Whatever happened to all those attempts to change access to General Practice?

GP-SUS
Access to General Practice: Innovation, impact and sustainable change

GP-SUS Briefing Paper 4: Focused ethnographic case studies.

Background

We conducted focused ethnography within general practices that had previously tried different innovative approaches to improve appointment access. We were interested in how access systems worked now, in the everyday, busy, reality of General Practice, and how different aspects of earlier access approaches had been sustained, adapted or abandoned.

We also examined how access systems were adapted in response to Covid-19 pandemic ways of working, and which, if any of these changes were retained once the pandemic restrictions were lifted.

Objective

To describe and compare the longer-term impacts of different approaches to patient access to General Practice to understand whether the various access systems worked as anticipated, were adapted or abandoned, and whether practices were able to sustain any improvements over time.

Methods

Focused ethnography is an applied research method that involves studying a setting in a short timeframe with targeted data collection focused on predefined research questions.

We purposively sampled eight English general practices, informed by the findings from our scoping review (see briefing sheet 2) and to ensure that we reflected different levels of socio-economic deprivation. Six practices had taken part in research studies about access, the earliest in 2003 and most recent in 2018. Two were selected on the basis of measures that marked their location as one of significant deprivation.

In each practice we conducted non-participant observation and held informal conversations with staff and patients. With permission, relevant documentation (such as protocols) on use of the access system was collected. In addition, 74 patients and 70 staff (GPs, receptionists and other practice staff) were interviewed across the case studies.

Site	Innovation system studied	Main access modes	List size
A	Advanced Access	Telephone; in person; online triage	33,000
B	Telephone First	Telephone; in person; online triage	13,000
C	Telephone First	Telephone; in person; online triage; online booking	8,000
D	Telephone Triage (GP or Nurse)	Telephone	5,000
E	Email/video/phone consultations	Telephone; in person; online triage	20,000
F	Telephone First	Telephone; in person; online triage	9,000
G	N/A (sampled for maximum variation)	Telephone; online messaging/SMS	12,000
H	N/A (sampled for maximum variation)	Telephone; online triage	12,000

University of Southampton
University of Copenhagen
Warwick Medical School
University of Oxford Nuffield Department of Primary Care Health Sciences
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Findings

All eight practices wanted to address their access challenges by introducing new systems. However, many systems introduced previously no longer existed in their original form, and some had been replaced several times over.

Local contexts and wider system challenges often made access systems unworkable. Increased demand for appointments, workforce shortages, digital technologies and external factors (such as changes to GP contracts or new policy directives) created turbulence and drove the need to abandon or adapt access systems.

Often patients and staff had very different views about how access worked. Many patients were resigned to delay and frustration when seeking appointments. Practice staff were very focused on the management of demand for appointments, and this resulted in layers of access: e.g. online triage followed by telephone call-backs, appointment booking in person at the desk, and by phone.

The role of reception and front desk staff has changed over time as they now increasingly take on significant triage responsibilities and try to manage how patients use or move between the different 'layers'' of access. Staff were adept at workarounds, and access systems evolved and were adapted over time. While these adaptations helped manage demand for appointments, they did not always meet patient's needs e.g. turning off online consultation tools. Where there was evidence of sustainability, this was often linked to clear leadership and adequate staffing.

Irreconcilable perspectives

'it's very rare that I hear a patient couldn't get through and wasn't seen and there was a problem.' **GP, Practice E**

'the appointment system, it doesn't work. First of all you ring at eight o'clock and then you're on the phone because you're number 26, or whatever in the queue, and then you eventually get through and there's no appointments left.' **Patient, Practice E**

Changing reception work

'they're the gatekeepers, they're making that decision whether a patient needs to come in or not based on what the patient tells them. … when they get to half nine and the appointments have gone it must be a heart-sink moment' **Nurse, Practice F**

Adapting access systems

'I'm not sure many of us [GPs] understood that the waiting times [were] up to 40 minutes… [but] once we got that feedback, we were very keen to change it, because that was just ridiculous and we weren't happy at all, so that prompted us to change.' **GP, Practice A**

Conclusions

At times patients and practice staff have very different experiences and understandings of how access systems 'work'. Patients want appointments with their GP but many access systems appear to focus on managing demand in ways that thwart patient access to these appointments. Practices constantly tweak and adapt access approaches in response to feedback and trial and error-based learning about what works in their context. In a context of significant staff shortages, especially of GPs, and rising patient demand for appointments, alongside external pressures such as the impact of the pandemic and continual policy changes, it is not surprising that single, one-size fits all access systems are unsustainable. Fundamental staff resourcing and patient demand problems need to be addressed, and many solutions lie outside General Practice (in financing primary care, training GPs, and addressing the causes of disease and health inequalities). Rather than propose further, top-down, singular, solutions to the access problem, we suggest that there are opportunities for cross-practice learning and knowledge sharing about access systems, combined with strong public and staff engagement, that could identify adaptations that 'work' and systems that can be tailored to meeting the needs of patients and local practice contexts.

Team

Prof. Catherine Pope, Prof. Helen Atherton, Prof. Sue Ziebland, Dr. Annelieke Driessen, Dr. Carol Bryce, Dr. Abi Eccles, Dr. Bella Wheeler, Mr. Jacob Heath

Contact

Prof. Catherine Pope
Nuffield Department of Primary Care Health Sciences, University of Oxford
Email: Catherine.pope@phc.ox.ac.uk
https://www.phc.ox.ac.uk/research/groups-and-centres/health_experiences/gp-sus

Outputs

Outputs will include academic articles, public-facing materials and information for professional audiences.

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