in part because of the merger, and that contributed to them not knowing her.

After the most recent merger the surgery is now split over two sites. She explained that it feels "disjointed, because it's in two places, and people get confused. They don't know where they are going."

She mentioned that the staff are not as welcoming. While in the past, ten or fifteen years ago, the staff would make her feel relaxed and might ask how she is or whether she had been on holiday. She described, "But now I don't get anything. I just get, 'Right, your name.' That's it. 'Take a seat.' That's it. I am not saying they should spend two hours chatting about what you had for tea, but I'm saying there's no making you feel comfortable…and when you are in an environment where you might be ill or might feel vulnerable, that's what you need."

She further explained the situation with the GPs since the merger. She had one GP she tended to see and now there were about five GPs altogether. She explained that the GPs alternated between the different surgery sites, which meant that if you wanted to see a specific doctor, and they were at the other site, you might have to go there to see them or wait to see them at the closer site. For her with her disability, it was difficult and potentially expensive to travel to the other site, which was in another town in the area. It caused confusion, and she said she did not understand how it was supposed to work efficiently. She found the reasoning behind that setup was not clear to her as a patient.

She continued to say that she tried to join the PPG. She attended a couple of meetings but found she was the youngest person there, and she felt like "Okay, who's this coming into our little clique."

This vignette deals with both the issues of depersonalisation and the confusion inherently built into the larger practices, with multiple GPs over multiple sites in different towns. She also felt like because the receptionists did not 'know' her, they did not recognise that the aspects of travel to the other surgery site would be a challenge and expense for her that she could not afford. Other data demonstrate the strain on continuity for the doctors within the workforce who are stable throughout the various changes, including mergers. The demand for those doctors becomes greater among the uncertainty of the other changes, yet it becomes even harder to accommodate because of the factors that make the larger surgeries complex.

At 8:15 AM, a receptionist was on the phone with a patient who was requesting an appointment with a certain GP that the staff referred to as 'Dr. Popular.'

The GP is one of the remaining partners, with various GPs retiring, leaving, or off sick in recent years. The receptionist tried to give the appointment for 4:10pm to that patient. Then she stated, "No, that's gone….4:20 has just gone. Now nothing for today."

While she had been on the phone with that patient, the last two appointments with that GP were scheduled by other receptionists on other lines with other patients.

The person on the phone obviously asked about tomorrow. "No. All 'book on the day' tomorrow. Would have to call back tomorrow. All book on the day. [GP name] will be in all day."

The above excerpt shows the chaos of multiple receptionists fielding calls simultaneously in a large surgery. It also demonstrated how there was continued desire for continuity by patients within a large surgery, yet with only a few doctors known by patients, and the inability of strict and complicated rules systems to allow for flexibility, this was not able to be accommodated.

The understanding of the value of continuity and the relation to size was not only expressed by patients. Staff and GPs also expressed the value in knowing patients and how that is difficult to maintain at a certain scale. A GP reflected on this during an interview, expressing doubt about the potential efficiency gains of mergers, because of the difficulty in maintaining that knowledge of patients, as shown in the following quote.

> *"I'm always a bit suspicious about the idea then, people start thinking about efficiency savings that you could make across admin staff. And you think, well, the admin staff here are sort of highly evolved to work here… I still think of us as a small practice. I still think that most people who walk in, will be recognised by admin and would have a GP in the building at any one time, who knew them by sight, if they were a reasonably frequent attender. So I'm not sure where that tipping point happens, whether it's about 10,000 or something, where you go from a business that can provide a really sort of bespoke service to people that they know, through to something quite sort of large and unwieldy. I suspect it's probably about 10,000. And above that, you're going to struggle." (IR13, GP)*
>
> *"Yeah. I think some of the larger practices do struggle." (JV)*
>
> *"Yeah, they're like little hospitals, aren't they? Where care has to be much more kind of protocol driven, and you're not going to be able to personalise it." (IR13)*
>
> *"Yeah. And yet the push is to go towards bigger practices." (JV)*
>
> *"Yeah, yeah, which is supposedly more efficient, but I'm not actually sure that it is, and I'm not actually sure how you could go about proving the case one way or the other. It's just a gut feeling." (IR13)*

This GP also linked the need to be more protocol driven and less personal to the larger size surgery, supporting the observations I included in the previous section around rules.

As the above GP described, the knowledge of the receptionists of the patients in the practice population was an asset at the small surgeries. I observed how that knowledge and that form of relational continuity could contribute to patient care, because the patients had reciprocal knowledge of the receptionists and therefore, trust in them.

Vignette 12: Receptionist trust

One small surgery had some GP sessions devoted to drug addiction treatment. When a particular patient arrived for their appointment, they were greeted by first name, and checked in, as most patients were at that site. There were two other patients in the small waiting room at that time. The receptionist and the patient chatted briefly about the weather.

When this patient was alone in the waiting room space, the receptionist called over to him. "You alright, [name]?" He then came over to the reception desk to talk. He told the receptionist, who he clearly knew, that he was nearly done with his script. He had started at '50' and was now on '5'. He said that he was doing well and (to me) that the receptionist had 'got him help.' He went on to say he is going to ask the GP if he can go down to '3' and then off. The receptionist asked if he would be ok with that. The patient said that it had been four years and a long process to get to this point.

It was clear that the receptionist had been able to be support for the process of treating addiction for this patient. (S20)

It was evident that this patient trusted this receptionist. In addition to the trust that existed, the environment facilitated this relationship. This was a sensitive issue that would have been difficult to talk about in the setting of a larger waiting room that was never quiet or private. Equally the receptionist and this patient did not discuss things when there were other patients in the space because the discussion could have been overheard. When it was safe to, the receptionist was able to provide personal support for the patient. It would be hard to imagine this kind of interaction happening at a large surgery, where patients were checking in with the screen and were not happy for receptionists to ask the reason for their appointment. Indeed, I did not witness any similar type of conversation in a large surgery.

While I was able to observe the use of receptionist continuity at small surgeries, it was also in a small surgery where, because continuity was the norm, I could see the detrimental effects of even small disruptions to that continuity. This excerpt from my fieldnotes of what I saw that was missed when the one receptionist who had been working in the morning in a small surgery was on a break and another covered.

The receptionist received a call from a patient who had DNAd this morning. He apologised that he had a family crisis. His grandson had been poorly and he had rushed over to another town where they lived to help. The patient explained that he was going away and would like to be seen before going if possible.

The receptionist asked the patient if he could come at 17:40 that day because there had been a cancelation at that time.

That receptionist had been the only one on duty at the small surgery reception, but another admin/receptionist who had come in later and would take over later had relieved her for a break. During that time, a mother had called because she wanted her child seen after school. There had not been any appointments available, so that mother had been given the information for the walk-in centre.

I noted that receptionist continuity was important in knowing the range of patients who had been in contact over a morning, including those they had been unable to be accommodate. On the small scale, it would have been possible even to call a patient back. But since the mother had called while the *receptionist was on break, it was the one request she did not know about. One can imagine that multiplied in a large surgery where multiple receptionists are taking calls and patient requests. It would not be possible to keep track of individual requests as the norm. (S38)*

There are two important observations in this fieldnote excerpt. The continuity being broken to allow, reasonably, for one person's break, had consequences for the ability to accommodate patient needs. Observing that on a small scale, made me realise what must have been lost at large surgeries where that lack of continuity was the norm. In addition, this observation shed more light on the complex issue of DNAs. This patient had missed his appointment because of a family emergency. He had called and apologised, and was able to be accommodated. That seemed more possible at a smaller surgery because of the knowledge of cancellations on that day and other factors about the whole picture of the day's capacity by one or two receptionists. It was also reflective of the more personal approach to patients they consistently demonstrated.

6.6. Work and practice size

For the reasons explained so far around demand, rules, and continuity, and for the size and complexity of the practices, there was a noticeable amount of extra work at the large practices, which is evident from the data provided so far. In this section, I will highlight further examples of this work. It is relevant to understand the extra work generated by practice size because it can add to the increasing feeling of demand that comes with additional workload and further drive the paradox by using capacity that could otherwise have been directed towards those with unmet need. One important aspect of this work is that it was often receptionist work because they were the front facing part of the surgery for any type of query and the first point of call. The work of explaining the changes and the rules at the large practices, and the reasons for the patient request not fitting into the available service, was communication work the receptionists had to do over and over (S19).

There were other examples, which demonstrated the quantity of the work for a large practice size, which made routine tasks more complex. For example, I noted that in a small surgery there was just one container at reception for paper prescriptions to be collected, whereas at the larger surgeries I had noted multiple bins for different letters of the alphabet, making the job of sorting and finding them bigger (S20O1, S27). While many surgeries have now moved to electronic prescriptions, which may reduce the workload associated with this particular task, at the time it was a visual representation of the scale of the work at the larger practices for receptionists and how that scale impacted on each request.

There were also differences in the quality or the nature of the work, with the larger practices having less human interaction as part of the exchanges. A receptionist who worked in a smaller surgery, but who was a patient at a larger surgery in the area, described the difference in experience of the service she provided and the service she received.

> *The receptionist and I discussed the human interaction component of calling people back for their appointment. She told me that at the surgery she attends in [town name], they use a screen for check in and a screen that flashes your name when it is your turn. Sometimes she can arrive and get 'called back' without every interacting with a person.*
>
> *She described that once she had the experience where she had checked in with the screen and was waiting for a very long time. She finally went up and asked at reception, and it turned out the machine had not actually checked her in. She said it 'only happened once, but still...'*
>
> *She said she prefers what they do here, but that she understood why the other practice, which was bigger, did that. (S38O1)*

In this example, there was more work generated on the part of the patient in terms of time spent seeking care, because she waited for a long time while the system did not know she was there. There was likely also more work on the part of the receptionist to then check the patient in long after the appointment time slot had passed, because it may have required extra communication with the GP to explain what happened, and on the part of the GP who perhaps had finished the surgery session or moved onto other tasks or had taken longer with other patients because it had seemed like there had been a DNA. In general, it shows how individuals can get lost in the large, impersonal surgeries.

Besides the work created when the machine-driven check in and call back process did not work as planned, several respondents spoke negatively about the various aspects of the processes that had previously been human contact, being replaced with machines. The experience of being in the waiting rooms where patients were called back by beeping was unpleasant to me as an observer, because the beep was quite loud, likely so that it could be heard in a large space over the noise of many people in the room. Patients spoke of the difficulty of waiting when one needed to keep an eye on the screen for their name. Some surgeries gave you a number when you checked in, so that it was not your name flashing, and that added to the complexity as well because you had to remember your assigned number. Some patients did not like the systems where your name was displayed for all of the waiting room to see (IR11). It felt more intrusive for people to see your full name in writing for a period of time, rather than it being said verbally once. In addition, even if it was a person calling the name at a large surgery, they had to say it quite loud, and it often felt like a shout. This was jarring to me as an observer and seemed to be so to the patients. In contrast, in a small surgery, I noted the difference in quality of the interaction when the receptionist spoke to a patient to tell them to go back and see the nurse.

> *The receptionist told the next patient to go back and see the nurse. I note to myself again that she does not have to shout to do this, and it is a personal interaction of sorts. (S38O1)*

The personal interaction, from the proactive greeting and checking in, to the process of being called back for the appointment, set the tone for more personal interactions at the small surgeries.

For various reasons, the more human the interaction, the more efficient it was because it was able to be more accommodating, which enabled the work to be done then, rather than pushing it to another day. Importantly, at the small surgeries, this work could sometimes take the form of the proactive care that is needed to address health inequalities and unmet needs. The combination of the knowledge of patients, the ability to interact with them as individuals, and the feeling that the demand was more manageable, meant that the receptionists were able to be more thorough with a task, think about the person behind it, and proactively take a step that was actually more work. The lack of the other work generated by the complexity of the large practices, facilitated this ability of receptionists at the small practices. The vignette below from my observation in a small surgery demonstrates this.

Vignette 13: Proactive, opportunistic care at a small surgery

A woman arrived for an appointment and also submitted a prescription request. After checking the request, the receptionist called the woman back over.

The prescription was for the patient's daughter, and the receptionist had noticed that she had requested two Ventolin inhalers. She asked the mother if one was for school and one for home. The woman said, "yes" and that her daughter was "really struggling with it." The receptionist asked, "Is she due for an asthma check?" and looked in the record on the computer. The mother said that "she's never had one here" and goes on to explain that her daughter used to have a brown inhaler as well, but when they had registered at this surgery it had not continued. She did not remember what the strength was.

The receptionist asked, "Do you want to bring her in at 6:40 tomorrow for an appointment with the nurse?" The mother enthusiastically replied, "Yeah!"

The receptionist continued on that the GP would also be in the surgery at that time so could "sort out a prescription if needed."

The receptionist then wrote an entry into the daughter's record.

The other aspect of work besides the surgery work, is the work on the part of the patient and carer. This proactive care by the receptionist saved work on the mother's part by offering and scheduling the appointment while the mother was already there. She also anticipated that the GP would be able to sort the prescription for the patient if needed. If the patient's asthma had continued to go unchecked, it could have led to a poor health outcome, which would have been worse for the patient and likely more work on the mother's and the surgery's part to deal with an exacerbation of asthma due to poor control. It is another example of something I observed at a small surgery, but did not observe a similar example in the larger surgeries.

In summary, there was work at the larger practices which was caused by the cumulative effects of demand, rigid rules that did not fit needs, and an undermining of continuity of multiple types. In contrast, the small surgeries had less work of that type and therefore had an ability to do some proactive work instead that met patients' needs.

6.7. Unmet need and practice size

As I have shown so far in this chapter, practice size, and the effects on elements of the access paradox, seemed to affect the ability of staff and clinicians to consider and to perform some of the more proactive care work needed to address the unmet need in the population. The complexity of the large surgeries, combined with the greater sense of demand, meant more people feeling like they did not know how they fit into the practices' rigid rules. In smaller surgeries, the receptionists were more able to see and treat each individual as such, and they were able to coordinate more easily with the smaller number of clinicians to meet needs. Also the smaller surgeries were more embedded within communities, facilitating certain populations to seek care without physical distance as a barrier (S20, IR11).

Some patients commented on the issue of practices growing larger going hand-in-hand with losing a personal touch and not being proactive, even towards those in the population who needed it. One respondent (IR02), felt that the larger surgery size was almost being used as an excuse as to why the personal touch was not possible. She explained to me that especially for certain patients, that could be a real risk. She was referring to the care of her daughter, who had issues with depression and was a new mother, and who had not been contacted proactively by anyone from their large general practice about how she was doing, nor to discuss whether to restart her medication, post-delivery and through the first year of the child's life. Earlier in the interview, the respondent had explained how she had been an advocate for proactive care for her mother-in-law at the end of her life. She saw the similarities between the two needs.

> *By almost not being more proactive to follow up with her, as you said? (JV)*
>
> *Yeah, and, as I say, I do understand that time is limited, and if you're talking about having thousands of patients, and I'm sure practices are going to become bigger and bigger, but we daren't lose that personal touch. I'm absolutely certain that there must be some mechanism of being able to flag up people. They don't need to flag up me, because I'm the sort of person that, you know, "You can leave me. I'm alright. If there're any issues I'll get on to you," but somebody like her I think falls through the net, and my mother-in-law. (IR02, patient/grandmother)*

This patient and others, drew a distinction between themselves—who because of her own personality and other characteristics, did not need to be proactively followed up— and some of the more vulnerable members of the population and their own families who should be flagged to have more proactive follow up care. She attributed the inability to do this to the fact that surgeries were becoming larger, but she still thought it was needed and should be able to happen.

Besides the more personal feel of the smaller surgeries, the benefits of the local aspect, being more embedded within smaller communities, was discussed by several respondents. Several respondents mentioned this in terms of knowledge of the local area, which they felt more reassured by when the surgeries were staffed by people who knew the community or lived in or near it themselves, including the clinicians (IR02). One practical issue discussed by several respondents in regard to the high levels of deprivation within the patient population of T&G was the ability to travel to a GP appointment. Car ownership was very low in certain areas, and patients would therefore need to walk or take public transport, or rely on a ride from another individual or the local charity that helps give people rides to health appointments. A receptionist at one of the small surgeries within a community of high need mentioned this to me as noted in my fieldnotes below.

> *The receptionist explained to me that the surgery is here because the community needs it. There is low car ownership. (S20O2)*

The area of this particular surgery was also poorly served by public transport, with further cuts being made to the area’s bus service during the time of the study. Another receptionist at a practice that spanned two sites explained the issue as well that the locations meant most patients live within a mile of their surgery, so walk down (S44O1). The patient from Vignette 11 (IR11), mentioned that some of the receptionists at her surgery post-merger, like other people, have wrongfully assumed that she was entitled to a car because of her disability and that she drove. She expressed that they did not appreciate how difficult or costly it would be for her to travel to the other practice site when offering her appointments. She did not feel they were thinking of her and how much work that would require or how uncomfortable she might be, especially if unwell. She explained she usually would end up taking a taxi if she did have to go to that site, because she found the bus too difficult, and that was an expense she could not necessarily afford. She did not think that these receptionists who did not ‘know’ her considered these factors (IR11).

As I previously stated, some of the larger practices were known to be the hardest to contact via telephone. This was noted in the focus group of volunteers who tried to facilitate people with their care (FG2). The respondents described further inequities, with certain savvy people using auto-redial on their mobile phones to be more likely to get through, while some people did not know of or have access to such a function. In general it was felt that those who were able to advocate for themselves would do alright, regardless of these different factors, but for those who could not, size of the surgery, the rigidity of their policies, and the lack of personal touch, made it more difficult for those for whom advocating for themselves was difficult. At one large surgery, the local group had helped several deaf patients, who had multiple issues with the way the surgery functioned in regard to telephone triage rules and waiting room systems reliant on beeps, which had not taken their needs into account (FG2).

Another issue, related to size and safety netting, brought up by a GP (IR18) was that if a larger surgery failed, it would be a problem for more patients. This had happened in other parts of the country during the time of the study, and the upheaval caused was not one that the local GPs and patients wanted to experience. Given that it was actually the large surgeries struggling on several of the issues within the paradox, it was not unimaginable that it could happen. As with a lot of major changes, the people within the population least able to cope with the change, because of ill health and other factors, would fare the worst.

In general, the larger surgeries with the most rigid rules and problems with continuity, were the least able to be accommodating to the needs of patients in the population who required a more proactive or flexible approach. The smaller surgeries, often more embedded in the local community, were more able to understand and accommodate the needs of patients, including when a personalised touch was required.

6.8. Chapter summary

In this chapter I have built upon the understanding of the paradox of access problems to critique the trend towards larger practices that was favoured in policy circles, though not necessarily by patients and service staff, during the time of this study. The broad understanding of access that I applied to this research, along with my inclusion of multiple perspectives through my participatory approach and application of multiple qualitative methods, allowed for me to observe nuances of the elements of the paradox within surgeries of different sizes. In general, larger practice size added to the overwhelming feeling of demand, caused practices to be more rigid in their rules, created more barriers for continuity of several types, generated more unnecessary work, and left those with unmet needs feeling further isolated. This critique, utilising the understanding of access problems within the paradox, suggests *how* one might try to mitigate against the negative aspects of increasing size, in the reality of the mergers that have already occurred and larger practices that already exist. In the following chapter, I will build on the findings presented in these three chapters to elaborate on how the access theory that informed this work can be advanced to reflect the insights gained, and how the understanding of access in this way, combined with the understanding of existing problems of access gained, can lead to a different approach to optimise access to general practice in order to address persistent health inequalities.

Chapter 7. People-centred access: optimising the fit of human factors

7.1. Chapter overview

In this research I have applied a broad conceptualisation of access (Levesque et al., 2013), which along with my participatory approach and qualitative methodology, has allowed me to understand the complexity of people's experiences in context. In the previous three chapters, I presented a novel description of access problems in general practice as a paradox and critiqued the effects of two major policy trends on this paradox. In this chapter, I move beyond my application of the theory and present how my analysis processes enabled me to advance the theory (Kislov, 2019). While my application of theory helped me to understand the problems of access, my theoretical insights direct my novel suggestions for *how* to address those problems. In section 7.2, I present my advancement of the Levesque et al. (2013) framework from patient-centred to people-centred, emphasising the *people* on both the service and population sides, and the fit of human factors within the interaction of services and population needs. In section 7.3, I return to the paradox with this advanced theory applied to suggest how to address issues of access described in this work while also improving the workforce experience and reducing population inequalities of health. Through the insights presented in this chapter, I will demonstrate how I have met my research aim: population access to general practice can be optimised by focusing on the fit of human factors affecting the interaction of people on both the health service and the population. I argue that a lack of attention to these human factors is a driver of the issues of access with the paradox that I have described.

