ResearchSummary

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An evaluation of approaches to improving access to general practitioner appointments

Advanced Access is a significant, yet poorly researched innovation in general practice. This research summary is the largest ever study of GP appointments and in particular, into Advanced Access as introduced in the UK. It compared general practices that did or did not introduce Advanced Access as a method of improving access to appointments. It explored how practices responded to the pressures and incentives from government to improve access and to implement the Advanced Access approach. It also assessed patients' needs and priorities at the time of seeking a GP appointment.

The research was commissioned by the NIHR Service Delivery and Organisation Programme (SDO) and was carried out by a team at Bristol University under the leadership of Professor Chris Salisbury. The research was undertaken between April 2004 and March 2006 and the final report was published in February 2007. The findings will be of interest to GPs, PCTs, policymakers and patients.

Key findings

- Access to general practice in the UK is generally good. More than half of all patients can usually see a practitioner on the day they call to make an appointment, more than four out of five are seen as soon as they wish but 1 in 6 patients are unhappy with current opening hours.
- Practices of all types are actively implementing a wide range of strategies to improve access. It is incorrect to characterise 'Advanced Access' practices as pro-actively seeking to improve access and non-Advanced Access practices as being resistant to change.
- Most general practice consultations are about long-standing health problems. Speed of access is less important to most patients than being able to choose a convenient time of appointment (which may involve booking in advance). For some groups of people being able to choose to see a particular GP or nurse is more important. Yet most Advanced Access practices have prioritised speed of access at the expense of patient choice.
- There is no single right appointment system: patients have different priorities according to age, family situation, working hours and health problem. Appointment systems need to be flexible. Attempting to impose one particular way of improving access on practices with different patient populations is unlikely to be effective.
- Before the introduction of Advanced Access, some doctors were concerned that it would reduce continuity of care and increase total workload, while advocates of Advanced Access claimed the opposite would occur. There is no evidence that Advanced Access is associated with reduced or improved continuity of care. There was a considerable increase in appointments offered and patients seen in both types of GP practices during the period in which this research was carried out, and this was probably associated with the introduction of NHS access targets rather than Advanced Access.
- Advanced Access was introduced with little prior evaluation and has had only a minor impact on access, patient satisfaction, and staff work satisfaction.

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Background

1. Several patient surveys have identified access to GPs as a priority for reform within the NHS. One in four patients had to wait four days or more for an appointment with the GP of their choice, according to a 1998 survey. A recent MORI poll suggested that waiting times were a significant cause of dissatisfaction with general practice and that one in two patients want an improved GP appointment system.

2. Access to general practice has been traditionally managed by receptionists streaming cases as urgent or non-urgent or by carving out a proportion of daily appointments for urgent cases. The adverse consequences of these traditional approaches are:

- long waits for 'non-urgent' appointments, resulting in inappropriate use of A&E departments and an increase in DNA (Did Not Attend) appointments;
- greater stress for receptionists as a result of abusive patients frustrated at the lack of early appointments.
- tension between doctors and patients who have exaggerated their problems in order to be seen the same day.

3. The NHS Plan (July 2000) included a target that by 2004 all patients should be able to see a primary care professional within 24 hours and a GP within 48 hours. These targets were associated with financial incentives for practices. Advanced Access was actively promoted as a way of meeting these targets.

4. Advanced Access was originally developed in the early 1990s in the USA as a method of responding more appropriately and with greater immediacy to patients' needs. Described as 'Doing today's work today', it was based on the belief that with detailed understanding, demand can be predictable and manageable. Within general practice, Advanced Access involved a variety of strategies to support same day appointments including: telephone triage, booked telephone consultations, email consultations, advice about self-care for minor illnesses in leaflets or practice websites and delegation of clinical work to suitably trained nurses and health care assistants. The US model of Advanced Access also promoted improving continuity of care, but this featured less strongly in the way the model was promoted in the UK.

5. UK GPs assume that demand will always exceed supply and has to be capped. This belief contributed to a narrower and more rigid interpretation of Advanced Access in the UK: most Advanced Access practices prioritised same day appointments and restricted the booking of advance appointments.