7.2. Advancing the Levesque et al. (2013) access framework

As I explained in chapter 2, I chose the Levesque et al. (2013) conceptualisation of access because I felt it was broad and comprehensive and appropriately highlighted the importance of the abilities of patients and factors that affected them. As I described in chapter 3, I utilised the access theory in multiple ways during this research, including discussing it with people during initial engagement and data collection, and throughout the analysis processes. This critical engagement allowed me to make several insights about the theory, in terms of how it resonated with the complex experiences that I came to understand. The breadth of the Levesque et al. (2013) conceptualisation of access resonated with the experiences I observed and heard. Respondents were appreciative of an idea of access that allowed for a range of relevant issues to be discussed, and felt it reflected their realities better than the more common use of access as timely access (IR01, IR04). The critical engagement also allowed me to consider what was missing from the conceptualisation that would enable it to better address the problems within the paradox and optimise access. I will explain these insights in the sections below.

7.2.1. Access is about people

Despite its clear relevance, one key omission in the Levesque et al. (2013) access framework, first pointed out to me by an interview respondent (IR10), was that it did not give equal weight to the people within the service side of the interaction, and their abilities. Reflecting on this insight across the whole of my data during analysis, it became clear that people were at the core of every interaction I observed or heard about. From multiple sources and in multiple ways, my data and analysis revealed that: access is about people. A word cloud created from a query across my entire NVivo project[12] depicts this insight visually, with ‘people’ as the most commonly occurring word, as shown in figure 5.

Figure 5: Project word cloud with ‘people’ at the centre

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[12] Query of 100 most frequent words with minimum 3 letters, with some words excluded, including participant identification codes and standard exclusions through NVivo. People appeared 2825 times.

Importantly, the *people* interacting, and their respective abilities, mattered in terms of whether a fit could be reached between the service and the need. Even when the issue was *about* something physical, like the location of the surgery and transport logistics, or the rules around appointments, it was an interaction between the person on the service side and the person on the patient side that mattered. Similarly, the ability of a GP to listen, whether their innate or learned ability, or their ability within the constraints of the appointment system and other demands on their time, affected the fit of another human interaction described by many participants. The people in the workforce even affected the interactions with the check-in screens or information materials, which would have had to be designed, chosen, or placed by people; or as my data showed, compensated for when the fit was not right. When present, knowledge or acknowledgement *of* the other person in the interaction *as* a person optimised that fit, while lack of this contributed to the inefficiencies I observed, and fuelled the paradox. Some patients described their realisation that 'GPs were people, too' as an important moment. Several patients expressed empathy for staff in difficult positions or a desire not to waste time or resources. For me, observing that acknowledgement of the other person as a person, when it *was* present, made it more obvious how the fit was adversely affected when it was not.

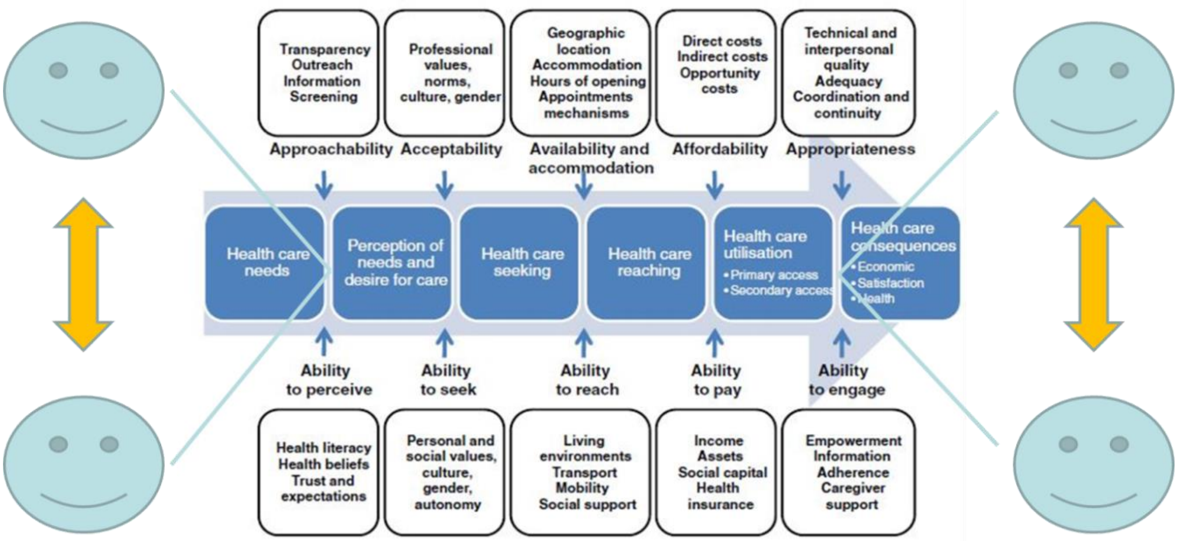
The importance of this insight can be understood in the context of existing theories of access. As I explained in chapter 2, while Penchansky and Thomas (1981) conceptualised the dimensions of accessibility of 'services,' others including Levesque et al. (2013) and McIntrye et al. (2009), embraced and modified that notion in terms of the naming of the various dimensions. However, my approach and analysis demonstrated that services are essentially clinical and non-clinical staff, people, working to provide care. The Levesque et al. (2013) conceptualisation had improved upon previous work by emphasising people's abilities in the population, as I explained in chapter 2. With my insights, the top portion of the Levesque et al. (2013) diagram becomes just as much about people as the lower half. I develop the work of Levesque et al. (2013) by also emphasising the people within the health service, and their ability to contribute to the human fit within the interaction of services and population needs.

7.2.2. From patient-centred to people-centred access

In this way, while the Levesque et al. (2013) diagram was relatively comprehensive in scope, it lacked an emphasis on the importance of the human aspect of interactions at the core of access, and specifically on the human component of the workforce within service delivery. Across my data, when things worked well, it was because of the fit of the human interactions and the optimising effect that it had on the limited resources of the services and the abilities of patients. When things did not work well, it was usually because of the lack of fit in those human interactions causing unnecessary work, frustration, and unmet needs in the population. At different points in the care process, the relevant interactions might be between patients or carers with receptionists or clinicians. Even previous interactions, knowledge of the other person, or lack of that knowledge, affected future decisions and behaviours. All people on both sides, and their respective relationships, were important.

Levesque et al. (2013) called their model ‘patient-centred’ in that it emphasised the importance of people’s abilities in the population (Levesque et al., 2013, p. 1). Given the above insights, I propose that an access model that embraces the importance of people and their abilities, on *both* the service and population sides of the interactions equally, would be called ‘people-centred,’ rather than patient-centred. Importantly, I do not intend for this conceptualisation to detract from the importance of being patient-centred, but rather to acknowledge the humans necessary to be *able* to be patient-centred. Figure 6 demonstrates this initial advancement of the access theory to people-centred access, with an emphasis on the fit of the interactions between people on both sides.

Figure 6: 'People-centred access' as the fit of human interactions between people in the service and the population [modified from Levesque et al. (2013)]



It is necessary here to acknowledge the wording choice of my advancement and once again acknowledge an area of the conceptual literature with overlapping use of terms: patient-centred, person-centred, and people-centred. A brief review of the meaning and use of these terms will also clarify that I intend this advancement to be more than semantic. Also, while resonating with the existing use of the 'people-centred' term, namely by the WHO, it is also an advancement of that conceptualisation (World Health Organization (WHO), 2015).

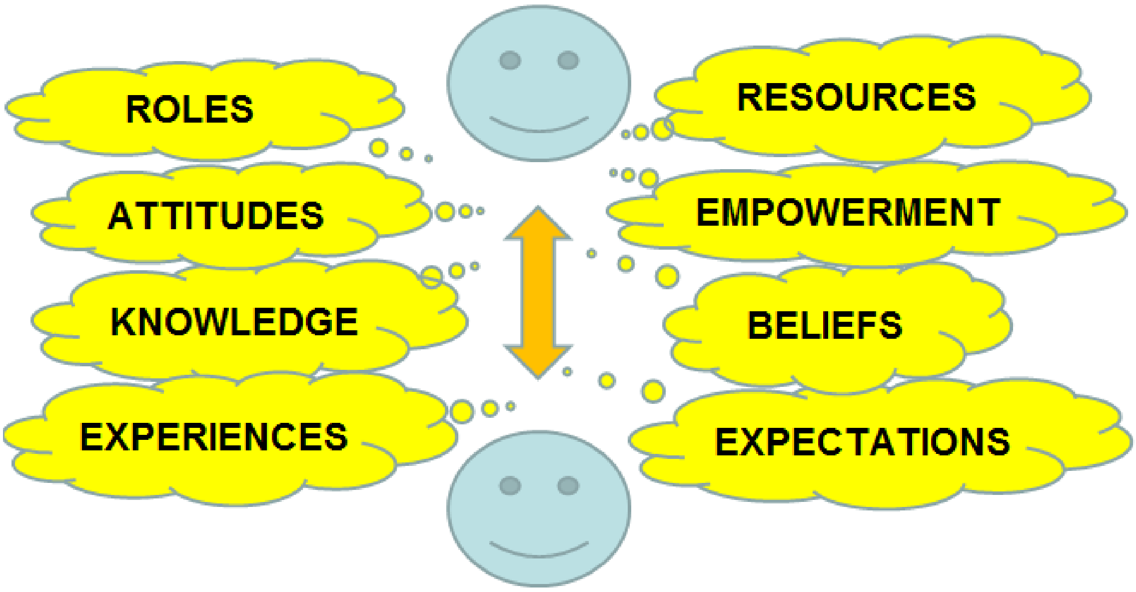
To simplify decades of conceptual work on the matter (Corrigan, 2005; Greene et al., 2012; Ishikawa et al., 2013), patient-centred implies healthcare services designed and delivered with the patient's needs as the core focus. Person-centred is closely related, but some prefer it in order to recognise the whole person and their circumstances, rather than just their identity as a patient (Koubel and Bungay, 2008; World Health Organization (WHO), 2015, p. 48). The Levesque et al. (2013) model could have been called person-centred given that it certainly considered the whole person and social determinants of health, but use of these terms often varies between countries and disciplines without specific substantive difference. People-centred, as the WHO uses it, recognises the plurality that people live within families and communities and the importance of carers in caring for and seeking health care for a patient (World Health Organization (WHO), 2015). In this respect, the Levesque et al. (2013) model could have also been called people-centred, given that he specified the abilities of people within ‘populations, communities, households, and individuals’ (Levesque et al., 2013, p. 4). The WHO’s definition of people-centred care also emphasises the need for people to have the education and support to make decisions and participate with their own care (World Health Organization (WHO), 2015, p. 48), an idea that is reflected in the content of the population’s abilities boxes and the interactive nature of the Levesque et al. (2013) model.

My advancement of the people-centred concept, in light of the above insights into the original Levesque et al. (2013) model, is that the plurality *extends* to include the *people* within the service workforce, whose abilities and other factors, as I will elaborate below, are essential components of *how* to provide care that is based on an understanding of, and able to meet the needs of, *people* within the population. I suggest that to truly understand access as the interaction or fit, is to focus on the human factors affecting the abilities of people on both sides.

7.2.3. Human factors affecting the interaction between services and the population

Focusing on the interaction between people on the service and population sides, several factors emerged inductively from my analysis processes as relevant to achieving a fit between services and needs. I have called these human factors the ‘roles,’ ‘resources,’ ‘attitudes,’ ‘knowledge,’ ‘beliefs,’ ‘experiences,’ ‘expectations,’ and ‘empowerment’ of people on both sides, in a relatively equal milieu of importance and individual complexity. Figure 7 represents these factors, present for people on both sides of every interaction, but varying from individual to individual.

Figure 7: Human factors, of people with the health service and the population, affecting access interactions [to accompany modified version of Levesque et al. (2013)]



Below I will demonstrate the utility of conceptualising access as the interaction of these human factors with illustrative descriptions of each. Understanding access in this way indicates *how* to optimise the fit and these factors represent targets for improvement. In the paragraph that follows the list of factors, I will relate them to relevant existing concepts in the literature.

- The concept of ‘roles’ reflects each individual’s place within the interaction and also their other roles in life. A receptionist might also be a mother, a patient, or might have had other skills from previous jobs. While a patient is more than just a patient, within care seeking, their main role is to be a patient. Still, patients might draw on their individual professional skills and other life experiences. While these roles can enhance the interaction, they can also detract. For example, if someone is distracted by something else in their life in one of their other roles, it may affect how they interact with someone else. Knowledge of or acknowledgement of these roles can improve the interaction.
- The ‘resources’ available to people on each side are important as well. Within the service side these vary as each practice has different facilities, different rules, different colleagues, and different ways of working. Patients clearly have different

resources available to them, which directly affect their health and their ability to seek care.

- Crucially, ‘knowledge’ relates to health literacy, both the ability to understand issues of health and illness and of how to seek care. Acknowledging the different knowledge that the people on each side of the interaction have is key to addressing access, as I will expand on further. This includes having knowledge, or an openness to knowing, about the other person, first as a person, and then about their individual circumstances.
- Past ‘experiences’ inform how people will interact, for better or worse. Patients reported feeling judged by the actions of others, with strict rules or questioning from receptionists, when they were not someone who had abused the system.
- ‘Empowerment’ has to do with people’s abilities within their roles to act as they see fit or not. This can vary for a number of reasons on both the service and population sides of the interactions.
- ‘Beliefs’ affect people’s actions on both sides and are important to understand even when they are different.
- ‘Expectations’ are relevant on both sides as well. Patients have expectations, based on a lot of the above, and people on the service side do too. Understanding these expectations and considering them can go a long way towards optimising the interactions.

Drawing attention to these human factors, as affecting people on both sides, represents another aspect of my advancement of the Levesque et al. (2013) framework. While some of these concepts are reflected in the boxes of the Levesque et al. (2013) framework affecting the abilities of the population side, they are not present to the same extent on the service side of the diagram. Furthermore, some of these factors resonate with components of other theories of access, but generally those have only focused on the patients, such as Aday and Andersen’s ‘enabling components’ (Aday and Andersen, 1974). Similarly, the effect of experiences on future patient expectations and behaviours is inherent in candidacy (Dixon-Woods et al., 2006), yet I observed these factors affecting receptionists and clinicians as much as I did the patients. Equally these observations go beyond current efforts to consider skill-mix of service staff, yet acknowledge the need, as some authors have, of considering and empowering the staff involved in these interactions to shape and implement changes (Brant et al., 2018; Sibbald et al., 2004). Focusing on the interaction between two people can help to neutralise some of the tension around the roles, expectations, and other factors listed which affect people on both the service and population sides. In this conceptualisation, it is not about who is 'right' or 'wrong' on either side of the interaction: the goal is to obtain a fit. As I will explain below in section 7.3, aiming to achieve a fit reflects a different approach to addressing the issues within the paradox of access.

In addition to the literature mentioned above, with which these insights resonate, there is relevant research about the role of receptionists as the leading human face of access to general practice. This research supports the idea of a focus on the people and the human factors affecting these interactions. Previous research has established that receptionists have to deal with the patient expectations of the "dragon myth" in these interactions (Hammond et al., 2013). How patients anticipate these interactions affects their ability to seek care, and yet also affects different patients differently. Furthermore, the importance of individual-level receptionist differences has been demonstrated by a recent study that analysed routinely recorded telephone interactions at GP surgeries and characterised differences between individual receptionists' helpfulness in terms of their style of interaction and how that affected patient burden (Stokoe et al., 2016). The contribution of these research efforts is synergistic with my insights, as one can imagine being the patients in the example the authors present, in which a receptionist might say 'no' to the patient's request and leave it at that, or might say 'no' but still try to help (Stokoe et al., 2016). This type of detail suggests the kinds of changes or the types of skills that could be directed towards receptionists to account for personality differences and facilitate a more equitable access experience for patients. I will explore further suggestions and relevant literature around the work of receptionists in section 7.3.

7.2.4. The role of continuity within access

A final aspect of theoretical advancement to discuss, before moving on to addressing the paradox, is the role of continuity within access. As I described in chapter 2, I chose the Levesque et al. (2013) framework because it included continuity within access, rather than as a separate, opposing entity, and because it reflected a more nuanced understanding of different aspects of continuity (Haggerty et al., 2003). Understanding 'people-centred' access reinforces this notion that continuity is part of access. However, rather than being confined to one box (appropriateness) on the service side, (Levesque et al., 2013), within my concept of people-centred access, continuity permeates the entirety of the interface. As I will discuss further in section 7.3, continuity is a crucial component of the fit of human factors at each stage of the care seeking pathway, and therefore contributes directly to the optimisation of access.

During the course of my research several further studies have been published which highlight the importance of continuity for important outcomes such as secondary care utilisation and death. Using a database from GP electronic medical records, Barker and colleagues examined the association of continuity of care and hospital admissions for 'ambulatory sensitive conditions' (Barker et al., 2017). They found that higher continuity of care was associated with fewer admissions. They also found that continuity was lower in practices with more doctors (Barker et al., 2017). Other researchers examined the effect of continuity on mortality in the first systematic review to examine this question. They found 18 of 22 qualifying studies reviewed showed a statistically significant reduction in mortality with increased continuity of care (Pereira Gray et al., 2018). These studies, in addition to those I reviewed in chapter 2, represent further evidence of the value of continuity, and support my theoretical insights, which emphasise the central importance of continuity within access.

In chapter 2, I acknowledged that the RCGP had embraced the above definition of continuity and was a proponent of the role of continuity within general practice, despite governmental policies that had devalued it (Baker, 2016; Hill, 2011). Recently, both the RCGP and NHS England have launched separate, but related, efforts to advance 'person-centred care’ and ‘personalised care’ respectively (NHS England; Royal College of General Practitioners). The fact that the efforts are somewhat coordinated is a promising sign. However, by and large, these organisations view these initiatives as separate from their efforts on continuity, and importantly, their efforts around access. My people-centred advancement of the access theory demonstrates how these concepts are linked. Therefore, my insights can help to bridge the gaps between these currently different work streams by finding the common goal that unites the concepts: optimising the human fit between the people in the service and the population: people-centred access.

In summary, the above advancements in the Levesque et al. (2013) access framework reveal *how* to optimise access: by focusing on the fit of the human factors of people in the population and people within the health service. In the next section I will apply this understanding to the paradox of access problems described in this work.

7.3. Addressing the access paradox

In this section, I will apply the advanced understanding of ‘people-centred access’ described above to the paradox of access problems presented in chapters 4-6. I will discuss the resulting novel targets for change to optimise access by addressing existing problems of access in the context of this understanding, focusing on people and the human fit of interactions. As I explained in chapter 2, one of the reasons I chose the Levesque et al. (2013) framework of access was that it opened up targets for change that included the abilities of people within the population. Further research by the IMPACT team, which used Levesque et al. (2013) framework to categorise international access interventions, found that most interventions targeted the organisational and system-level determinants within the health sector, with few aimed at improving patients’ or populations’ abilities (Richard et al., 2016, p. 1). To address these gaps, my suggestions are aimed at people on both sides and at their interactions and relationships. My findings and theoretical advancement suggest this is *how* to address access: to target the factors affecting people’s abilities to reach a fit from both sides.

Before addressing the individual parts of the paradox, I will establish a few principles for addressing access, which have emerged as important from my research. The first principle is to clearly define access. This work strives to be an example of the difference it makes in the ability to understand people’s experiences to broadly and purposefully define the concept, and the value of that was echoed by many participants. The second principle is to understand the problems before thinking of solutions. This work also strives to be an example of that, having established within the literature review and the findings how many efforts have not done this important step. The third principle is that big change is disruptive and creates more work. When one considers the people who have to explain, deliver, and access services, the persistent confusion and resulting inefficiencies around past and recent changes are clear. The final principle is that more is not necessarily better. As my literature review and my findings have shown, supply-side interventions to create more service are expensive and often still fail to address the underlying issues.

Despite my recommendation of a major shift in how access is conceptualised and addressed, my suggestions are more along the lines of incremental improvements to the human fit than transformational change of services. They are suggestions that consider and respect the people at the core of these interactions, and as I did with my participatory approach and qualitative methodology, involve working together with these people and considering their perspectives. Importantly, they are about understanding and optimising the resources we have, including the knowledge and other human factors of people on both sides. Along these lines, once again aided by the Levesque et al. (2013) framework, which was designed to be relevant at different levels, from individuals to populations and health systems, these suggestions are aimed towards and can be taken up by people on all levels. Indeed the purpose of these suggestions is to engage and empower more people to address these problems by turning these ideas into action. As I describe my suggestions, I will relate them to ongoing efforts, often not badged as ‘access,’ to further make the case for optimising existing resources that this view of access facilitates. However, in the following discussion of addressing the paradox, sections will not represent an exhaustive list of all possibilities. Rather they consist of a legitimisation of addressing the paradox as an approach to optimising access, and aim to provide a sense of *how* efforts to address access in this way would be different.

7.3.1. Influence demand

In this section I will discuss *how* to address the demand that is affecting general practice by influencing demand rather than merely reacting to it. Notably, this strategy of influencing demand goes beyond recent work to describe the increased workload in general practice and GP strategies for coping with it (Croxson et al., 2017; Fisher et al., 2017). This strategy requires a focus on the population side of the access framework, which is often missing in access interventions (Richard et al., 2016). There are many potential ways to influence demand, and these could be discussed and acted upon at various levels, including national and regional policy, commissioning, among practices and their PPGs, and within patient populations. Many participants felt that influencing demand was possible and should be pursued as an alternative approach to optimising access than creating more services. Importantly, coordinated efforts to proactively influence demand could free up capacity within general practice to address the unmet need within the population.

One example of an important target to influence demand is health literacy (Nutbeam, 2008), present in the Levesque et al. (2013, p. 5) diagram as affecting the ‘ability to perceive’ health care. Health literacy is directly linked to the human factor of knowledge that I described in my theoretical advancement, and therefore, like the other human factors, it affects interactions at every stage of the care seeking pathway, as I depicted in figures 6 and 7. My data reflected a lack of awareness, by people within the service, of the knowledge gaps between the population and themselves, particularly about health and about the provision of services. My data also showed the information efforts to inform people about changes were often not a priority, and they did not reflect the general poor understanding of increasing complex service provision and rules that had resulted from decades of poorly-explained changes. These gaps in knowledge and lack of awareness are examples of the lack of fit of the human factors that can be addressed through a focus on health literacy. Improving health literacy within the population has the potential to directly improve health, which is the ultimate goal, and to influence demand through improved health in the population (Berkman et al., 2011). Importantly, health literacy also affects health seeking behaviours and care utilisation (Berkman et al., 2011), and so has potential to directly influence demand. On the service side, receptionists' knowledge and health literacy would benefit from being improved, including some basic training on mental health first aid or about common conditions that can affect one's ability to articulate a healthcare need. Importantly, the purpose of this type of service-side intervention, aimed at the people within the service, would be to improve their ability to reach a fit with more patients. In general, improved awareness of the health literacy, and general literacies, levels of others within the population would help the health service to reach a fit for more people.

Understanding access in this way establishes health literacy as an important target when addressing access by influencing demand. Importantly, some of the relevant resources that could help tackle this issue lie outside of the NHS. For example, health literacy could be improved through changing curriculum in secondary education, so that more people finish school with a practical understanding of both issues of human health and illness and the NHS. Within the NHS, improved information campaigns could be run at multiple levels, filling the many information gaps. With more attention paid to this issue, those in the service and other parts of the public sector could realise the importance of focusing on information and the knowledge of people. Another important source of this information and services to address health literacy and population health to influence demand is public health, technically separate from the NHS after the HSCA (2012) (following a long history of debate within government over the place of preventative care). Several participants cited current public health campaigns, which encouraged patients to seek care for certain symptoms, as adding to the overall demand on general practice. Public health and general practice could work together to create better campaigns that, on the whole, optimise access to general practice through efforts to improve health and health literacy. While there are efforts within NHS England to address health literacy, they are not necessarily supported with the resources on the scale of the expensive service creation, and there is not widespread acknowledgement of their value (Berry, 2016; Greenhalgh, 2015). Importantly, they are generally not what is considered or done when trying to ‘improve access.’ However, my data and insights, as described, indicate that these efforts are an example of what should be bolstered and invested in to improve access in the ways I have defined: to influence demand in order to optimise the human fit of access. As I have stated, there are many more possibilities to further influence demand, which as I will expand on in the next chapter, can and should be devised by others. Here, I have established influencing demand as an alternative way to directly address the access issues described in this project.

7.3.2. Simplify and flex rules

In this section I will discuss how to address the complicated and rigid rules that I found to exist within the access to general practice paradox. As I described in chapter 4, some of the rules were explicit and some were implicit, almost hidden, which compounded the complexity. In addressing this aspect of the paradox, it is useful to consider relevant literature around organisational routines (Pentland and Feldman, 2005), as well as observational studies within general practice, which have explored the dynamic interplay between the actions of people and the rules, as they exist or are understood (Swinglehurst et al., 2010; Swinglehurst and Fudge, 2019). Pentland and Feldman (2005) conceptualised two key aspects of routines: ostensive (the generalised rules or organisational scripts) and performative (what people actually do in practice). Swinglehurst and colleagues applied these concepts to reveal hidden work and ‘workarounds’ by various members of the primary care team (2010), which were relevant to important issues including safety within medication management in polypharmacy (2019). The lens and the language of organisational routines resonate with the observations around the complex and varied rules in general practice that I have presented in this thesis, and shed light on the dynamic interplay between the ‘rules’ and the people within the system working to understand and enforce those rules.

Applying my concept of people-centred access, with the goal of achieving a fit of human factors to optimise access, one can see that after first accounting for both the rules that exist and that are implied by the routines observed, a logical alternative to creating more rigid rules, as many interventions still try to do, is to reconsider and simplify the rules, in order to appropriately anticipate and consider exceptions to the rules. The Levesque et al. (2013) framework established that ‘appointment mechanisms’ and ‘opening hours’ represent a small aspect of access. My review of interventions and my data showed that they have received a lot of attention over the years as possible solutions, often in a one-size-fits-all fashion. As I have demonstrated, even when interventions were not successful, such as Advanced Access, the associated rules have lingered, which has created numerous instances of an ill-fit between services and needs, and within conversations between people on both sides, increasing work and unmet need as a result.

Therefore, my suggestion is to focus less on the rules as a solution, and to reverse some of the problems caused by the current rules by reconsidering them and planning for exceptions. This suggestion is informed by my people-centred access concept, the human factors affecting the interactions between patients and receptionists, and the literature around organisational routines (Pentland and Feldman, 2005). In addition to the roles each person has, knowledge and empowerment were revealed in my data as important in terms of whether or how an exception to a rule was made. To be able to make an exception, a receptionist had to acknowledge the patient as a person and take into consideration their individual circumstances. At different surgeries, the resources, including the environment and practice size, affected the ability of receptionists to be empowered to make such exceptions. I noted that GPs were more empowered to make the exceptions. Sometimes this appeared to be because of their greater knowledge of the patient or their condition, and sometimes because of the authority associated with their role, compared to the receptionist. The human factors involved in such dynamics are essential to address in order to strive for a more equitable rule system that allows for appropriate flexibility and achieve a fit of the service and the needs. Knowledge of organisational routines could help practices understand the complexity of this issue to begin to address the various rules and resulting routines.

Efforts to focus on reconsidering and flexing the rules could largely be done at the practice level. However, practices could work with their PPGs and all of their staff to articulate both written and hidden rules, and reconsider which ones are creating extra work or additional access barriers. This type of exercise would also improve the participating patient population's knowledge of the existing rules, since as my data demonstrated, even PPG members might not understand these. It would also improve the staff members' awareness of the patients' understanding of rules, since, as I discussed above, there were gaps observed. Practices could also coordinate at the neighbourhood or CCG level to align their rules more to help reduce variations, which would allow patients at different surgeries to share knowledge about rules. Further steps could then be taken to address these knowledge needs from a health literacy standpoint, from these different levels, as I described in the last section.

7.3.3. Restore continuity

In this section, I propose a focus on restoring and improving continuity as a way to optimise the human fit of access in general practice. At the heart of the access paradox, and my advancement of the access theory, is the mutual knowledge and acknowledgement of the people on both sides. As I explained in section 7.2.4, the Levesque et al. (2013) framework included continuity under appropriateness, yet the idea of considering the interaction of human factors permeates the entire understanding of access that I have described. Continuity can be addressed at a number of levels and in a number of ways. Practices could examine continuity of all types, and question how things have changed over time, how continuity currently exists, and what is possible to improve. Once again, they could do this exercise with all staff and with their PPGs. This approach would acknowledge and address the multiple perspectives of people on both sides of the interaction, and generate a space for understanding and addressing differences in valuing continuity that the literature I reviewed in section 2.3.1 (Alazri et al., 2007; Guthrie and Wyke, 2006) and my data demonstrated. This improved understanding around the valuing of continuity and appreciation of existing continuity would increase the likelihood of achieving a fit of human factors, consistent with my theoretical insights.

Continuity has not been a priority in policy around general practice and particularly around access interventions. Rather than further undermining continuity, policies should consider the growing body of evidence around the importance of continuity for desired health outcomes (Barker et al., 2017; Huntley et al., 2014; Pereira Gray et al., 2018), and aim to promote it. Importantly, the full scope of the concept of continuity should be applied to the issue so that the value of aspects, such as receptionist continuity, is recognised. This way of viewing and valuing continuity resonates with the idea of access as the interaction or fit of human factors between the service and the population, which I have established in this research. As I described in chapter 2, a Nuffield Trust report examined the effect that access policies have had on continuity (Palmer et al., 2018). However their relatively narrow view of access limited the ability to see how the two can be synergistic. My recommendations go beyond those in this report to highlight the importance of continuity in achieving a fit within access that reduces the unnecessary work that an ill-fit creates and optimises the use of healthcare resources to reach more of the population.

7.3.4. Reduce unnecessary work

Following on from the above, in this section I discuss reducing unnecessary work that my data revealed as being generated through the rigid rules and lack of continuity within the access paradox. In applying my people-centred access concept, to acknowledge the people on both sides of the access interactions is to value them and their time. Previous research has revealed the important and often hidden work of receptionists in general practice (Swinglehurst et al., 2011; Ward and McMurray, 2011). My findings resonate with these, and more recent work published during my study, which reveal the nuances of receptionist work around access (Neuwelt et al., 2015; Neuwelt et al., 2016) including in facilitating new interventions (Brant et al., 2018). Once revealed, the hidden work generated by some of the access routines of general practice, and by some of the interventions to improve access, can be acknowledged and addressed. Particularly the work generated from the ill-fit of certain rules not aligning with patient needs can be acknowledged and reduced by applying the understanding of access achieved in this project. The increased work on the service side generated by this lack of fit can contribute to increased stress and decreased job satisfaction, which can further contribute to staff shortages and turnover. My findings suggest opportunities to reduce future work by aiming to reach a fit during initial interactions, something that was not always done. Consistent with the studies mentioned in section 7.2, some of this depends on individual receptionists (Stokoe et al., 2016), and therefore training efforts could be aimed at improving the ability to reach a fit with patients' needs and abilities. There is a relevant movement within the UK healthcare landscape to take a small amount of time to do something that will save someone else much more time, called 15s30m (Bradford Teaching Hospitals NHS Foundation Trust, 2019). This quality improvement (QI) initiative resonates with my data on work within the paradox, in which it was sometimes clear that if someone had taken a little more time to reach a fit, a lot of work could have been saved, on both the service and population sides.

Focusing now on the population side, the hidden work of accessing care presented in my findings resonates with other research efforts to understand the hidden work of being a patient. Corbin and Strauss described three types of work by patients and caregivers: illness work, everyday life work, and biographical work (Corbin and Strauss, 1985). Minimally disruptive medicine is an international movement in healthcare that specifically aims to consider and reduce the work of being a patient in relation to patients' individual capacities (Leppin et al., 2015; May et al., 2009; Shippee et al., 2015). While the movement focuses on treatment burden and creating plans with patients that are reasonable and realistic in the context of their lives, the concept is also relevant more broadly within access. My data suggest that the work of care seeking is potentially competing within patients' overall capacity, potentially limiting them from being able to do something positive for their health or within other aspects of their life, or causing some to decide not to seek care. People-centred access, focusing on achieving a fit, aims to optimise people's abilities and reduce unnecessary work. Addressing this issue practically, practices could look for the hidden work on both sides and trace back to the causes of it to make changes. As with other suggestions, reception staff as well as the patient population should be included in looking for ways to reduce this work. Reducing this work has the potential to free up capacity on both sides and optimise the fit by reducing barriers.

7.3.5. Tackle unmet need

In this section I will discuss how to address the unmet need described in the paradox of access problems. My people-centred access concept includes a focus on finding a fit of human factors across the population and health services. Viewing access in this way demonstrates the importance of people in the health service being able to reach out to people whose own circumstances may affect their abilities to seek care. The Levesque et al. (2013) framework included outreach in the ‘approachability’ dimension of access. My theoretical insights move beyond that to suggest the importance of staff being able to be proactive along the care pathway to compensate for various limitations in the abilities of patients. These insights resonate with the work on health equity that I reviewed in section 2.3.4, which highlighted the importance of primary health care services considering the social determinants of health in addressing health inequalities (Rasanathan et al., 2011). In this way, on the service side, interventions can consider what resources and knowledge staff need to be able to be proactive and create a fit. On the population side, interventions can focus on patients’ abilities and factors necessary to help them successfully identify a need and reach care for it. Health literacy is relevant once again as an access intervention directed at the population side.

While focusing on the human fit across the population can reduce demand, flex rules, restore continuity, and decrease unnecessary work, the ultimate goal of addressing the paradox is to be able to address the unmet need that drives health inequalities. Many participants recognised the need for this capacity within the system, yet described the current lack of efforts to address this unmet need. Within the UK there are some ongoing efforts to raise similar awareness of this unmet need and provide appropriate resources, skills, and support to GPs, for example in the most deprived areas (Watt et al., 2012). Similarly, there are some specific efforts to commission dedicated care for certain at risk groups, such as homeless populations. These efforts are promising and resonate with this work. However, to optimise access across the population, these approaches need to become more the standard way of providing care, so that the NHS is more inclusive and meets its own vision for equity, not just in provision, but in access (Powell and Exworthy, 2003). More engagement from the service is needed with existing groups to understand their needs and the barriers that they face, with a goal of shaping services and resources that allow for a human fit.

7.4. Chapter summary

In this chapter I have returned to the access theory that informed this work and advanced it by emphasising the human fit of the interactions of people on both the service and population sides. I have shown through this advancement that to optimise access is to focus on the human factors that affect these interactions. I have applied this advanced theory of people-centred access to the paradox of access problems in general practice, which I have described in this thesis, and made suggestions to directly address the issues within the paradox in order to optimise population access. In the next, final chapter, I will discuss the overall contribution of this work in further theoretical and practical contexts.

Chapter 8. Discussion and conclusion

8.1. Chapter overview

In this final chapter, I will summarise the contribution of the work described in this thesis. I will then relate my findings, theoretical insights, and recommendations to the existing literature and to current real-world developments. I will reflect on the strengths and weaknesses of this research, including my methodological approaches. Finally, I will discuss the practical, policy, and research implications of this thesis for future work.

8.2. Summary of thesis contribution

This thesis is comprised of a qualitative, participatory case study of access to general practice in one area of northwest England. In chapter 1, I began with a contextual summary of the growing policy interest around access to general practice, since the founding of the NHS and in the decades leading up to this research. In chapter 2, I utilised a critique of the theoretical literature to apply a broad conceptualisation of access, as the interaction or fit of population needs and healthcare services, to review existing interventions in the UK. This application revealed several gaps around whether, how, and with whom previous efforts had defined access or articulated the access problems that interventions aimed to address. To address these gaps, I articulated the overall aim of this work to understand how to optimise access to general practice, and several research questions involving understanding multiple perspectives around existing issues, efforts to improve access, and the role of theory and participatory approaches in contributing to findings that were useful in practice, policy, and research. In chapter 3, I explained and justified my decision to conduct an instrumental case study using a participatory approach and qualitative methodology. In chapter 4, I presented a novel description of access problems as a paradox in which the demand has masked and created unmet need in the population through rigid rules, undermining of continuity, and unnecessary work. In chapter 5, I examined the main policy intervention around access during the period of the study and demonstrated that, like other interventions before, it had failed to adequately conceptualise access or address existing problems, and therefore had worsened the access paradox. In chapter 6, I examined the effects of the trend towards larger practices on the multiple issues within the access paradox. In chapter 7, I presented the theoretical insights I made during this work and described an advanced concept of people-centred access as the human fit of people within both the health service and the population. I ultimately addressed my research aim by concluding that addressing existing issues within the paradox with a focus on the human fit of people on both the service and population sides is *how to* best use resources and optimise population access. In the following sections I will further relate this contribution to the existing literature and to relevant current developments, highlighting how the approach I took to the topic, including the questions I asked and how and with whom I went about answering them, have facilitated novel advancement of theory, understanding of problems, critique of current trends, and suggestions for the future.

8.3. Relation to existing literature

It is important to relate my contributions to various relevant literatures. In this section I will discuss my findings and insights in the context of current literature around access theory, efforts to improve access, and other concurrent trends in general practice.

8.3.1. Access theory

As I have described in this thesis, to address the gaps I found in the intervention literature, I purposefully chose a broad theory of access (Levesque et al., 2013) to apply within this work. This application facilitated my understanding of experiences of access, and I was able to articulate an advancement of the theory that should help guide *how* to address existing access issues through interventions that focus on the fit of human factors in order to optimise population access. During the course of this research, further work was published around theoretical conceptualisations of access including their application towards understanding experiences and addressing existing issues. While my findings and contributions resonate with much of this work, I demonstrate in the discussion below that mine remain novel in this context.

In chapter 2 I briefly discussed the access framework published by Campbell and Salisbury (2015) in the *BJGP* after my project was already underway and I was generating data within my case study. Their model includes several concepts that I believe are important, including equity (Campbell and Salisbury, 2015). However, the model is difficult to follow, and the theories they cite are limited (Campbell and Salisbury, 2015) and do not include Levesque et al. (2013). While they adopt the 'A' dimensions of access from Penchansky and Thomas (1981) (Campbell and Salisbury, 2015), they do not embrace the 'interaction or fit' concept of access, which I found to be key and which I elaborated on in my advancement of the theory. However, despite my critiques of this model, it is an important example of leading scholars of general practice in the UK calling for consideration of theory in addressing longstanding issues of access and equity, something of which my work is very much an example.

Other recent efforts to conceptualise aspects of access include applying the concept of bricolage to describe the resourcefulness and improvisation necessary for diverse populations to have their healthcare needs met (Phillimore et al., 2019). While not specific to the UK or general practice, this conceptualisation resonates with my findings around the human factors necessary to seek and reach care, and different populations or individuals would be affected differently by the enforcement of rules and expend different amounts of their energy and capacity on seeking care. In this way, the work of Phillimore and colleagues (2019) also resonates with the minimally disruptive medicine movement (Leppin et al., 2015; Shippee et al., 2015), which I mentioned in chapter 7, and with my extension of that concept to the care seeking processes, in addition to the treatment burden focus of the movement.

Additional research in the UK during the time of this study also resonates with my contributions. A realist review of 162 international studies that focused on access to primary care for socioeconomically disadvantaged older populations generated a seven-step patient pathway with an accompanying context-mechanism-outcome configuration for each step (Ford et al., 2016, pp. 4-11). While the strengths of this research effort were their awareness and inclusion of concepts such as candidacy (Dixon-Woods et al., 2006) and their acknowledgment of the ‘dynamic, iterative and multidimensional nature of access’ (Ford et al., 2016, p. 2), they do not appear to be aware of the Levesque et al. (2013) conceptualisation of access. However, their resulting conceptualisation of a patient pathway is similar to the steps at the centre of the Levesque et al. (2013) framework. The context-mechanism-outcome configurations are detailed for each outcome/step of the pathway and resonate with the concepts mentioned in the Levesque et al. (2013) framework as abilities of patients and with my human factors. However, it is only in the ultimate ‘primary care interaction’ outcome (step 6) that they include anyone on the service side as being relevant in these processes (Ford et al., 2016. p. 11), something that is counter to the recursivity inherent in theories such as candidacy (Dixon-Woods et al., 2006) and the Kovandzic et al. (2011) model. While their concept is supported by the evidence synthesis presented, the contribution is limited by lack of emphasis on the interactions of people on both the service and population sides along the care pathway, which my thesis has demonstrated are important and reflect the issues described in the other theories above. Despite these limitations, the similarity between the findings of this work, based on a realist literature synthesis (Ford et al., 2016), and mine, based on an application of theory (Levesque et al., 2013) to empiric data, can be viewed as adding to the credibility of each.

Internationally, following the mapping of interventions exercise (Richard et al., 2016) that I have referred to in this thesis, the IMPACT team has continued to apply the Levesque et al. (2013) framework in six regions of Canada and Australia to address local issues of access (Russell et al., 2019). Although they have been applying the theory to design and deliver interventions, they have not yet completed their mixed-method evaluations of this work. Similarly, they have not published any revisions of the theory. I await further publications of the work of this team, applying similar participatory research approaches to address local access as I did. However, in my project, as I have discussed, I emphasised applying the theory to understand the problems in order to develop future solutions. In focusing on the interventions, perhaps these efforts may not have spent the time to understand the local problems before trying existing mapped ,or even local devised, interventions.

In summary, my contribution resonates with several of the more recent theoretical and applied work on access to health care, yet my contribution to the theory, building on the work of Levesque et al. (2013), remains unique.

8.3.2. Extended access

Within this thesis I have critiqued previous efforts to improve access to general practice in the UK, in chapter 2, and the main effort to improve access during the time of this study, seven-day extended access, in chapter 5. My application of a broad conceptualisation of access allowed me to understand the nuances of people's experiences and recognise that the seven-day access programme was flawed in logic and execution. It was not based on addressing the issues that those in general practice were facing, nor on the needs of patients. In this way, my findings are very much in line with other assessments of various seven-day extended access efforts around the UK, which were completed during the time of this study. The different publications and evaluations that I will describe below used a variety of methods and asked questions in various ways. As I discuss my findings in relation to these, mine stand out as an in-depth understanding, as few, including official evaluations, involved patients, GPs, and other stakeholders in determining what questions to ask and how to go about answering them, as I did. Few were qualitative, but those that were focused on how the implementation of the intervention worked and what barriers and facilitators were encountered (Elvey et al., 2018). Several of the quantitative evaluations focused on utilisation of the service (Whittaker et al., 2019). The approach many of these efforts took, or were commissioned to take, limited the research questions they were able to ask about the service. Despite that, as I will describe, the evidence overwhelmingly agrees with the experiences I observed in-depth. My application of theory throughout the project goes some way to explaining why this intervention did not solve relevant access problems: it was another example of an access solution, based on a narrow conceptualisation of access, that did not know what problems it was trying to solve and did not understand the potential implications of fuelling existing problems by using resources and yet worsening trends that have led to persistent inequalities in the population.

Research efforts to establish whether the seven-day access service was needed analysed GPPS data and used logistic regression to determine that most participants (80.9%) did not report any problems with opening times (Ford et al., 2015). Of the 19.1% who reported inconvenient opening times, 73.9% stated Saturday opening, and 35.8% Sunday opening, would make it easier for them, with only 2.2% stating that Sunday, but not Saturday, would make it easier (Ford et al., 2015). Authors found that younger people, those who work fulltime, and those who could not get time off work reported weekend opening would help, while those with Alzheimer’s disease, learning difficulties or problems with activities of daily living were less likely to report weekend opening would help (Ford et al., 2015, p. 1). These findings resonate with the utilisation, or lack thereof, of the hub appointments I observed, and as I will demonstrate below, with several other studies and reports on whether there was demand for these extended services at the weekend, particularly Sundays.

A report by the National Audit Office (NAO) in 2017 examined the resources dedicated to improving access to general practice under the extended access schemes. They compared cost per appointment hour per 1,000 registered patients, and calculated extended access to be £230, while core general practice was £154 (National Audit Office, 2017). This represents the disproportionate expense of the extended access appointments. The expense appears even greater when considering the high DNA rate and questionable reasons for the appointments, including self-limiting conditions that may have resolved without care, and the inability of GPs to multitask around the many other aspects of their workload besides seeing patients face-to-face, that I demonstrated in chapter 5. The NAO report explained several key findings that are synergistic with my contribution: “The Department [of Health] has recognised the importance of improving access and set some high-level objectives for this, although it has limited understanding of the pressures in general practice” (National Audit Office, 2017, p. 5) and “The Department and NHS England have not fully considered the consequences and cost-effectiveness of their commitment to extend access" (National Audit Office, 2017, p. 6). My contribution is an in-depth understanding of general practice, along with insight into the consequences of this ideological commitment to extended access. The NAO report goes on to recommend that "NHS England should seek greater assurance that services in core hours meet the reasonable needs of patients" (National Audit Office, 2017, p. 10). My theoretical insights around applying the concept of people-centred access, suggests *how* NHS England and other stakeholder could go about meeting the needs of patients in the population by focusing efforts on the human fit with people in the health service. It is also worth acknowledging the aspect of the workforce in general practice, which this report highlights, and which is also a crucial factor in increasing the human fit. The government's original pledge of 5,000 more GPs and 5,000 more other workers in general practice would help, especially if trained in this understanding of access and in agreement in the goal of optimising the human fit as the goal of access. However as it is now 2020, the original deadline for the 5,000 increase, and the latest figures show that the numbers in general practice have only decreased since these pledges in 2015 (Pearce, 2020), it seems that, as I will discuss in subsequent sections, focusing on those workforce goals might be more in line with the way to address access that my thesis suggests.

Several evaluations of regional extended access programs also provide insight that is synergistic with my findings. A 2017 evaluation of seven-day access hubs in Nottinghamshire, dealt with the issue of the offer of weekend access to general practice and described it as a matter of incorrectly framing the question (Centre for Health Innovation Leadership and Learning, 2017). Its authors determined that asking if people want more access does not address whether it will actually be used if it is created. They also claimed it is not about the number of days. I agree with both of these insights into the issue. The evaluation itself, about use of the service found low uptake in general and that working people, at whom the service was targeted, were not using it (Centre for Health Innovation Leadership and Learning, 2017). My findings complement and explain some of the reason behind these patterns. However, the authors of this evaluation concluded that speed of access was the priority of patients, not seven-day opening (Centre for Health

Innovation Leadership and Learning, 2017). I feel that this finding is limited by their approach to the issue. Similar to other access efforts discussed in chapter 2, which framed speed of access and continuity as a dichotomy with a choice (Bower et al., 2003), they framed this question as a choice of two things, both of which reflect a narrow way of defining access. I would argue from my findings that it is not about a choice between seven-day access and speedy access, but about creating systems in which the people working are able to recognise and meet the needs of the population.

Several studies that have evaluated the use of services in regional initiatives, including in Greater Manchester (GM), showed the relatively low use of the services. One study looked at the rates across five of the areas within GM as part of the official evaluation of the extended access regional policy (Whittaker et al., 2019). Authors found that 65.33% of appointments provided were booked and attended, describing ‘spare capacity’ in the service, especially on Sundays where usage was 46.73% (Whittaker et al., 2019, p. 1). The author’s findings on usage are consistent with my experience of underutilisation on Sundays. However, my data go further to reflect the continued unmet needs that persist when the only effort to improve access continued to ignore the existing problems within general practice. In addition to evaluating whether the service was used, researchers have evaluated the effect on A&E use, one of the original goals of the initial pilots in GM. Authors found that patient-initiated or ‘minor’ A&E attendances were decreased through a difference-in-difference (DiD) analysis of those registered at a practice with extended access compared to those who were not (Whittaker et al., 2016). However, this analysis did not demonstrate a statistically significant decrease in total A&E attendances (Whittaker et al., 2016), raising questions about how the A&E attendances were categorised and whether a substantial number of patients were then referred by the extended-hours clinicians to the A&E for what may have been appropriate usage of A&E. One study evaluating the effects of extended access through weekend opening in general practices on A&E use in London found a 9.9% decrease in A&E attendance (Dolton and Pathania, 2016). Authors note that the impact on attendances was bigger among wealthier patients (Dolton and Pathania, 2016). It is notable that these pilots were within existing general practices, so in thinking of why or how they might have led to a decrease in A&E, I suspect that the continuity provided by a known GP had a role in the effect, rather than the generic access 'hub' model that has become more common. In addition, the fact that the decrease was greater among wealthier patients raises questions about their use of services and whether this intervention addressed the unmet needs in the population, including those facing economic deprivation.

In summary, while my findings resonate with these other evaluations of seven-day extended access efforts, the criticism remains that many of these efforts still defined access in such a narrow way as to miss the point of the true problem of what was missing. Because I was studying access, and this intervention as a part of it, I was able to examine effects, or lack thereof, on existing problems in a way that other evaluations did not attempt. In section 8.4 I will touch on some current developments to address access, which further resonate with the direction of my findings around the need to apply an access theory to address existing problems.

8.3.3. General practice size

As described in chapter 5, I observed notable differences in surgeries of different sizes, in terms of various aspects of the paradox. These findings resonate with other work about practice size and its effects on aspects of care quality and experience. Reviewing the existing literature, in light of my findings, provides further insights to guide future decisions within the provision of general practice, in order to compensate for the potential effects of larger-sized practices.

Some authors have noted overall mixed opinions and effects of practice size within general practice in relation to various important outcomes (van den Hombergh and Campbell, 2013). Certainly within the NHS, when the Quality Outcomes Framework (QOF) was introduced, there were potential differences in practices of different sizes being able to complete the additional work required to report to the scheme. However, whether that translates into improved quality of care or not remains unknown.

In a survey of two areas of London, researchers found that patient "responders from smaller practices reported improved accessibility of care and receptionist performance, better continuity of care compared with larger practices, and no disadvantage in relation to 10 other dimensions of care" (Campbell et al., 2001, p.644). These findings resonate with my observations within the smaller practices. This survey data can be explained through some of my more in-depth insights around *how* continuity and receptionists' knowledge of patients are important aspects of access. Interestingly, the authors found no disadvantage in relation to other dimensions of care. Authors went on to describe that "practices with smaller numbers of patients per doctor had longer average consultation lengths than those with larger numbers of patients per doctor" (Campbell et al., 2001, p. 644). This observation resonates with the multiple factors that affect the human fit. If doctors have the time to listen and use their abilities within the consultation, they will, but if they have less time per patient because of workforce ratios, the length of the consultation might be affected, and according to my insights, also the human fit.

While the above study sheds light on some of the positive attributes of smaller practices, other studies have cast doubt on assumptions about the presumed ability of larger practices to provide more enhanced services (Morgan and Beerstecher, 2009). Authors found that average-sized surgeries provided a similar volume and diversity of services as the largest, and that there was little merit in creating 'supersurgeries' (Morgan and Beerstecher, 2009, p. e71). Other studies have cast doubt over the assumptions that larger surgeries offer superior care. Authors found that while smaller practices received fewer QOF points, it was due to lower attainment in the organisational domain with no differences in the other domains, including clinical care (Wang et al., 2006). Despite the mixed evidence around practice size, this has been the general trend, with the effects on experiences and the individual human fit that I described in my findings.

Along these lines, a systematic review of international studies on quality of care and practice size found that "of the three studies on patient-reported outcomes, smaller practices were consistently found to be associated with satisfaction with access, but evidence was inconsistent for other patient-reported outcomes evaluated"(Ng and Ng, 2013, p. e604). This synthesised survey data is consistent with my insights that the ability of receptionists and clinicians to make appropriate accommodations and exceptions for individuals relates to an overall likelihood of reaching a fit. That these abilities were more readily observable at smaller practices, and that patients whose practices had changed and grown over time reported less satisfaction in reaching a human fit, provides further potential explanation for these patterns.

In general, my findings contribute to a developing picture of the impact of practice size on clinical factors and experience. By considering both the paradox and the understanding of access attained as the interaction and fit of human factors on both the service and population sides, one can begin to see *how* size matters and *how* one could mitigate against some of the effects of increasing size, since that trend is in motion for complicated reasons.

8.4. Relation to current developments

In this section I will relate my findings to some of the current developments within general practice and access. I will discuss developments and their relation to my insights beginning with the local level and expanding to the regional and national levels. I will use this section particularly to highlight elements of my participatory approach that have allowed me to engage with these ongoing developments.

In some respects the conversation around access has moved on in ways very much consistent with my findings. Locally and regionally at least, I have wondered if my engagement and earlier dissemination of my approach and my findings has influenced any of this thinking. However, as I will explain, the extended access ideas and programs have become further embedded at all levels, despite the various forms of evidence against them. Nationally, there is slightly less focus on extended access as *the* solution, perhaps because of the change of health minister from one that was pushing the idea of a seven-day NHS throughout the service. However, what has replaced it as *the* solution, in terms of digital-first and online consultations models endorsed by a new health minister who was formerly the digital minister, have the potential to repeat all of the same mistakes as extended access and previous interventions, in terms of the ill-defined concept of access and the touting of solutions that do not match with existing problems or evidence.

8.4.1. Local developments

Within Tameside and Glossop, as within the region and nationally, the extended access services have continued since the time of my data generation, though with some changes. The priority of integration of health and social care through Care Together resulted in the merger of Tameside council and the CCG as commissioners (Tameside and Glossop CCG, 2020). The focus has been on healthy life expectancy and reducing health inequalities within the area. In many ways the shared responsibilities and budget have potentially allowed for appropriate targeting of the human factors, including social determinants of health, that affect the demand on general practice and the other elements of the paradox, as well as the overall human fit of services and needs.

On multiple occasions, I have shared my interim findings with various local groups that I engaged with throughout the project. I have done some feeding back sessions with existing patient groups, networks, and other community groups to discuss what they can to do contribute to next steps, and I plan to do several more. The Equality and Diversity Group within the CCG that I served on, as well as a few of the patient and community engagement teams, have been affected by the merger of the CCG and council and no longer exist. However I have made links with the Partnership Engagement Network that has replaced it and hope to present at future workshops to inform more broadly about this work and this understanding of access to enable others to help take next steps. Although the CCG has changed and many people have moved on, including from various positions of power, I have many links still existing within it. I have presented to the Primary Care Delivery and Improvement Group, and I will again in order to plan next steps. I will also present to and engage with the local workforce groups including the relatively newly appointed ‘workforce fellow’ in T&G, funded by the CCG. Related to that, I have an opportunity to inform the future specifications for the Local Enhanced Service around access. I have followed up with some individual practices, and several of my team members who are based in practices have brought insights from the project back to their own work, and shared the resulting discussions and decisions with me. I have presented the early findings at a forum for local practice managers and hope to again. Together, raising the awareness locally of this understanding of access and the current problems should spur activity on multiple levels to begin to reconsider *how* we address and improve access to optimise population health.

Going forward, there is scope to influence the shape of the extended access services, including through the out-of-hours provider who is now providing the service. However as it is a commissioning decision, the CCG will remain as the main place of influence as I have described above. The goal would be to demonstrate *how* to build in some of the elements of care that have been eroded through the paradox, which were certainly not considered in early iterations of these services. The Primary Care Networks (PCNs), and the neighbourhoods that had previously formed in T&G, will be another avenue for dissemination. I have plans to present the work to our local monthly continuing professional development event for clinicians, in partnership with the CCG and perhaps other stakeholders around this work. The intention would be to share this understanding of access more broadly, have more surgeries and individuals hear about what I found, and let staff decide at what level(s) they would like to start addressing access in this way.

The local hospital trust has become an Integrated Care Organisation (ICO), and through their Person and Community Centred Care Approaches team, they are looking to better integrate with primary care. One early effort is to understand demand on general practice, and they are currently supporting local practices to assess the extent to which a concept called ‘failure demand,’ in which demand for general practice services is generated by a failure elsewhere in the health or social care system, is a factor (Downham, 2019).Through this effort, individual practices are currently incentivised to collect two types of data around demand for services over a brief period before the end of the financial year in order to explore this. I look forward to working with this team from the ICO in order that this effort and other future activities stemming from my project work can together address issues of access in ways that optimise population health.

Locally, as elsewhere, more work still needs to be done to directly address the unmet need I discussed in this work. However, some services are beginning to work in partnership with community organisations that are close to the people needing a different kind of approach. I hope that the efforts and findings from this thesis can help those collaborations go about the changes in service provision in a way that addresses the underlying problems in equitable access that have been present for so long.

In general, in line with the principles of participatory research, there is still much dissemination, engagement, and future work to be done together with those I have engaged with in the local area. It is consistent with the principles of CBPR that this work would serve to enhance the area that allowed itself to be studied and the people who partnered with me in various ways to do the research and be able to use the knowledge gained to move forward with next steps together.

8.4.2. Regional developments

Within the Greater Manchester region, the HSCP has shaped the context of the evolving developments. As I have explained, the seven-day service mandate affected what was done around access to general practice during the study period. I have made links within the HSCP and will continue to feed back these findings to the relevant teams. The HSCP recently released its newest Primary Care strategy (Greater Manchester Health and Social Care Partnership, 2020), and compared to the earlier strategy that I presented in chapter 1, there are some notable differences. Even though the extended access of routine and urgent appointments at weekends seems to be here to stay within the region, there is a lot that is *not* being said about access or a focus on timely access, compared with the previous strategy. Instead, for example, there is a section on continuity. Through the engagement work early on in my project, I was involved in some interim discussions around the GM primary care strategy, though I did not have any direct influence on this document. Once again, it is difficult to know how I may have affected conversations or understanding through this engagement. There is further potential for me to work within this strategy with the links made within GM to inform as many as possible about this alternative way to view access, the problems within it, and the types of changes needed to address these problems.

My PhD was embedded within the NIHR CLAHRC GM, as I have explained. The regional focus of academic and service collaboration has been continued through the NIHR ARC

(Applied Research Collaborations), with which I still have links. The new infrastructure involves a partnership with Health Innovation Manchester (HIM), which means that I will have a continued platform of collaboration that I can inform with my findings and use to potentially influence policy and evaluation decisions at the regional level. This collaboration represents an important opportunity for this work to have further impact within the region. While there is PPI required through the ARC, my hope is that, in addition to the content of my findings, my approach will serve as an example of working with people through participatory research to best value the skills and perspectives that different stakeholders can bring to such a collaborative effort.

8.4.3. National developments

Nationally, this work resonates with some recent developments, yet still remains distinctive in its contribution. I presented this work at the RCGP conference, and it was well received, including by leaders within the college. Several other presenters at the conference genuinely questioned the dichotomy of access and continuity. However, my insights provided a crucial and unique overarching understanding through my application of theory of how the two concepts are related in a way that can address longstanding issues. Many of the GP presenters at the RCGP conference spoke from their own experiences around the UK, which provided assurance that these insights were not specific to Tameside & Glossop (T&G) or Greater Manchester.

As I mentioned in chapters 2 and 7, the RCGP has long been a proponent of the value of continuity and currently has several streams of work around continuity, person-centred care, and workforce. I have become a part of the Person-Centred Care Network of Champions and hope that will be a place to disseminate this work and build future partnerships, helping the College to link these efforts, which seem disparate on their webpages, by disseminating a broader view of access. The RCGP person-centred care programme is working in partnership with NHS England’s personalised care effort, as I mentioned in chapter 7. The contribution of my thesis resonates with these various work streams, as I have shown. However, my findings could be further leveraged to unify some of what appear to be disparate efforts, and to demonstrate the connection to the broad understanding of people-centred access.

On the national political scene, access to general practice is still a focus, with the prime minister mentioning it in his first official speech in the role (Bostock, 2019). However the discourse is still somewhat stunted with the narrow concept of access as timeliness. Access was mentioned in terms of waiting times to see a GP, without consideration for whether any waits were acceptable and requested, or the fact that many practices have a separate system for dealing with urgent appointments, making the wait for a routine appointment less meaningful.

There are some signs that NHS England is looking to approach access differently in order to reduce inequalities, based on a 2018 report (NHS England, 2018). In this report, authors applied Ford's pathway concept (Ford et al., 2016), which is a rare example of consideration of theory in such a document. However, as I discussed above, this framework fails to capture the importance of the fit of human factors on the service and population side at the various stages of the pathway. Knowledge or incorporation of the Levesque et al. (2013) framework, and of my people-centred advancements of it, could make the ideas in this document more relevant to the day-to-day experiences of patients and people within general practice. Despite this, the document is a promising example of a broader conceptualisation of access and awareness of the theoretical literature by a part of the health service, and it resonates with my findings.

8.5. Strengths and limitations

In this section I will summarise the strengths and limitations of this thesis. Along with the strengths, I will include a summary of the quality of this qualitative research and a final summary of the reflexivity that I undertook throughout this work. The limitations will include a scrutiny of my methodologies and direct the implications that I will elaborate on in the subsequent section.

8.5.1. Strengths

This thesis has several strengths as an example of a qualitative, participatory case study. One strength was my application and advancement of theory. As I have made clear in this thesis, the important step of defining access, or not, has implications for the success of efforts to understand access. By choosing a broad theory (Levesque et al., 2013), I was able to include a variety of relevant experiences to understand the current situation in general practice and identify what access problems existed. Importantly, because of my analysis processes, I was able not only to apply the theory, but also advance it, a step that has been flagged as often omitted in applied health research (Kislov, 2019).

Another strength was my participatory approach. Having engaged with a diverse group of stakeholders early on in the project formation, I was able to make decisions about the research with them and with their perspectives in mind. I found that the CBPT's input was crucial in the design, execution, and dissemination of this work. Given the links made, I did not struggle with recruitment, as I had individuals who knew the practices and groups in the area, and were able to suggest and facilitate connections which strengthened the diversity of my sample. People respected that I had come to them early, and others who participated in the study appreciated that I was working with local patients and GPs on the efforts. The CBPT also assisted with analysis, as we made sense of the findings from and for the multiple perspectives we had included. Finally the CBPT has helped to plan the local dissemination, which is in progress and will ensure that these findings will be shared with those who gave their time for the project or were otherwise interested. Several groups that were engaged are looking to move forward with the findings, given that, as I have described, they agreed that the research was needed in order to better approach access than what was coming down from the top through policy.