Practical findings

1. Waiting time for an appointment

- In the simulated patient study all practices were contactable relatively easily – though in the survey of patients a substantial minority at both types of practice reported problems in getting through on the phone.
- Access to appointments was generally good. In the patient survey 54 per cent of all patients stated they could usually get an appointment on the same day, 88 per cent were being seen on their day of choice and 87% were seen as soon as they thought necessary. 83% of patients were satisfied with practice opening hours.
- Patients in Advanced Access practices were seen more quickly than those at control practices, and were more satisfied with the wait for an appointment.
- The main difference between Advanced Access and control practices was in the use of same day appointments. Advanced Access patients with both routine and urgent problems were more likely to get a same-day appointment.
- Patients at both types of practice were offered an earlier appointment if they were prepared to see any doctor.
- In the simulated patient study, a substantial minority of patients at both types of practice (three out of ten of Advanced Access patients and four out of ten of control practice patients) failed to get an appointment within 48 hours of contacting the surgery.
- Embargoing the number of same day appointments was a common practice in Advanced Access practices – requiring a substantial number of patients to call back the following day.
- Advanced Access practice prioritised patients able to call early in the morning. This led to some patients becoming adept at working the system to get through at the earliest possible time – though patients at control practices were also seen as 'getting wise' to the system.
- Triage by both doctors and nurses, telephone consultations and the deployment of work to practice nurses and nurse practitioners were used to varying degrees by both types of practices in order to reduce waiting times for appointments.
- Patients in Advanced Access practices were slightly more likely to have tried and failed to make an appointment – and significantly more likely to have not bothered trying to make an appointment because of the perception that the practice would not let them book in advance.
- While over half of patients at both types of practice were completely or very satisfied with the practice appointment system, a sizeable minority experienced problems at both Advanced Access and control practices.

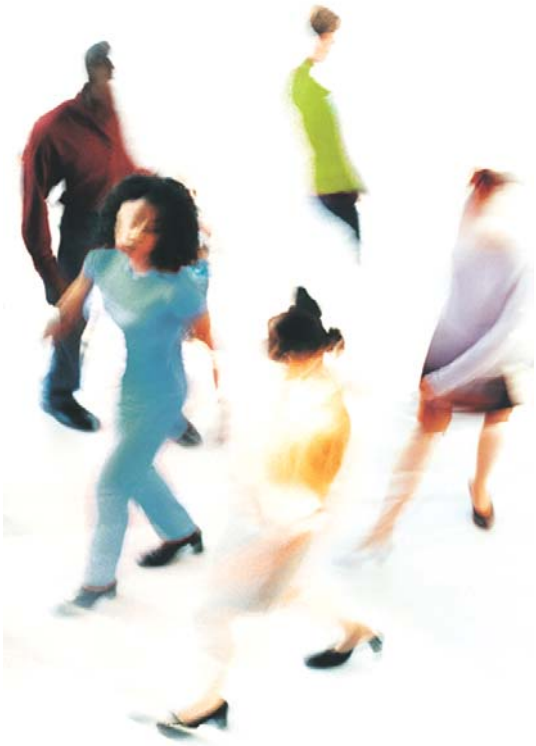
2. Continuity of care

- The desire for continuity of care was probably the most significant of four factors that influenced patients' preferences for access to primary health care, according to a discrete choice experiment. The other three factors, in order of importance, were convenient timing of an appointment , seeing a GP rather than a nurse, and fast access.
- These valid preferences were dependent on whether the patient's health problem was acute or chronic and whether it was causing high or low worry. For an acute, low worry problem, patients were prepared to wait an extra 3.5 days on average to see their doctor of choice. For an on-going, high worry problem, patients were prepared to wait an extra five days to book an appointment with their doctor of choice.

- In the patient survey, seven out of ten patients questioned were consulting about a problem from which they had suffered for at least a few weeks. Seeing a particular doctor or nurse in order to receive continuity of care was particularly important for people with chronic problems and for the elderly.
- Patients were prepared to wait between two and three days to get an appointment at a convenient time and date. Convenience was most important for people in full-time work who expressed most frustration at not being able to make an appointment in advance at Advanced Access practices.
- Staff at both Advanced Access and control practices highlighted concerns that an excessive emphasis on speed of access could have a detrimental effect on continuity of care, adversely affecting difficult or demanding patients, drug addicts and elderly people with chronic problems. There was also concern among GPs that a reduction in continuity of care would reduce job satisfaction.
- In practice, however, there was no evidence of any difference between Advanced Access and control practices in continuity of care. Patients at both types of practice traded off ease or speed of access for continuity of care: in Advanced Access practices patients would take an appointment with a doctor other than their own rather than have to phone again the next day; at control practices patients would sometimes choose a same day urgent appointment even if this meant they did not see their own doctor.