A third strength was the multiple qualitative methodologies I employed. I was able to gain an in-depth understanding of complex issues by getting close to my participants in the most appropriate way according to their circumstances. For receptionists and others within general practice, it was key to be able to observe and question their work and their interactions with patients, and to have informal opportunistic conversations with more and a more diverse group of practitioners than I could have invited for formal interviews or focus groups. The individual interviews and focus groups allowed me to accommodate those who needed me to visit their homes or place of work, or to utilise the space and community of an existing group to hear a collective experience.

8.5.2. Quality, rigour, and transparency

As a qualitative research endeavour, it is worth reflecting on relevant aspects of quality and rigour. Mays and Pope (2000) describe processes and concepts to assess quality in qualitative research, based upon rigour, transparency, and transferability. I have endeavoured to make this thesis a transparent account of my approach to the topic of access, including justifying and demonstrating my processes and decisions, while designing the study and generating and analysing data. While my identity as the main researcher on this project undoubtedly has shaped its ultimate contribution, my awareness of this and my efforts to account for this by partnering with my CBPT are strengths of the work. In this way, while this research was about a specific area, the findings, presented along with my transparent account of research processes, are reasonably transferable to other areas and the wider context of general practice in the UK.

Another aspect of quality in qualitative research is the triangulation of different perspectives and different forms of data (Mays and Pope, 2000). This project is an example of that, given the multiple perspectives sought during data generation, through interviews, focus groups, and observation sessions. In addition, these perspectives were highlighted further by utilising my diverse CBPT to contribute to analysis of the data. My sampling was able to include meaningful interaction with or information about a majority of the practices in the area, with variation in practice size, contract, and location. This maximum variation of the sample also contributes to the idea of transferability described above.

8.5.3. Reflexivity

Reflexivity is an important aspect of quality within qualitative research (Mays and Pope, 2000). It involves being mindful of one’s own experiences and bias, and aspects of one’s own identity that affect the research. I practiced reflexivity throughout this project. I kept a diary of thoughts and made regular reflections, as my own identities changed over the course of the project and when an event or conversation outside of the official project data generation affected my perspective. Specifically, as I alluded to in the ‘About the author’ section that precedes the main body of this thesis, I have reflected on my initial identity as someone who was trained as an equivalent to a GP, but new to this country and system, and not yet allowed to work as a GP here. This identity prevailed throughout data generation, which allowed me to emphasise certain knowledge that I had to relate to different people within the system, yet certain access I did not have, which allowed me to relate to various lay people. During the writing stage and later analysis stages of this thesis, I became a practising GP within this system and area, which created opportunities to reflect on the contribution of my work in a different way. Also, I became a mother at the same time that I was able to begin practicing as a GP. This identity necessitated a break from my PhD in the form of maternity leave, yet it also has brought me closer to the identities of the various patients and carers who I heard from during data generation. It also gave me a shared identity on a human level with several members of my CBPT and with individuals within the area who I engaged with around the implications of my findings. It is also worth noting that the GP and mother identities prolonged the writing stage of this work, given that I worked part-time on the PhD to allow time to work in and acclimate to general practice, whereas before that I was full-time on the PhD. Overall, my awareness of my identities described here, as well as my own personal motivations as a researcher and clinician, which I elaborated on in chapter 3, have comprised an additional aspect of transparency for this work.

8.5.4. Limitations

There are several important limitations to this work. One is that it was a single case study consisting of only one area. Although I have justified this decision and the resulting depth of my coverage of the area, and of the understanding of existing issues, suggest that it was the correct one, there is the chance that what I found in T&G is not transferrable to other areas. While that is a possibility, I do not think that is the case. T&G represented a relevant area with representative issues of diversity and deprivation that make this work relevant to England. In addition to the findings, the theoretical application and approach to access that this work represents, is not limited by the application to one area. Indeed limiting the study to one area facilitated my engagement activities and participatory approach, and allowed for thorough coverage of the diversity of the area through sampling. Both of these important factors would have been undermined if I had chosen either a larger area or multiple areas.

Another limitation of this thesis is that it was strictly a qualitative study. There could have been some benefit to generating quantitative data as well as qualitative, to complement the depth of my research with breadth across the area. However, given the practical limitations of an individual PhD project, the restriction to multiple forms of qualitative enquiry was justified. Earlier in this chapter I was able to relate the contribution of this work to other existing literature, including quantitative research. My project is unique in this space in the amount of depth and complexity captured through these methods. Since, as I explained in the gaps I saw in the literature that a broad understanding of existing issues is what was needed, the decision to limit this work to qualitative is further justified.

A third limitation of this work is the pace at which it was completed. Thorough research can be a slow process, and as has been made apparent, policy decisions are often made before research can inform such efforts. I have explained above the circumstances leading to this work being completed over a longer period of time. However, it is also important to note that the initial stages through the data generation and a significant portion of analysis were done over a shorter, intense period of two years. While the data was initially generated several years ago, the analysis has continued during the writing process, and the continual reflection I have done within my various identities into the implications of this work has assured me, and should the reader, that unfortunately the findings and the contribution are still very relevant and reflect the different approach to access to general practice that is still very much needed.

While not a limitation of the PhD itself, the changing landscape of the NHS over the course of this study, including people’s roles, created additional challenges, particularly for the participatory aspects of the research effort. While some CBPT members were able to participate throughout the project, others only contributed at certain stages either because of roles being changed or eliminated, or because of secondment. Additionally, NHS leadership, both local and regional, changed over the course of the project, such that several of the people I initially engaged with around the idea of doing this work were no longer in post upon completion of this thesis. Importantly, the additional work created by the continual system and role changes also prevented some CBPT members from participating on the team to the extent they originally hoped. My interim updates during the project helped to mitigate this reality, and I balanced my focus on developing the thesis as a product, with the desire and tasks of engaging with and updating those within the CCG, council, hospital system, and regional infrastructure who occupied relevant roles.

8.6. Implications

In this section, I will summarise the implications of this research for the future in terms of practical implications for people within the population and within general practice, for policy-makers, and for researchers.

8.6.1. Implications for the population and general practice

There are many practical applications of this work for the population and general practice, some of which I have mentioned in the above sections. At the multiple levels I described in section 8.4, there is potential to target the population directly to improve their health literacy in a way that would shape demand to make the fit more efficient. There are also multiple levels to alter the focus of improving the delivery of general practice to some of its earlier core values that have been eroded over the years, like continuity and therapeutic relationships. Some of these changes could happen with the knowledge and perspective change that my thesis provides, which should enable people in multiple roles to see the shortcomings of previous efforts to address access and the lack of justification for a narrow conceptualisation of access. Quality improvement (QI) efforts within general practice could incorporate this understanding in the design and execution of ideas for improvement around the human fit. This work reinforces some of the key principles within QI and highlights the need for diverse perspectives in understanding the problems (Royal College of General Practitioners, 2015). In some ways, QI principles and participatory action research principles overlap, so my contributions should transfer to inform that world relatively easily. As I have mentioned in chapter 7, this work could be done in partnership with PPGs, or PPGs and other patient and community groups could take action on these issues themselves.

8.6.2. Implications for policy

There are several implications for policy from this work, some of which I have alluded to in other sections. In general, as multiple chapters of this work have indicated, policy makers need to think more broadly about access. The trends of the past several decades and the in-depth evidence and insights I have demonstrated here show the impact of the narrow definitions and politically-driven discourse around access. RCGP does not have a direct effect on policy, but it is in a position to influence policy, especially if able to show synergistic abilities to solve multiple longstanding problems through a broader conceptualisation of access. As I described in chapter 7, the contribution of this work resonates with some national efforts around person-centred or personalised care, but not necessarily with the efforts badged as addressing access.

8.6.3. Implications for research

There are several implications for research relating both to the content of my contribution of the thesis findings and the methodological approach I have taken. In this section I will discuss the implications within different related realms of health services research and also describe my own ideas and plans for future research.

As I have described, my work makes a theoretical contribution to the access literature. Other researchers looking to understand access or develop interventions to improve access can consider this alternative way of defining access and of understanding the complex problems of access that exist in the context of general practice in the UK. In addition to building on my theoretical advancement and findings, health services researchers who are required through NIHR funding to do PPI can look to this work as an example of participatory research that goes beyond some of the mechanical tokenistic tendencies of PPI.

The next steps for further research are clear for myself and other researchers. While the gaps identified in this thesis necessitated that I focused on understanding access itself and the problems of access in UK general practice, next steps must involve actively trying to address these existing issues by applying this understanding of people-centred access. I plan to continue to work locally to develop and evaluate relative interventions in partnership with stakeholders. As I mentioned, there will be lessons to learn from the work of the IMPACT team internationally (Russell et al., 2019). Regionally I plan to continue to work with the ARC and encourage collaboration to address these longstanding issues. Nationally I hope to influence research projects and will continue to share my findings and interact with relevant communities of researchers to develop a relevant shared understanding of access that looks to optimise existing resources and address population health inequalities.

8.7. Conclusion

In this final chapter I have summarised and scrutinised the contribution of this thesis. I have demonstrated that I have met my overall research aim to understand access to general practice from multiple relevant perspectives in order to consider how to optimise population access, and have answered all of my research questions. I have demonstrated the value of applying theory and with working with people in a participatory approach. I have made a novel contribution to the literature, actively contributed to current developments, and identified multi-faceted implications for the future.

In summary, this thesis has identified gaps in the literature around previous approaches to understand and improve access to general practice in the UK. By working with and considering the perspectives of multiple relevant stakeholders in a single area, I conducted an instrumental case study of access. I have presented a description of a paradox of access problems, in which demand on general practice has created and masked a persistent problem of unmet need through rigid rules, undermining of continuity, and unnecessary work. I have also critiqued the major effort to address access during the time of this study and examined the effect of an ongoing trend towards larger practices. My in-depth understanding facilitated key insights into the broad access theory I applied, allowing me to present people-centred access which focused on the fit of human factors of people on both the service and population side. I have related my findings and insights to current literature and current real world developments to demonstrate how they complement various efforts to address issues, yet contribute a novel vision for how these complex issues are related and *how* they can be addressed by people at multiple levels. I am hopeful for the future, that with the right understanding of access, the right targets in mind, and the right approach, that those in the population, in general practice, in policy, and in research, can begin in address the longstanding issues in general practice, optimise these valuable resources, and reduce health inequalities.

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Appendix 1: Project team member role description and agreement forms

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Access to General Practice in Tameside and Glossop
Project Team Member Role Description

This document *describes* the role of the community-based project team for the *Optimising Access to General Practice in Tameside and Glossop through Community-Based Participatory Research* project. It was co-written with initial project team members.

Why study access to general practice in Tameside and Glossop?

Appropriate access to general practice is an important issue for the sustainability of National Health Service (NHS) and the health of the population. Patients contact general practice more than any other part of the NHS, and general practice plays an important role in tackling population health disparities.

Within Tameside and Glossop (T&G), an area with large population health disparities, access to general practice has not been studied in depth. We aim to understand the experiences of patients accessing general practice services and of healthcare staff and commissioners responsible for general practice services. We will use qualitative research techniques such as interviews, focus groups, and observation to understand experiences in context.

We will do this to help inform local efforts to improve care delivery, care experiences, and the health of the population of T&G. We also hope to learn how a model of partnership on a local level can be used to examine the issue of access can lead to a different level of understanding and different solutions than what has been tried before.

Who is doing this project?

Dr. Jennifer Voorhees, a general practitioner, is facilitating the project to earn a PhD in Medicine (Population Health and Primary Care) at The University of Manchester. The project is sponsored by the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester. CLAHRC is a grant from the National Institute of Health Research that the university has in order to work with health and community organisations in Greater Manchester to study issues of local health importance.

Jennifer's aim is to do this research in partnership with a community-based project team. She also has a supervisory team of faculty at the university: Dr. Kath Checkland, Professor Heather Waterman, and Dr. Simon Bailey.

Why do 'community-based participatory research'?

Community-based participatory research (CBPR) is an approach to research that recognises the potential contributions local community members can make by bringing them onto the research team. The resulting 'academic-community partnership' can make research more culturally and logistically appropriate and more relevant for the community. It can also improve the research outputs and lead to more sustainable changes. Participation in the research process can also build capacity of the local community members.

Who will make up community-based project team?

Jennifer reached out to individuals in the T&G community from October 2014 through March 2015 to identify initial team members. The goal was to create a project team with a mix of service users (patients/carers/members of the public/representatives from community organisations) and service providers (commissioners, healthcare professionals, general practice staff). This mix reflects the range of research participants we plan to recruit for the qualitative study. She asked individuals who else she should reach out to.

An initial project team met in March, April, May, and June 2015. Members have contributed to the design of the research including this role description. Membership will be open to other people who may become interested in joining us over the course of the project.

Why have I been invited to be on the team?

You are either a resident of T&G, a patient or carer or service user registered with a general practice surgery in T&G, a member of a community organisation based in T&G, or a healthcare professional, healthcare staff member or commissioner in T&G. Because of your experience as the above, as well as other life experience you may have, you have something valuable to contribute to the research process.

What will I be asked to do as a member of the team?

The role of the team is to partner together to design, implement, and disseminate the research project. You will be invited to attend project team meetings every 1-2 months, lasting 1-2 hours. These meetings will be facilitated by Jennifer. Team work at the meetings will consist of planning data collection, analysing data, planning dissemination products, and planning next steps. Team members will contribute to the decision-making of the research project.

Some individual members may be involved in additional work outside of meeting times, for example to help with data collection at focus groups, or to be involved in different stages of analysis. The individual team member can decide whether to contribute in these ways as the project progresses. Each individual team member's contribution may be different, and while members are welcome to contribute in these other ways, they are not obligated to do so.

Jennifer will work to support team members to ensure they are comfortable with their roles, and training will be provided as appropriate to allow members to contribute to the extent that they would like to. Lay members will be offered compensation for their meeting attendance time at a rate of £15/hour and a contribution towards their travel costs of £5/meeting. Additional reimbursement for additional activity time will also be available.

Are there ground rules for the community-based project team?

There will be ground rules for the community-based project team. While the identity of the team members is not confidential, team members are to treat project-related information discussed at team meetings as confidential. This pertains to any personal stories individual team members might share and discussion of the research participants and/or the data project data (until we agree upon dissemination.)

We may record the project team meetings in order to capture the dialogue and discussion to feed back into the project. These recordings may be transcribed, and will feed into project team meeting summaries and the analysis process. We may choose to write about our research process, and this will help keep track of our thoughts and decisions over time.

Your name, contact information, and agreement form will be stored safely at the University of Manchester. To check that the study is being carried out correctly, people from the University of Manchester, or other regulatory authorities such as the NHS, may look at the research documents, including your information. This is for auditing purposes only.

What will happen to the results of the project?

You have the ability to influence what we do with the results of the project. The aim is that the results will help to understand the current situation in T&G and improve care. We will write reports, including in academic journals and for the community. Jennifer will include the results in her PhD thesis. Results may also be presented at conferences or on websites. Team members will be able to be co-authors on products from the results and to co-present at conferences or community meetings if they would like.

Do I have to take part in the team?

No. It is your choice to decide whether to take part, and your choice will not affect your health care, your professional role, or any of your legal rights. You are also allowed to change your mind at any time. Even once you have signed the agreement and/or have been on the team, you may chose to leave and do not have to give a reason why. If you would like to suggest someone else to serve in your place, you may do so, but are not obligated. If you cannot come to an individual meeting and would like to nominate someone to attend in your place, you may do so. Jennifer will brief them on the ground rules and ensure they sign an agreement form.

What if there are any problems?

If you have a concern or complaint about the study, please tell Jennifer, or bring it up to the team. If this does not resolve your concern, or if you prefer, you may contact the University of Manchester Research Practice and Governance Coordinator at research.complaints@manchester.ac.uk 01612757583.

Who can I contact with further questions or concerns?

Dr. Jennifer Voorhees: jennifer.voorhees@postgrad.manchester.ac.uk 0161 306 3513
or Dr. Kath Checkland: katherine.h.checkland@manchester.ac.uk 0161 275 7650
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Access to General Practice in Tameside and Glossop
Project Team Member Agreement Form

Please initial each box to confirm each statement:

1. I have read the information sheet for the team member role (version 1, dated 5/8/15) and I understand it. ☐
2. I have had a chance to think about this role and ask questions, and I am satisfied with the answers. ☐
3. I understand that my participation on the project team is voluntary, and I am free to withdraw at any time without giving any reason, without my health care, professional role, or legal rights being affected. ☐
4. I agree to take part on the research project team. ☐
5. I agree to the team meetings being audio-recorded if necessary. ☐
6. I agree that information discussed at the meetings, including personal stories of team members, the identity of research participants, and data analysis pre-dissemination, is confidential. ☐
7. I give permission for individuals from The University of Manchester, the NHS Trust, or other regulatory authorities, to have access to my data, if necessary for monitoring purposes. ☐

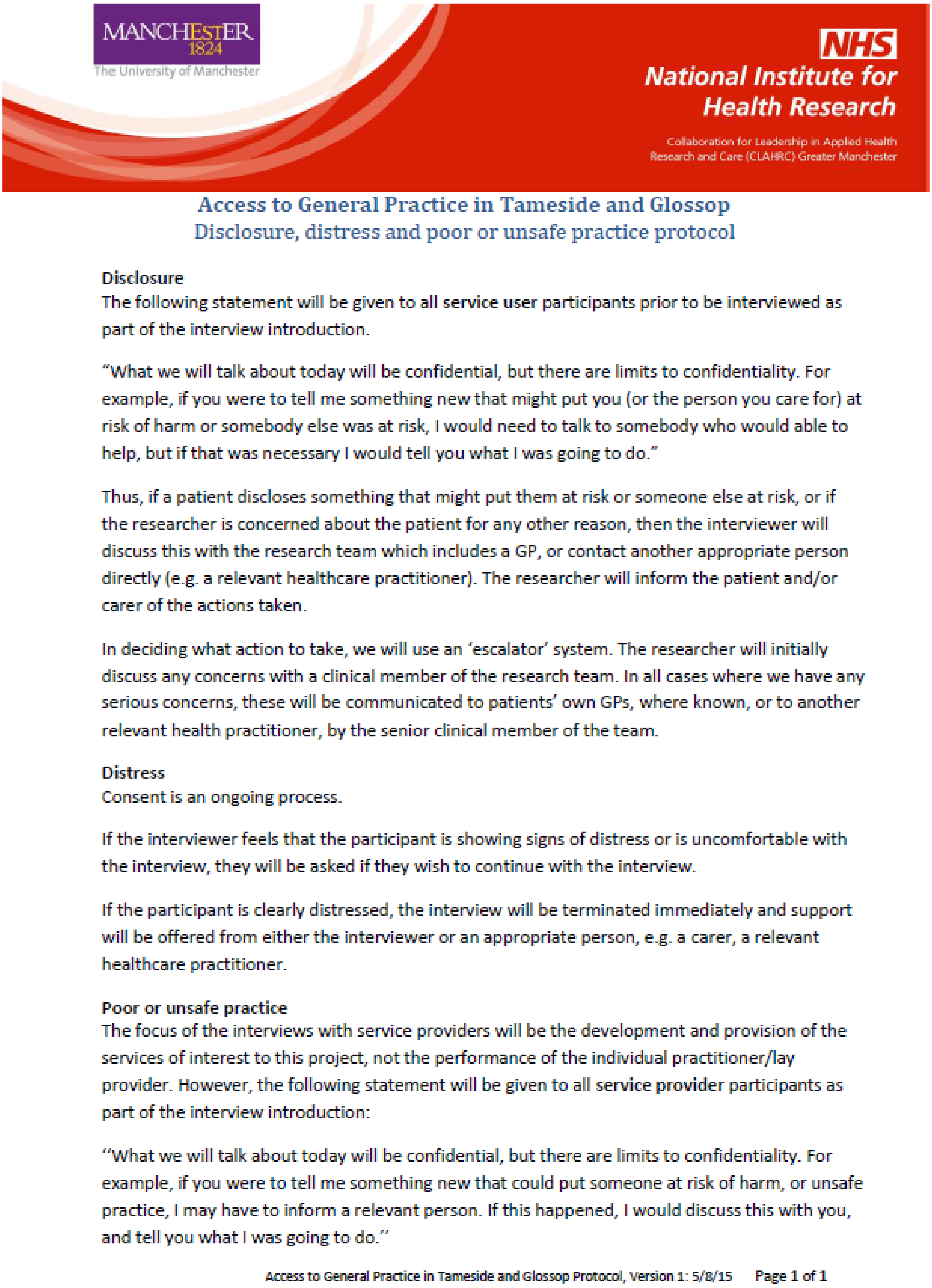
Name of Project Team Member____
Signature ____________________________________ Date ________________

Name of researcher facilitating agreement________________________________
Signature ____________________________________ Date ________________

Once completed: 1 copy for team member records, 1 copy for research study records.

Project Team Member Agreement form, Version 1: 5/8/15

Appendix 2: Disclosure and distress protocol



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Access to General Practice in Tameside and Glossop
Disclosure, distress and poor or unsafe practice protocol

Disclosure
The following statement will be given to all **service user** participants prior to be interviewed as part of the interview introduction.

"What we will talk about today will be confidential, but there are limits to confidentiality. For example, if you were to tell me something new that might put you (or the person you care for) at risk of harm or somebody else was at risk, I would need to talk to somebody who would able to help, but if that was necessary I would tell you what I was going to do."

Thus, if a patient discloses something that might put them at risk or someone else at risk, or if the researcher is concerned about the patient for any other reason, then the interviewer will discuss this with the research team which includes a GP, or contact another appropriate person directly (e.g. a relevant healthcare practitioner). The researcher will inform the patient and/or carer of the actions taken.

In deciding what action to take, we will use an 'escalator' system. The researcher will initially discuss any concerns with a clinical member of the research team. In all cases where we have any serious concerns, these will be communicated to patients' own GPs, where known, or to another relevant health practitioner, by the senior clinical member of the team.

Distress
Consent is an ongoing process.

If the interviewer feels that the participant is showing signs of distress or is uncomfortable with the interview, they will be asked if they wish to continue with the interview.

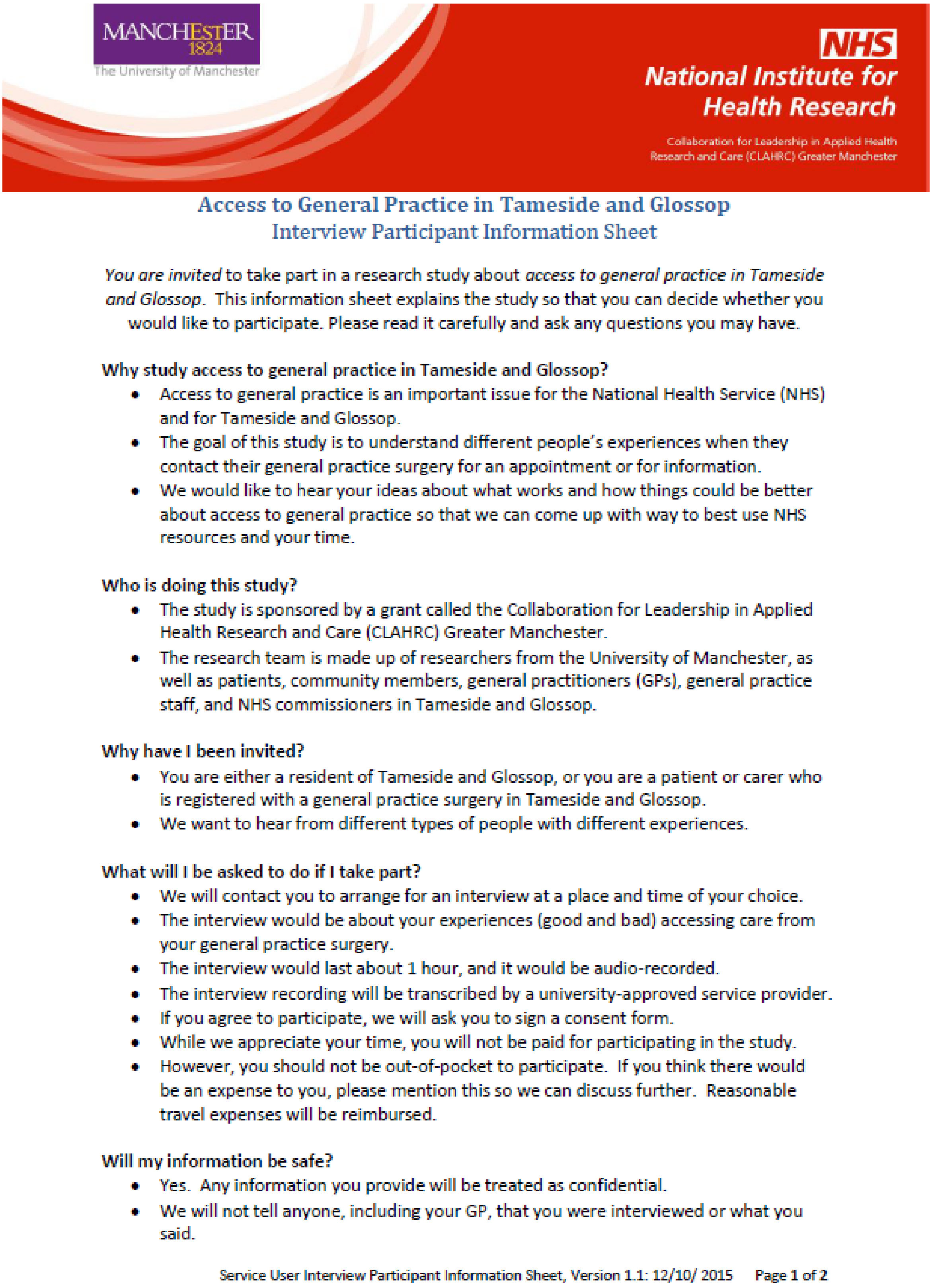
If the participant is clearly distressed, the interview will be terminated immediately and support will be offered from either the interviewer or an appropriate person, e.g. a carer, a relevant healthcare practitioner.

Poor or unsafe practice
The focus of the interviews with service providers will be the development and provision of the services of interest to this project, not the performance of the individual practitioner/lay provider. However, the following statement will be given to all **service provider** participants as part of the interview introduction:

''What we will talk about today will be confidential, but there are limits to confidentiality. For example, if you were to tell me something new that could put someone at risk of harm, or unsafe practice, I may have to inform a relevant person. If this happened, I would discuss this with you, and tell you what I was going to do.''

Access to General Practice in Tameside and Glossop Protocol, Version 1: 5/8/15   Page **1** of **1**

Appendix 3: Participant interview and focus group information sheets and consent forms



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Access to General Practice in Tameside and Glossop
Interview Participant Information Sheet

You are invited to take part in a research study about *access to general practice in Tameside and Glossop*. This information sheet explains the study so that you can decide whether you would like to participate. Please read it carefully and ask any questions you may have.

Why study access to general practice in Tameside and Glossop?

- Access to general practice is an important issue for the National Health Service (NHS) and for Tameside and Glossop.
- The goal of this study is to understand different people's experiences when they contact their general practice surgery for an appointment or for information.
- We would like to hear your ideas about what works and how things could be better about access to general practice so that we can come up with way to best use NHS resources and your time.

Who is doing this study?

- The study is sponsored by a grant called the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester.
- The research team is made up of researchers from the University of Manchester, as well as patients, community members, general practitioners (GPs), general practice staff, and NHS commissioners in Tameside and Glossop.

Why have I been invited?

- You are either a resident of Tameside and Glossop, or you are a patient or carer who is registered with a general practice surgery in Tameside and Glossop.
- We want to hear from different types of people with different experiences.

What will I be asked to do if I take part?

- We will contact you to arrange for an interview at a place and time of your choice.
- The interview would be about your experiences (good and bad) accessing care from your general practice surgery.
- The interview would last about 1 hour, and it would be audio-recorded.
- The interview recording will be transcribed by a university-approved service provider.
- If you agree to participate, we will ask you to sign a consent form.
- While we appreciate your time, you will not be paid for participating in the study.
- However, you should not be out-of-pocket to participate. If you think there would be an expense to you, please mention this so we can discuss further. Reasonable travel expenses will be reimbursed.

Will my information be safe?

- Yes. Any information you provide will be treated as confidential.
- We will not tell anyone, including your GP, that you were interviewed or what you said.

Service User Interview Participant Information Sheet, Version 1.1: 12/10/ 2015 Page **1** of **2**

- However, there are limits to confidentiality. For example, confidentiality may have to be broken if you tell us that you or someone else is at significant risk of harm.

- Your name, contact information, and consent form will be stored safely at the University of Manchester.
- The audio-recording of your interview and the typed-up transcript will be given a code, and will not refer to you by name.
- We will remove any other names you might mention from the transcript so no one can be identified when members of our research team read it.
- To check that the study is being carried out correctly, people from the University of Manchester, or other regulatory authorities such as the NHS, may look at the research documents, including your information. This is only for audit purposes.

What will happen to the results?
- The results of the study will help to understand the current situation in Tameside and Glossop and help to improve care.
- We will write reports about the results including in academic journals and the PhD thesis of Dr. Jennifer Voorhees. Results may also be presented at conferences or on websites.
- Quotations from your interview may be used when we report the results, but they would not include your name or information that would identify you.
- If you would like to see the study results, please let us know, and we will share them with you at the end of the study.

Do I have to take part in the study?
- No. It is your choice to decide whether to take part, and your choice will not affect your health care, your professional role, or any of your legal rights.
- You are allowed to change your mind at any time. Even once you have signed the consent form or begun the interview, you may withdraw from the study, without giving a reason why.

What if there are any problems?
- If you have a concern or complaint about the study, please tell us and we will do our best to resolve it.
- If this does not resolve your concern, or if you would prefer not to contact us directly, you may contact the University of Manchester Research Practice and Governance Coordinator at research.complaints@manchester.ac.uk 01612757583.

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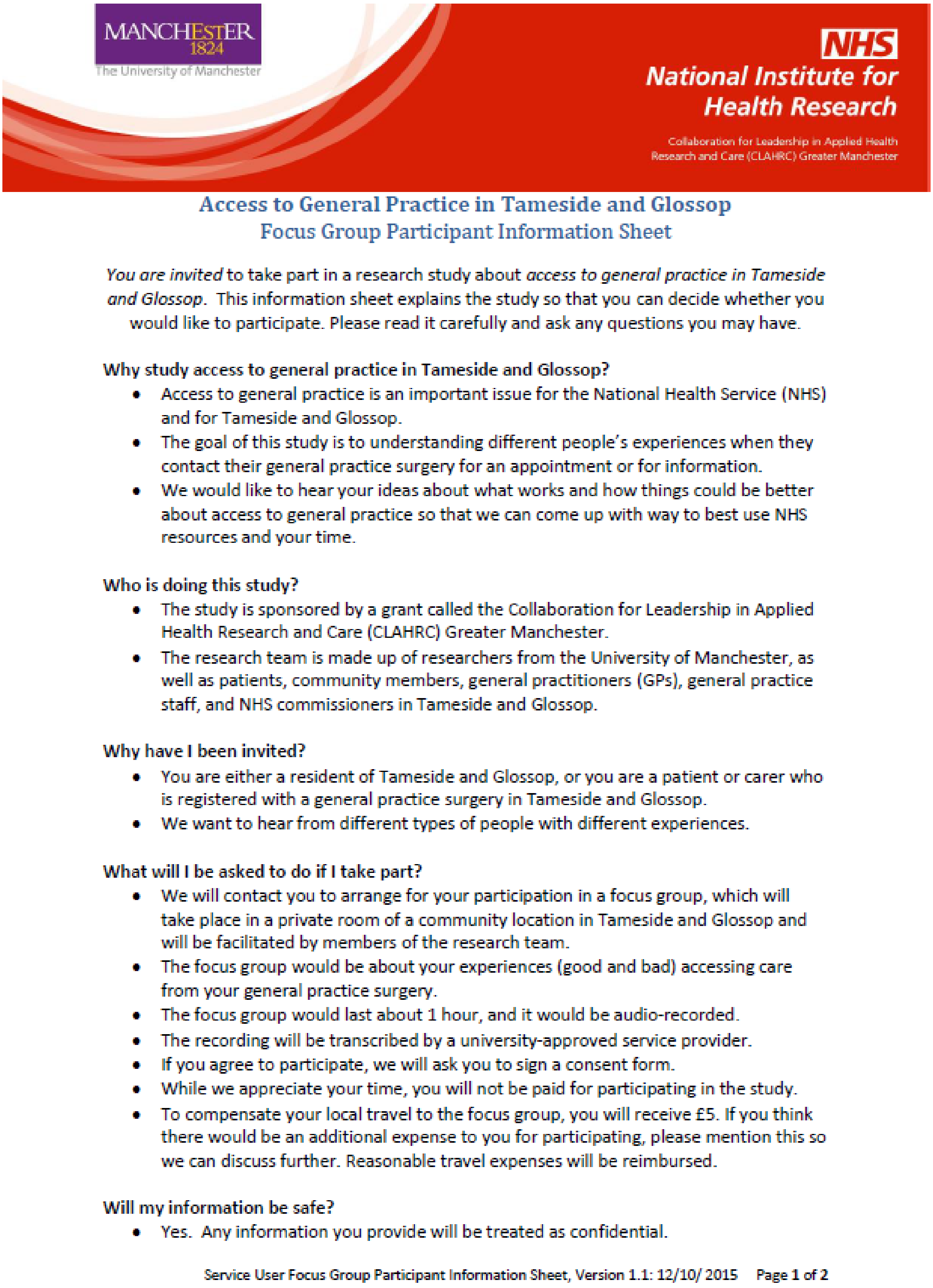

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Access to General Practice in Tameside and Glossop
Focus Group Participant Information Sheet

You are invited to take part in a research study about *access to general practice in Tameside and Glossop*. This information sheet explains the study so that you can decide whether you would like to participate. Please read it carefully and ask any questions you may have.

Why study access to general practice in Tameside and Glossop?

- Access to general practice is an important issue for the National Health Service (NHS) and for Tameside and Glossop.
- The goal of this study is to understanding different people's experiences when they contact their general practice surgery for an appointment or for information.
- We would like to hear your ideas about what works and how things could be better about access to general practice so that we can come up with way to best use NHS resources and your time.

Who is doing this study?

- The study is sponsored by a grant called the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester.
- The research team is made up of researchers from the University of Manchester, as well as patients, community members, general practitioners (GPs), general practice staff, and NHS commissioners in Tameside and Glossop.

Why have I been invited?

- You are either a resident of Tameside and Glossop, or you are a patient or carer who is registered with a general practice surgery in Tameside and Glossop.
- We want to hear from different types of people with different experiences.

What will I be asked to do if I take part?

- We will contact you to arrange for your participation in a focus group, which will take place in a private room of a community location in Tameside and Glossop and will be facilitated by members of the research team.
- The focus group would be about your experiences (good and bad) accessing care from your general practice surgery.
- The focus group would last about 1 hour, and it would be audio-recorded.
- The recording will be transcribed by a university-approved service provider.
- If you agree to participate, we will ask you to sign a consent form.
- While we appreciate your time, you will not be paid for participating in the study.
- To compensate your local travel to the focus group, you will receive £5. If you think there would be an additional expense to you for participating, please mention this so we can discuss further. Reasonable travel expenses will be reimbursed.

Will my information be safe?

- Yes. Any information you provide will be treated as confidential.

- We will not tell anyone, including your GP, that you attended the focus group or what you said.
- However, there are limits to confidentiality. For example, confidentiality may have to be broken if you tell us that you or someone else is at significant risk of harm.
- Your name, contact information, and consent form will be stored safely at the University of Manchester.
- The audio-recording of the focus group and the typed-up transcript will be given a code, and will not refer to you by name.
- We will remove any other names you might mention from the transcript so no one can be identified when other members of our research team read it.
- To check that the study is being carried out correctly, people from the University of Manchester, or other regulatory authorities such as the NHS, may look at the research documents, including your information. This is only for audit purposes.

What will happen to the results?

- The results of the study will help to understand the current situation in Tameside and Glossop and help to improve care.
- We will write reports about the results including in academic journals and the PhD thesis of Dr. Jennifer Voorhees. Results may also be presented at conferences or on websites.
- Quotations from the focus group may be used when we report the results, but they would not include your name or information that would identify you.
- If you would like to see the study results, please let us know, and we will share them with you at the end of the study.

Do I have to take part in the study?

- No. It is your choice to decide whether to take part, and your choice will not affect your health care, your professional role, or any of your legal rights.
- You are allowed to change your mind at any time. Even once you have signed the consent form or begun the focus group, you may withdraw from the study, without giving a reason why.

What if there are any problems?

- If you have a concern or complaint about the study, please tell us and we will do our best to resolve it.
- If this does not resolve your concern, or if you would prefer not to contact us directly, you may contact the University of Manchester Research Practice and Governance Coordinator at research.complaints@manchester.ac.uk 01612757583.

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- Access to general practice is an important issue for the National Health Service (NHS) and for Tameside and Glossop.
- The goal of this study is to understand the experiences of patients trying to access general practice and the experiences of the providers and commissioners of that care.
- We would like to hear your ideas about what works and how things could be better about access to general practice so that we can come up with way to best use NHS resources and your time.

Who is doing this study?

- The study is sponsored by a grant called the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester.
- The research team is made up of researchers from the University of Manchester, as well as patients, community members, general practitioners (GPs), general practice staff, and NHS commissioners in Tameside and Glossop.

Why have I been invited?

- You are either a general practice staff member, a health professional, or commissioner of health care in Tameside and Glossop.
- We want to hear from different types of people with different experiences.

What will I be asked to do if I take part?

- We will contact you to arrange for an interview at a place and time of your choice.
- The interview would be about your experiences (good and bad) providing or commissioning general practice care.
- The interview would last about 1 hour, and it would be audio-recorded.
- The interview recording will be transcribed by a university-approved service provider.
- If you agree to participate, we will ask you to sign a consent form.
- While we appreciate your time, you will not be paid for participating in the study.
- However, you should not be out-of-pocket to participate. If you think there would be an expense to you, please mention this so we can discuss further. Reasonable travel expenses will be reimbursed.

Will my information be safe?

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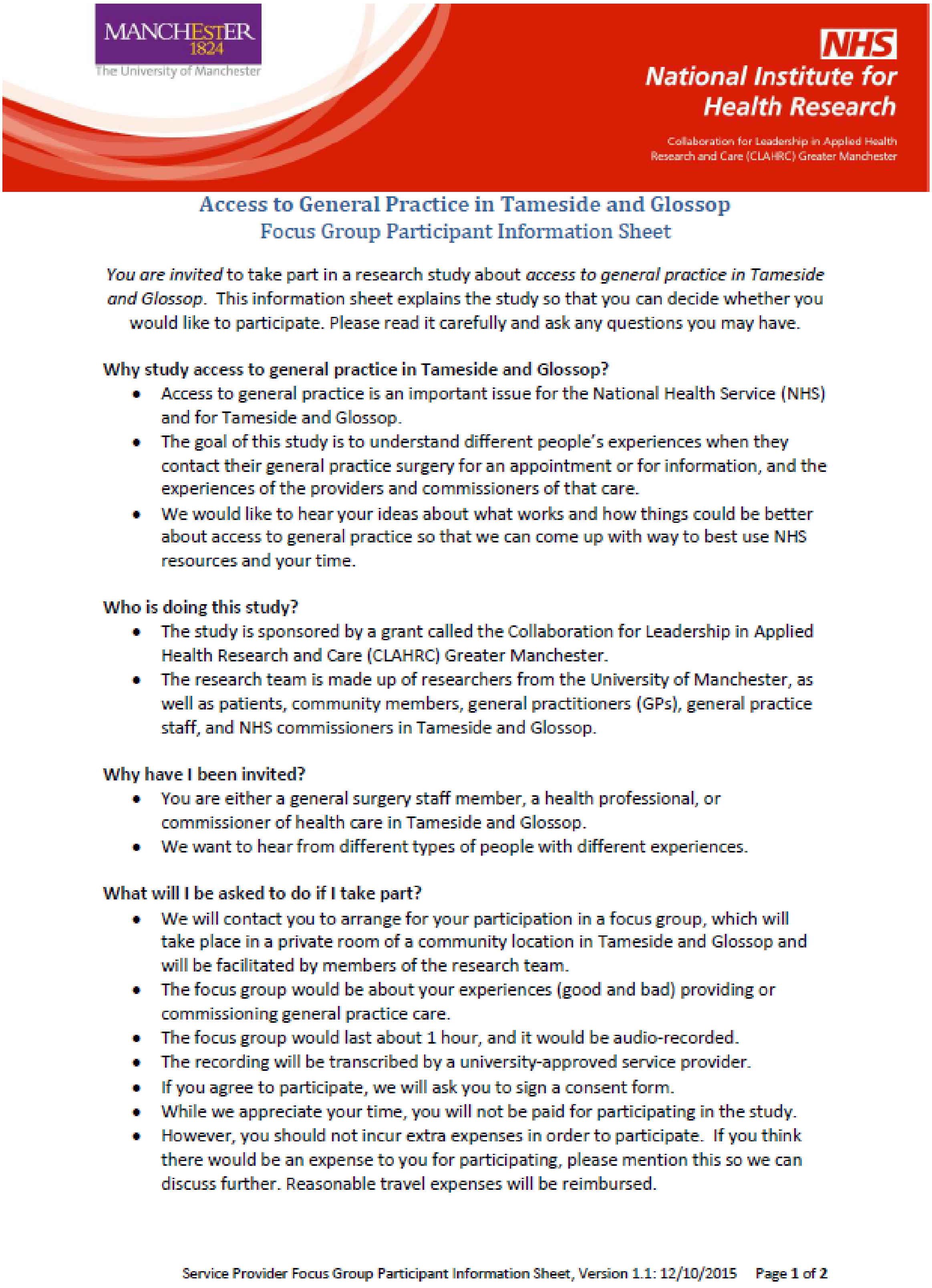

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Access to General Practice in Tameside and Glossop

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- We would like to hear your ideas about what works and how things could be better about access to general practice so that we can come up with way to best use NHS resources and your time.

Who is doing this study?

- The study is sponsored by a grant called the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester.
- The research team is made up of researchers from the University of Manchester, as well as patients, community members, general practitioners (GPs), general practice staff, and NHS commissioners in Tameside and Glossop.

Why have I been invited?

- You are either a general surgery staff member, a health professional, or commissioner of health care in Tameside and Glossop.
- We want to hear from different types of people with different experiences.

What will I be asked to do if I take part?

- We will contact you to arrange for your participation in a focus group, which will take place in a private room of a community location in Tameside and Glossop and will be facilitated by members of the research team.
- The focus group would be about your experiences (good and bad) providing or commissioning general practice care.
- The focus group would last about 1 hour, and it would be audio-recorded.
- The recording will be transcribed by a university-approved service provider.
- If you agree to participate, we will ask you to sign a consent form.
- While we appreciate your time, you will not be paid for participating in the study.
- However, you should not incur extra expenses in order to participate. If you think there would be an expense to you for participating, please mention this so we can discuss further. Reasonable travel expenses will be reimbursed.

Will my information be safe?

- Yes. Any information you provide will be treated as confidential.
- We will not tell anyone that you were part of the focus group or what you said.
- There are limits to confidentiality. Confidentiality may have to be broken if you tell us that you or someone else is at significant risk of harm or unsafe practice.
- Your name, contact information, and consent form will be stored safely at the University of Manchester.
- The audio-recording of the focus group and the typed-up transcript will be given a code, and will not refer to you by name.
- We will remove any other names you might mention from the transcript so no one can be identified when other members of our research team read it.
- To check that the study is being carried out correctly, people from the University of Manchester, or other regulatory authorities such as the NHS, may look at the research documents, including your information. This is only for audit purposes.

What will happen to the results?

- The results of the study will help to understand the current situation in Tameside and Glossop and help to improve care.
- We will write reports about the results including in academic journals and the PhD thesis of Dr. Jennifer Voorhees. Results may be shared at meetings or on websites.
- Quotations from your focus group may be used when we report the results, but they would not include your name or information that would identify you.
- If you would like to see the study results, please let us know, and we will share them with you at the end of the study.

Do I have to take part in the study?

- No. It is your choice to decide whether to take part, and your choice will not affect your health care, your professional role, or any of your legal rights.
- You are allowed to change your mind at any time. Even once you have signed the consent form or begun the focus group, you may withdraw from the study, without giving a reason why.

What if there are any problems?

- If you have a concern or complaint about the study, please tell us and we will do our best to resolve it.
- If this does not resolve your concern, or if you would prefer not to contact us directly, you may contact the University of Manchester Research Practice and Governance Coordinator at research.complaints@manchester.ac.uk 01612757583.

Who can I contact with further questions or concerns?

Dr. Jennifer Voorhees: jennifer.voorhees@postgrad.manchester.ac.uk 0161 306 3513
Dr. Kath Checkland: katherine.h.checkland@manchester.ac.uk 0161 275 7650
Centre for Primary Care, Institute of Population Health,
University of Manchester, Williamson Building, Oxford Road, M139PL

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Access to General Practice in Tameside and Glossop

Interview Consent Form

Please initial each box to confirm each statement:

1. I have read the information sheet for this study (version 1.1, dated 12/10/15), and I understand it. ☐
2. I have had a chance to think about this study and ask questions, and I am satisfied with the answers. ☐
3. I understand that my participation is voluntary, and I am free to withdraw at any time without giving any reason, without my medical care, professional role, or legal rights being affected. ☐
4. I agree to take part in a research interview. ☐
5. I agree to the interview being audio-recorded. ☐
6. I agree that quotations from my interview may be reported anonymously. ☐
7. I give permission for individuals from The University of Manchester, the NHS Trust, or other regulatory authorities, to have access to my data, if necessary for research monitoring purposes. ☐

Optional:

8. I agree to be contacted for follow up if additional information or an additional interview is needed for future stages of this project. ☐
9. I would like to be contacted to attend a community presentation of the results of this work and/or to receive a copy of the study report via email or post. ☐

Name of Participant ____

Signature ______________________________ Date ______________

Address____

Telephone Number____

Email address____

Name of researcher taking consent _________________________________

Signature ______________________________ Date ______________

Once completed: 1 copy for participant records, 1 copy for researcher records.

Interview Consent form, Version 1.1: 12/10/15

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Access to General Practice in Tameside and Glossop
Focus Group Consent Form

Please initial each box to confirm each statement: (Initials)

1. I have read the information sheet for this study (version 1.1, dated 12/10/15) and I understand it. ☐
2. I have had a chance to think about this study and ask questions, and I am satisfied with the answers. ☐
3. I understand that my participation is voluntary, and I am free to withdraw at any time without giving any reason, without my medical care, professional role, or legal rights being affected. ☐
4. I agree to take part in a research focus group. ☐
5. I agree to the focus group being audio-recorded. ☐
6. I agree that quotations from the focus group may be reported anonymously. ☐
7. I give permission for individuals from The University of Manchester, the NHS Trust, or other regulatory authorities, to have access to my data, if necessary for research monitoring purposes. ☐

Optional:

8. I agree to be contacted for follow up if additional information or an additional focus group is needed for future stages of this project. ☐
9. I would like to be contacted to attend a community presentation of the results of this work and/or to receive a copy of the study report via email or post. ☐

Name of Participant ____

Signature ________________________________ Date ______________

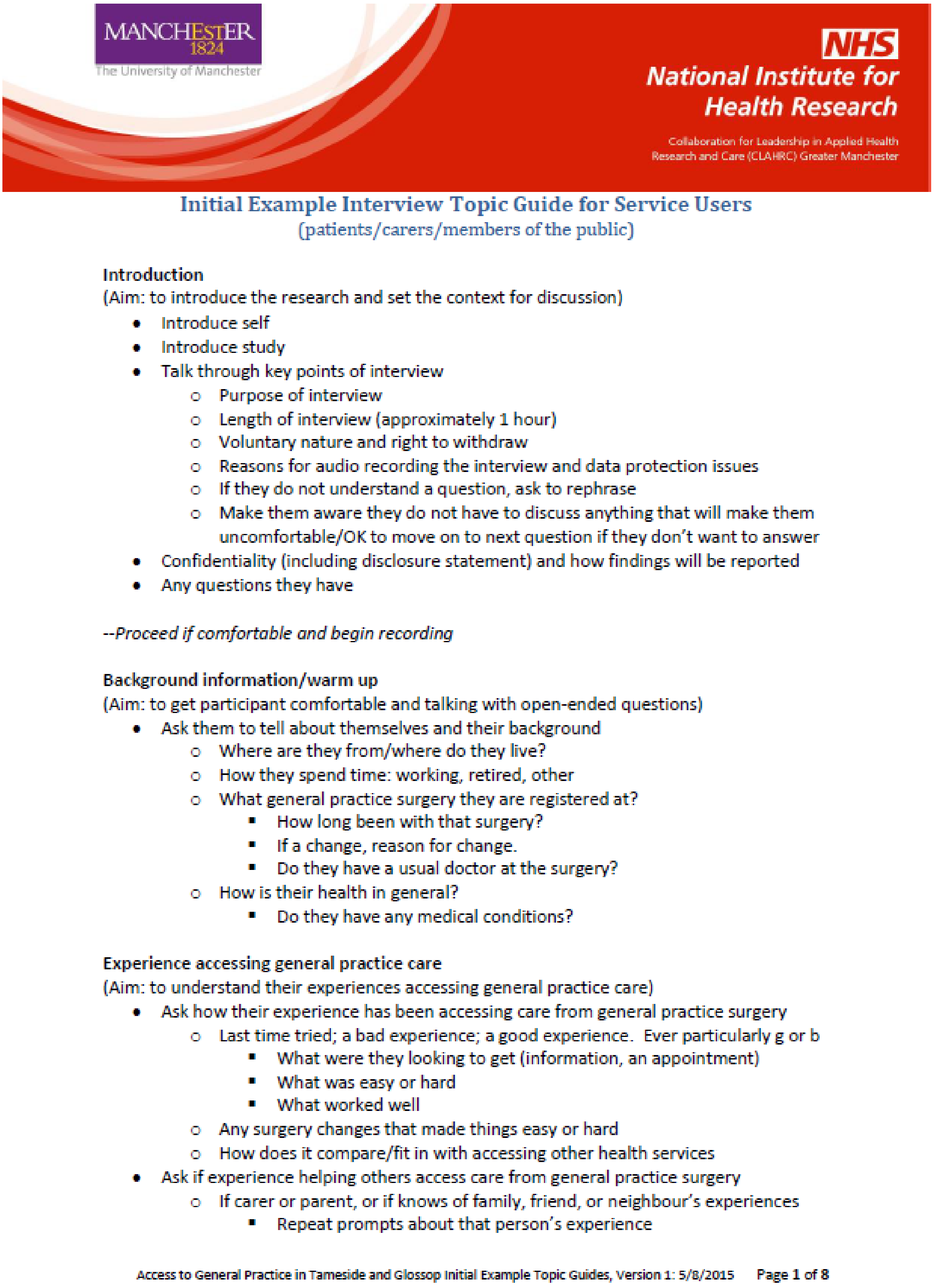
Address____
Telephone Number____
Email address____

Name of researcher taking consent _________________________________
Signature ________________________________ Date ______________

Once completed: 1 copy for participant records, 1 copy for researcher records.

Focus Group Consent form, Version 1.1: 12/10/15

Appendix 4: Interview and focus group topic guides



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Initial Example Interview Topic Guide for Service Users
(patients/carers/members of the public)

Introduction
(Aim: to introduce the research and set the context for discussion)

- Introduce self
- Introduce study
- Talk through key points of interview
  - Purpose of interview
  - Length of interview (approximately 1 hour)
  - Voluntary nature and right to withdraw
  - Reasons for audio recording the interview and data protection issues
  - If they do not understand a question, ask to rephrase
  - Make them aware they do not have to discuss anything that will make them uncomfortable/OK to move on to next question if they don't want to answer
- Confidentiality (including disclosure statement) and how findings will be reported
- Any questions they have

--Proceed if comfortable and begin recording

Background information/warm up
(Aim: to get participant comfortable and talking with open-ended questions)

- Ask them to tell about themselves and their background
  - Where are they from/where do they live?
  - How they spend time: working, retired, other
  - What general practice surgery they are registered at?
    - How long been with that surgery?
    - If a change, reason for change.
    - Do they have a usual doctor at the surgery?
  - How is their health in general?
    - Do they have any medical conditions?

Experience accessing general practice care
(Aim: to understand their experiences accessing general practice care)

- Ask how their experience has been accessing care from general practice surgery
  - Last time tried; a bad experience; a good experience. Ever particularly g or b
    - What were they looking to get (information, an appointment)
    - What was easy or hard
    - What worked well
  - Any surgery changes that made things easy or hard
  - How does it compare/fit in with accessing other health services
- Ask if experience helping others access care from general practice surgery
  - If carer or parent, or if knows of family, friend, or neighbour's experiences
    - Repeat prompts about that person's experience

Access to General Practice in Tameside and Glossop Initial Example Topic Guides, Version 1: 5/8/2015 Page **1** of **8**

Ideas for improvement

(Aim: to understand service users ideas for improvement)

- Ask how they think their experience accessing general practice could be improved
  - What would they like to see; how would they like their experience to be
  - Would they like to have influence on service provision and how would they like to contribute
    - Do they know/what do they think about patient participation groups
  - How could things be improved for all of Tameside and Glossop (T&G)?

Understanding of health system resources and limitations

(Aim: to understand service users understanding of health system resources and limitations)

- Ask them about their understanding of the NHS in general
  - Do they know/what do they think about the clinical commissioning group
  - Do they think there are enough general practitioners
- Ask them how system provider should deal with patient wants and patient needs
  - Whose responsibility to decide
- Ask how they think resource limitations affect Tameside and Glossop

Ideas for optimising access

(Aim: to see if broader idea of access resonates with service users)

- Show diagram of access framework and walk participant through it
  - Ask their thoughts on access as an interaction/fit between the system and needs of people
  - How does that idea apply to their surgery/ to the people of T&G
- Ask opinions about other efforts tried to improve access in United Kingdom
  - Extended general practice opening hours
  - Advanced access
  - Telephone triage
  - NHS direct
  - Walk in centres
  - Out of hours coverage
  - Access to their own medical records
- Ask about continuity and how it relates to access; safety

Wrap up

- Anything else they want to tell me?
- Demographic information if not already captured in interview (ie: age)
- Thank them for participating
- Reassure about confidentiality
- Check if any further support required
- Ask if they would be willing to be contacted in future for follow up interview
- Ask if they know of other people who may have similar or different experiences accessing care who may be willing to be interviewed
- Ask if they would like to be informed of the results

Initial Example Interview Topic Guide for Service Providers

(commissioners, health professionals, surgery staff)

Introduction

(Aim: to introduce the research and set the context for discussion)

- Introduce self
- Introduce study
- Talk through key points of interview
    - Purpose of interview
    - Length of interview (approximately 1 hour)
    - Voluntary nature and right to withdraw
    - Reasons for audio recording the interview and data protection issues
    - If they do not understand a question, ask to rephrase
    - Make them aware they do not have to discuss anything that will make them uncomfortable/OK to move on to next question if they don't want to answer
- Explain confidentiality (including poor or unsafe practice statement) and how findings will be reported
- Any questions they have

--Proceed if comfortable and begin recording

Background information/warm up

(Aim: to get participant comfortable and talking with open-ended questions)

- Ask them to tell about themselves and their background
    - Where are they from/where do they work?
    - Professional role
        - Length in that role; training and previous roles

Experience providing general practice care/providing access to general practice care

(Aim: to understand views on current care delivery and previous efforts to address access)

- Ask about experience of providing care
    - Their job satisfaction
    - Patient satisfaction/patient experience of accessing general practice
    - What do they think about population access within Tameside and Glossop?
- Ask about previous efforts to address access to general practice locally
    - Within surgery, from clinical commissioning group, NHS England, etc
        - What worked; what did not work. Unintended consequences.
        - Any efforts to ask or work with patients to design service changes?
        - Are there groups with different access needs? How being addressed?
        - How were health disparities addressed?

Ideas for improvement

(Aim: to understand service providers ideas for improvement)

- Ask how they think general practice services could be improved

    - What would they like to see; how would they like their experience to be
        - For patients; for themselves
        - For their surgery population? For all of Tameside and Glossop?
    - What do they think about patient involvement in service design?
        - What do they think about patient participation groups?

Conceptualising the healthcare system resources and limitations
(Aim: to understand service providers understanding of health system resources and limitations)

- Ask about their understanding of the NHS resources in general
    - Proportion spent on general practice compared to other parts of system
    - What resource limitations is general practice facing?
- Ask how system should deal with patient wants and patient needs
    - Whose responsibility to decide
    - What about most vulnerable patients?
- Ask how they think resource limitations affect Tameside and Glossop

Ideas for optimising access
(Aim: to see if broader idea of access resonates with service providers)

- Show diagram of access framework and walk participant through it
    - Ask their thoughts on access as an interaction/fit between the system and needs of people
    - How does that idea apply to their surgery/ to the people of T&G?
- Ask opinions about other efforts tried to improve access in United Kingdom
    - Extended general practice opening hours
    - Advanced access
    - Telephone triage
    - NHS direct
    - Walk in centres
    - Out of hours coverage
    - Patient access to their own medical records
- Ask about continuity and how it relates to access

Wrap up

- Anything else they want to tell me?
- Demographic information if not already captured in interview (ie: age)
- Thank them for participating
- Reassure about confidentiality
- Check if any further support required
- Ask if they would be willing to be contacted in the future for potential follow up interview
- Ask if they know of other service providers who may have similar or different experiences or services users who may be willing to be interviewed
- Ask if they would like to be informed of the results

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Initial Example Focus Group Topic Guide for Service Users
(patients/carers/members of the public)

Introduction

(Aim: to introduce the research and set the context and ground rules for discussion)

- Introduce self and research team member
- Introduce study
- Talk through key points of focus group
    - Purpose of focus group
    - Length of focus group (approximately 1.5 hours)
    - Voluntary nature and right to withdraw
    - Reasons for audio recording and data protection issues
    - If they do not understand a question, ask to rephrase
    - Make them aware they do not have to discuss anything that will make them uncomfortable
- Confidentiality (including disclosure statement) and how findings will be reported
- Any questions they have

--Proceed if comfortable and begin recording

Background information/warm up

(Aim: to get each participant comfortable and talking with open-ended questions)

- Ask each participant to tell about themselves and their background
    - Where are they from/where do they live?
    - How they spend time: working, retired, other
    - What general practice surgery they are registered at?
        - How long been with that surgery?
        - If a change, reason for change.
        - Do they have a usual doctor at the surgery?
    - How is their health in general?
        - Do they have any medical conditions?

Experience accessing general practice care

(Aim: to understand their experiences accessing general practice care)

- Ask how their experience has been accessing care from general practice surgery
    - Last time tried; a bad experience; a good experience
        - What were they looking to get (information, an appointment)
        - What was easy or hard
        - What worked well
    - Any surgery changes that made things easy or hard
    - How does it compare/fit in with accessing other health services
- Ask if experience helping others access care from general practice surgery
    - If carer or parent, or if knows of family, friend, or neighbour’s experiences
        - Repeat prompts about that person’s experience

Ideas for improvement

(Aim: to understand service users ideas for improvement)

- Ask how they think their experience accessing general practice could be improved
    - What would they like to see; how would they like their experience to be
    - Would they like to have influence on service provision and how would they like to contribute
        - Do they know/what do they think about patient participation groups
    - How could things be improved for all of Tameside and Glossop (T&G)?

Understanding of health system resources and limitations

(Aim: to understand service users understanding of health system resources and limitations)

- Ask them about their understanding of the NHS in general
    - Do they know/what do they think about the clinical commissioning group
    - Do they think there are enough general practitioners
- Ask them how system provider should deal with patient wants and patient needs
    - Whose responsibility to decide
- Ask how they think resource limitations affect Tameside and Glossop

Ideas for optimising access

(Aim: to see if broader idea of access resonates with service users)

- Show diagram of access framework and walk participant through it
    - Ask their thoughts on access as an interaction/fit between the system and needs of people
    - How does that idea apply to their surgery/ to the people of T&G
- Ask opinions about other efforts tried to improve access in United Kingdom
    - Extended general practice opening hours
    - Advanced access
    - Telephone triage
    - NHS direct
    - Walk in centres
    - Out of hours coverage
    - Access to their own medical records
- Ask about continuity and how it relates to access

Wrap up

- Anything else they want to tell me?
- Demographic information if not already captured in interview (ie: age)
- Thank them for participating
- Reassure about confidentiality
- Check if any further support required
- Ask if they would be willing to be contacted in future for follow up interview
- Ask if they know of other people who may have similar or different experiences accessing care who may be willing to be interviewed
- Ask if they would like to be informed of the results

Initial Example Focus Group Topic Guide for Service Providers

(commissioners, health professionals, surgery staff)

Introduction

(Aim: to introduce the research and set the context and ground rules for discussion)

- Introduce self and research team member
- Introduce study
- Talk through key points of focus group
  - Purpose of focus group
  - Length of focus group (approximately 1.5 hours)
  - Voluntary nature and right to withdraw
  - Reasons for audio recording the interview and data protection issues
  - If they do not understand a question, ask to rephrase
  - Make them aware they do not have to discuss anything that will make them uncomfortable
- Explain confidentiality (including poor or unsafe practice statement) and how findings will be reported
- Any questions they have

--Proceed if comfortable and begin recording

Background information/warm up

(Aim: to get participant comfortable and talking with open-ended questions)

- Ask them to tell about themselves and their background
  - Where are they from/where do they work?
  - Professional role
    - Length in that role; training and previous roles

Experience providing general practice care/providing access to general practice care

(Aim: to understand views on current care delivery and previous efforts to address access)

- Ask about experience of providing care
  - Their job satisfaction
  - Patient satisfaction/patient experience of accessing general practice
  - What do they think about population access within Tameside and Glossop?
- Ask about previous efforts to address access to general practice locally
  - Within surgery, from clinical commissioning group, NHS England, etc
    - What worked; what did not work. Unintended consequences.
    - Any efforts to ask or work with patients to design service changes?
    - Are there groups with different access needs? How being addressed?
    - How were health disparities addressed?

Ideas for improvement

(Aim: to understand service providers ideas for improvement)

- Ask how they think general practice services could be improved

    - What would they like to see; how would they like their experience to be
        - For patients; for themselves
        - For their surgery population? For all of Tameside and Glossop?
    - What do they think about patient involvement in service design?
        - What do they think about patient participation groups?

Conceptualising the healthcare system resources and limitations
(Aim: to understand service providers understanding of health system resources and limitations)

- Ask about their understanding of the NHS resources in general
    - Proportion spent on general practice compared to other parts of system
    - What resource limitations is general practice facing?
- Ask how system should deal with patient wants and patient needs
    - Whose responsibility to decide
    - What about most vulnerable patients?
- Ask how they think resource limitations affect Tameside and Glossop

Ideas for optimising access
(Aim: to see if broader idea of access resonates with service providers)

- Show diagram of access framework and walk participant through it
    - Ask their thoughts on access as an interaction/fit between the system and needs of people
    - How does that idea apply to their surgery/ to the people of T&G?
- Ask opinions about other efforts tried to improve access in United Kingdom
    - Extended general practice opening hours
    - Advanced access
    - Telephone triage
    - NHS direct
    - Walk in centres
    - Out of hours coverage
    - Patient access to their own medical records
- Ask about continuity and how it relates to access

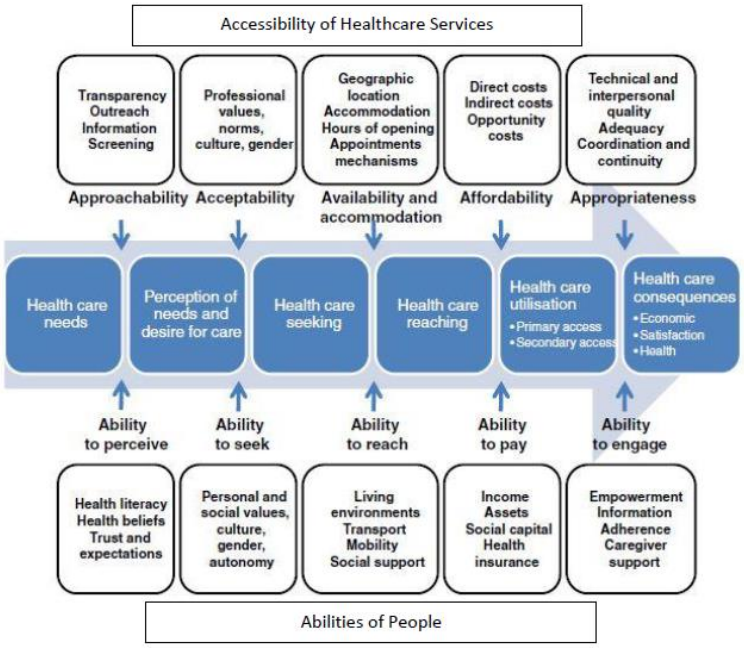
Wrap up

- Anything else they want to tell me?
- Demographic information if not already captured in interview (ie: age)
- Thank them for participating
- Reassure about confidentiality
- Check if any further support required
- Ask if they would be willing to be contacted in the future for potential follow up interview
- Ask if they know of other service providers who may have similar or different experiences or services users who may be willing to be interviewed
- Ask if they would like to be informed of the results

Appendix 5: Annotated Levesque et al. (2013) access framework visual prompt

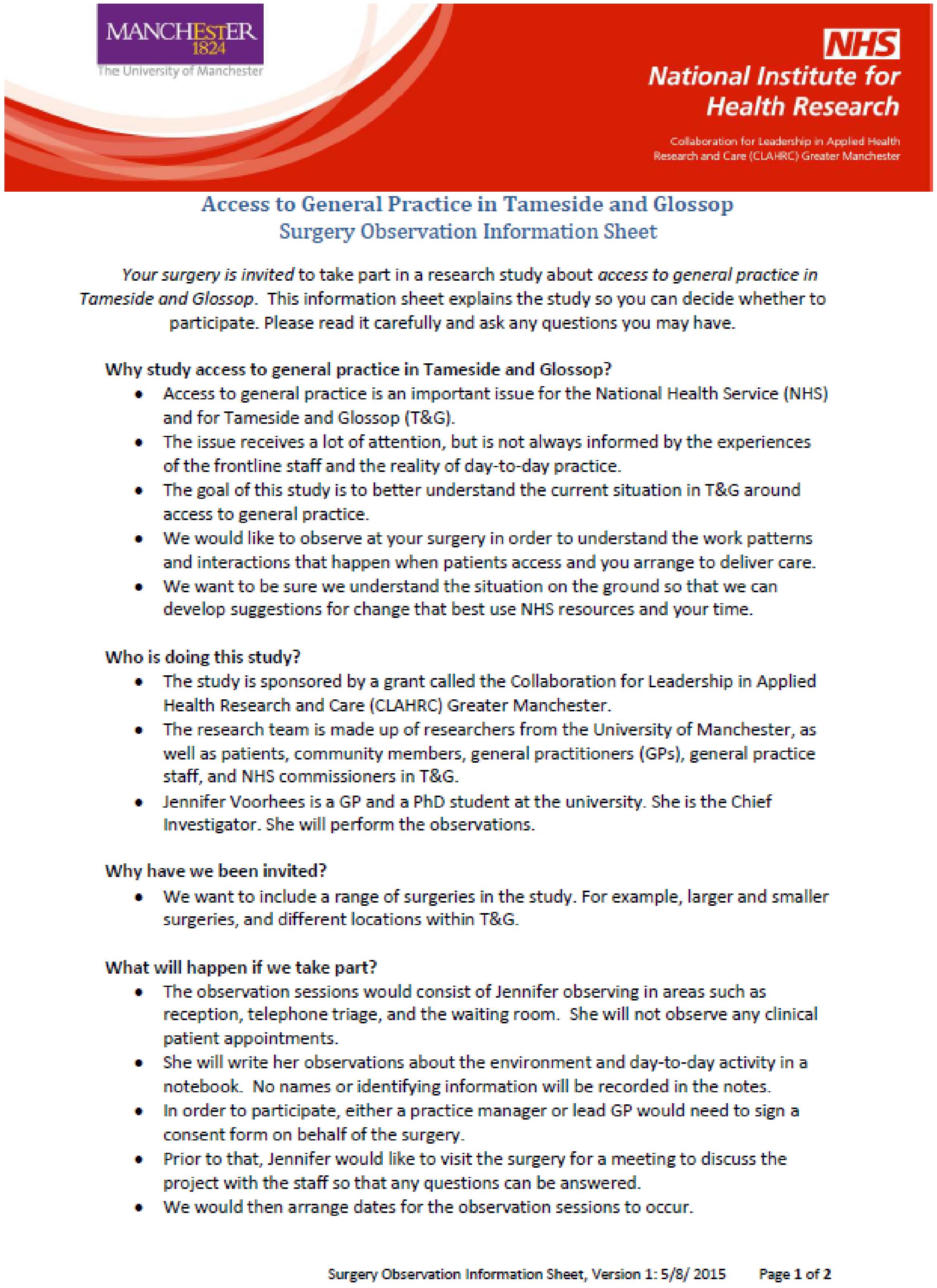
Patient-Centered Access to Health Care

Access = the interaction or fit between the needs of the population and health services



Levesque JF, Harris MF, Russell G. Patient-centered access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health, 2013.

Appendix 6: Surgery observation information sheets



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Access to General Practice in Tameside and Glossop
Surgery Observation Information Sheet

Your surgery is invited to take part in a research study about *access to general practice in Tameside and Glossop*. This information sheet explains the study so you can decide whether to participate. Please read it carefully and ask any questions you may have.

Why study access to general practice in Tameside and Glossop?

- Access to general practice is an important issue for the National Health Service (NHS) and for Tameside and Glossop (T&G).
- The issue receives a lot of attention, but is not always informed by the experiences of the frontline staff and the reality of day-to-day practice.
- The goal of this study is to better understand the current situation in T&G around access to general practice.
- We would like to observe at your surgery in order to understand the work patterns and interactions that happen when patients access and you arrange to deliver care.
- We want to be sure we understand the situation on the ground so that we can develop suggestions for change that best use NHS resources and your time.

Who is doing this study?

- The study is sponsored by a grant called the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester.
- The research team is made up of researchers from the University of Manchester, as well as patients, community members, general practitioners (GPs), general practice staff, and NHS commissioners in T&G.
- Jennifer Voorhees is a GP and a PhD student at the university. She is the Chief Investigator. She will perform the observations.

Why have we been invited?

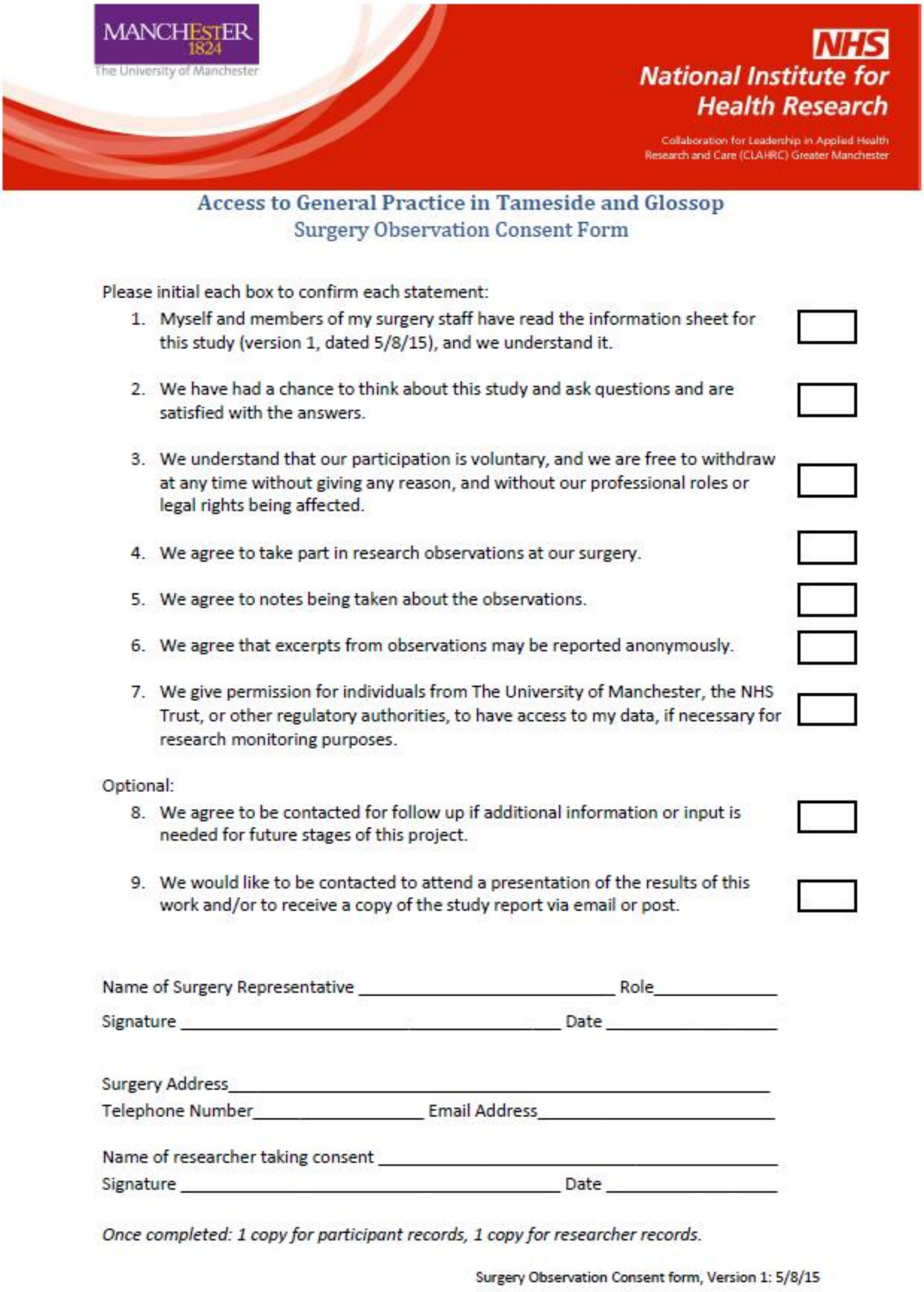
- We want to include a range of surgeries in the study. For example, larger and smaller surgeries, and different locations within T&G.

What will happen if we take part?

- The observation sessions would consist of Jennifer observing in areas such as reception, telephone triage, and the waiting room. She will not observe any clinical patient appointments.
- She will write her observations about the environment and day-to-day activity in a notebook. No names or identifying information will be recorded in the notes.
- In order to participate, either a practice manager or lead GP would need to sign a consent form on behalf of the surgery.
- Prior to that, Jennifer would like to visit the surgery for a meeting to discuss the project with the staff so that any questions can be answered.
- We would then arrange dates for the observation sessions to occur.

Surgery Observation Information Sheet, Version 1: 5/8/ 2015 Page **1** of **2**

Appendix 7: Surgery observation consent form



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Access to General Practice in Tameside and Glossop

Surgery Observation Consent Form

Please initial each box to confirm each statement:

1. Myself and members of my surgery staff have read the information sheet for this study (version 1, dated 5/8/15), and we understand it. ☐
2. We have had a chance to think about this study and ask questions and are satisfied with the answers. ☐
3. We understand that our participation is voluntary, and we are free to withdraw at any time without giving any reason, and without our professional roles or legal rights being affected. ☐
4. We agree to take part in research observations at our surgery. ☐
5. We agree to notes being taken about the observations. ☐
6. We agree that excerpts from observations may be reported anonymously. ☐
7. We give permission for individuals from The University of Manchester, the NHS Trust, or other regulatory authorities, to have access to my data, if necessary for research monitoring purposes. ☐

Optional:

8. We agree to be contacted for follow up if additional information or input is needed for future stages of this project. ☐
9. We would like to be contacted to attend a presentation of the results of this work and/or to receive a copy of the study report via email or post. ☐

Name of Surgery Representative ____________________ Role__________
Signature ______________________________ Date ____________

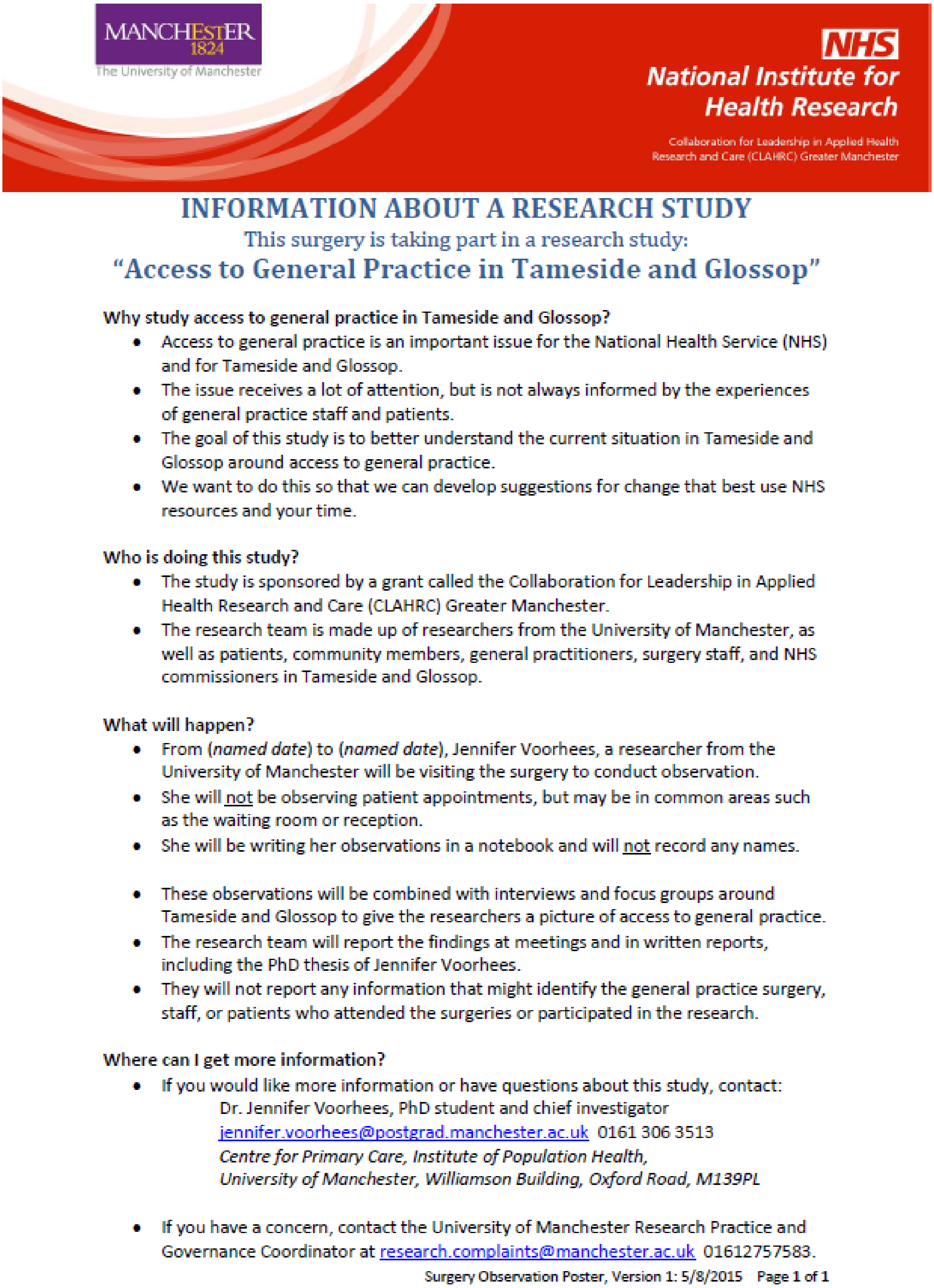
Surgery Address____
Telephone Number______________ Email Address__________________

Name of researcher taking consent ______________________________
Signature ______________________________ Date ____________

Once completed: 1 copy for participant records, 1 copy for researcher records.

Surgery Observation Consent form, Version 1: 5/8/15

Appendix 8: Surgery observation poster



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INFORMATION ABOUT A RESEARCH STUDY

This surgery is taking part in a research study:

"Access to General Practice in Tameside and Glossop"

Why study access to general practice in Tameside and Glossop?

- Access to general practice is an important issue for the National Health Service (NHS) and for Tameside and Glossop.
- The issue receives a lot of attention, but is not always informed by the experiences of general practice staff and patients.
- The goal of this study is to better understand the current situation in Tameside and Glossop around access to general practice.
- We want to do this so that we can develop suggestions for change that best use NHS resources and your time.

Who is doing this study?

- The study is sponsored by a grant called the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester.
- The research team is made up of researchers from the University of Manchester, as well as patients, community members, general practitioners, surgery staff, and NHS commissioners in Tameside and Glossop.

What will happen?

- From (*named date*) to (*named date*), Jennifer Voorhees, a researcher from the University of Manchester will be visiting the surgery to conduct observation.
- She will not be observing patient appointments, but may be in common areas such as the waiting room or reception.
- She will be writing her observations in a notebook and will not record any names.

- These observations will be combined with interviews and focus groups around Tameside and Glossop to give the researchers a picture of access to general practice.
- The research team will report the findings at meetings and in written reports, including the PhD thesis of Jennifer Voorhees.
- They will not report any information that might identify the general practice surgery, staff, or patients who attended the surgeries or participated in the research.

Where can I get more information?

- If you would like more information or have questions about this study, contact:
  Dr. Jennifer Voorhees, PhD student and chief investigator
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- If you have a concern, contact the University of Manchester Research Practice and Governance Coordinator at research.complaints@manchester.ac.uk 01612757583.

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