3. Workload

- Practices of both types were providing more appointments and seeing more patients in the aftermath of the introduction of Advanced Access – probably as a result of the introduction of the NHS Plan access targets. GPs at Advanced Access practices expressed concern that more patients were consulting with acute, one-off problems that might have cleared up if the wait for an appointment had been longer.
- There was no evidence that Advanced Access increased or reduced staff stress levels – though the length of surgeries was seen as marginally more stressful by Advanced Access GPs and receptionists in Advanced Access practices reported higher levels of stress at peak times.
- Job satisfaction was high in both types of practice.
- There was a perception amongst staff that Advanced Access significantly reduced the number of DNAs (Did Not Attend). This was not borne out by quantitative findings.
- Primary Care Trusts had employed access facilitators and practices were encouraged to share ideas and learn quality improvement principles by joining a primary care collaborative. However these initiatives appeared to have relatively little influence on how practices devised and managed their appointment systems. Practices rarely seemed to use quality improvement principles and were more focused on meeting the access targets.



Stengths and limitations of research

Strengths

This was the largest ever study of appointment systems in general practice and, in particular, of Advanced Access, as widely implemented in representative practices. It involved a number of integrated studies compromising both qualitative and quantitative research, all conducted by the same research team and in the same practices – thereby providing a more confident understanding of the relationships between context, process and outcomes.

Limitations

There was considerable overlap in the approaches used to improve access by practices. The research team attempted to maximise the differences between Advanced Access and control practices for the main evaluation by selecting only those practices that did or did not both describe themselves as Advanced Access and indicate that they used four key principles of Advanced Access. However there was a spectrum of activity rather a clear dichotomy between the approaches.

Conclusions

1. Access to general practice in the UK is good whereas Advanced Access was originally designed as a solution to much bigger problems of access to primary care clinics in the USA.

2. On the basis of this study, Advanced Access has had only a modest impact on British general practice. It has led to slightly improved access but has not improved continuity of care or patient or staff satisfaction.

3. Most practices claiming to offer Advanced Access have done so to only a limited extent and have wrongly interpreted the approach as requiring the embargo of a high proportion of appointments for same day use. This is largely because GPs in the UK assume that demand is potentially unlimited and therefore can only be managed by limiting supply.

4. Advanced Access is an approach based on quality improvement principles. However there was little evidence that general practices had implemented these underlying principles. Instead they had focused on achieving the waiting time targets backed by incentive payments that were introduced at the same time as Advanced Access was being promoted.

5. Any appointment system should be sufficiently flexible to meet the needs of different types of patients. It should reflect the fact that most consultations are non-urgent and that an important priority for many patients with non-urgent problems is being able to see a doctor of their choice at a convenient time.

6. Advanced Access was widely promoted following enthusiastic reports from 'early adopter' practices. Significant investment was made to encourage all practices to implement this approach. However, the anticipated benefits were not seen when Advanced Access was implemented more generally. This illustrates the benefits of rigorous evaluation before encouraging widespread change in service provision.

Recommendations for future research

Further investigation should focus on:

- the relationship between supply and demand in primary health care.
- the question of whether faster access to primary care is related to improved health outcomes, as well as increased or decreased efficiency.

About the study

This evaluation was based on a survey of all general practices in 12 PCTs, followed by a comparison of 48 general practices, half of which operated Advanced Access appointment systems and half of which did not. It involved several component studies including a study of appointment availability using simulated patients; a (quantitative) questionnaire survey of over 10,000 patients carried out at 47 of the participating practices over a period of several days along with a separate survey of non-attenders; qualitative interviews with staff and direct observation of appointment-making at eight case study practices; a discrete choice experiment; and assessments of workload and continuity of care based on routine records.

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Further information

The full report, this research summary and details of current SDO research in the field can be downloaded at: www.sdo.lshtm.ac.uk

Feedback

The SDO Programme welcomes your feedback on this research summary. To tell us your views, please complete our online survey, available at: www.sdo.lshtm.ac.uk/researchsummaries.html

About the SDO Programme

The Service Delivery and Organisation Programme (SDO) is part of the National Institute for Health Research (NIHR). The NIHR SDO Programme is funded by the Department of Health.

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Addendum

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene and Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk