Comparison of mode of access to GP telephone consultation and effect on A&E usage

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How might different models of access to GP by telephone affect A&E usage?

1. Background
2. Method
3. Results
4. Discussion
5. Conclusions
6. Further study

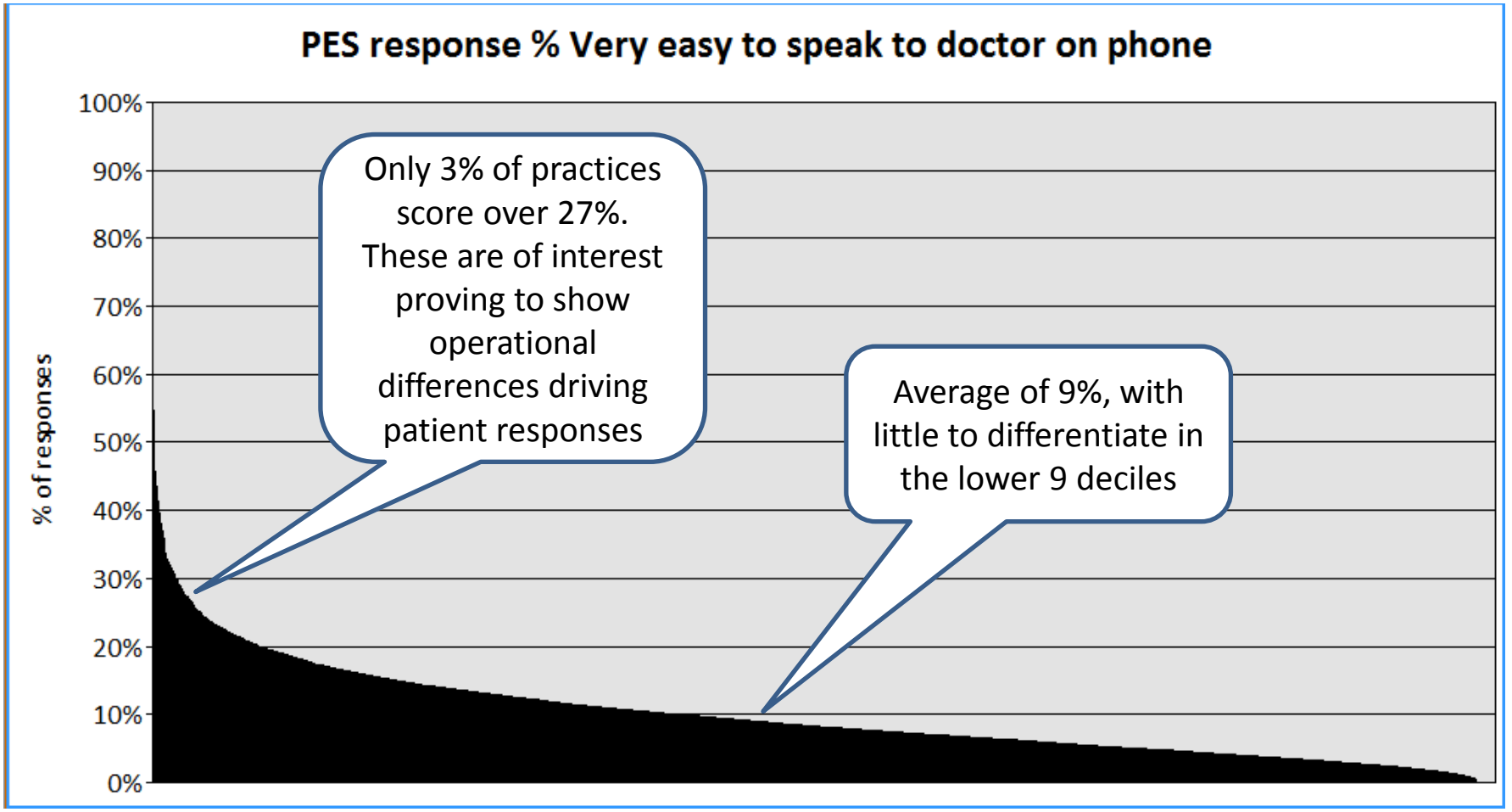
1. Background

- Reduction of demand for emergency care through hospital A&E, urgent care centres and ambulance calls is a high priority for commissioners in the NHS
- In recent years demand has outstripped the growth which demographic changes would predict
- Hospitals complain that much of their demand could be treated in primary care, and beds are taken up with patients admitted through A&E
- It is plausible to link perceived accessibility of primary care to patients' self referred demand for emergency (secondary) care.
- Available data on ease of telephone access to the GP provides a starting point for investigation of any effect.

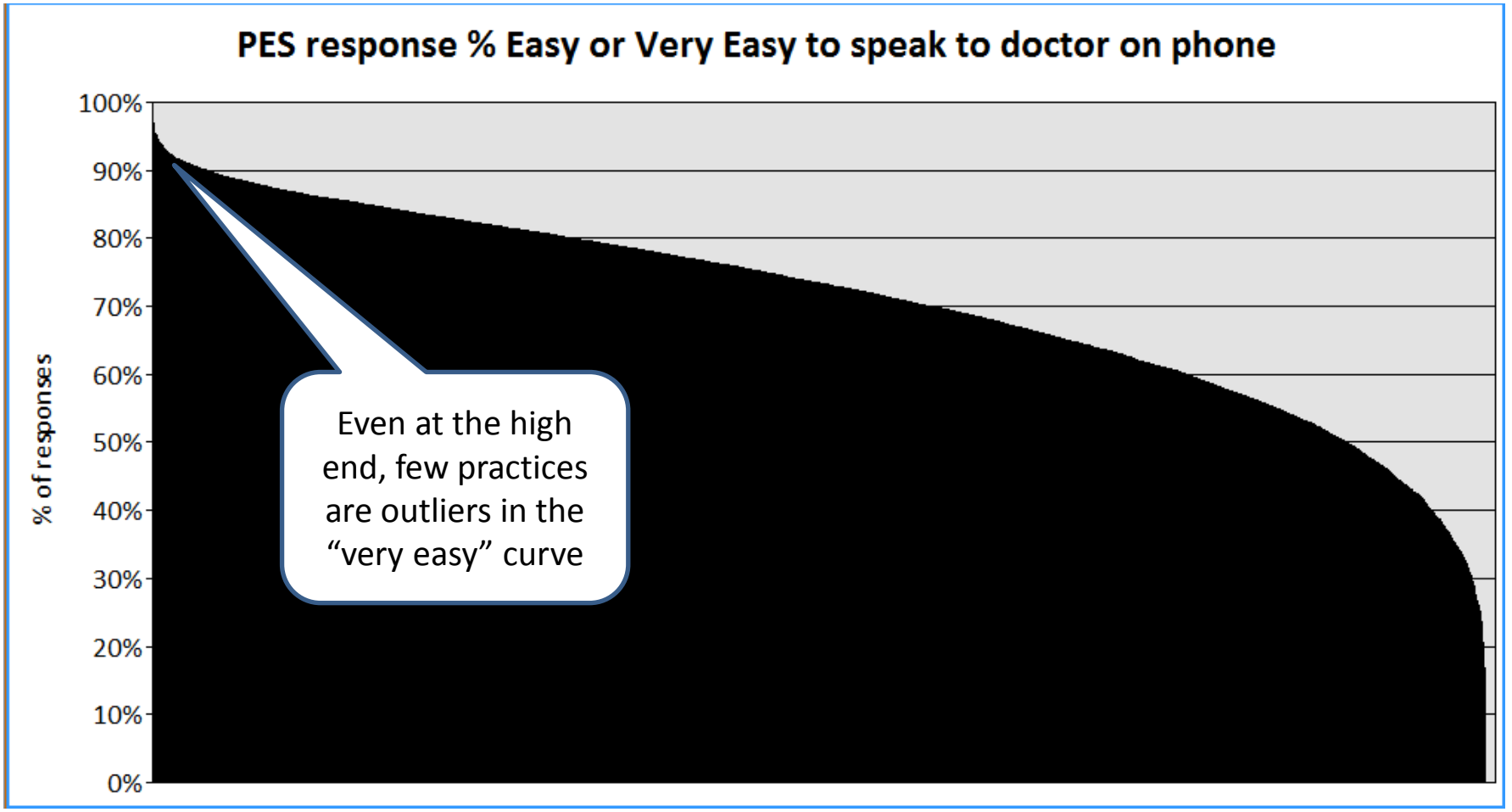
2. Method

- Observational study – telephone interview of English GP practices to understand their mode of access, specifically telephone access to GP
- Subject selection: those practices who scored in the top 3% on the 2010 GP Patient Experience Survey on the question "Very easy to speak to doctor". The mean is 9%. The subjects scored over 27%.
- Interview question: "What happens when a patient calls the surgery?", followed by conversation to understand the detail. Question put to receptionist, or referred to practice manager or GP. Notes taken and recorded roughly verbatim during the conversation, surveyed Jan – May 2011
- Classification of the access mode. Emerging from the raw data were four types, distinctions between them somewhat continuous rather than discreet at the margins, but sufficient to enable further analysis by type.
- Comparison of A&E demand by practice, to understand any effect which might be linked to the access mode. 14 PCTs out of 152 were excluded because of poor data.
- A&E demand had previously been shown to be influenced by age & sex of patients, and by deprivation. Raw data for the full year 1/4/09 to 31/3/10 was directly standardised, and plotted by practice against the IMD (Index of Multiple Deprivation), by practice, derived from 2007 data by ward.

The PES asks patients how easy it is to speak to a doctor on the phone. The average is about 9% in each practice, but a few are different.



Summing the answer “Easy” with “Very Easy” changes the shape of the curve, and proves a poor differentiator between practices



3. Results – classification of mode

- Some practices appeared to have no particular provision for telephone access to GP. Given that over 8,000 practices are covered in the PES (Patient Experience Survey), their results may be randomly higher than average.
- Some practices dubbed “informal” allowed very free access to the GP, without or in addition to an appointment system
- Some, dubbed “partial”, had a system where a limited number of GP telephone appointments could be booked by patients on request, or the GP was available for telephone calls during a limited period of the day or week.
- Some made “systematic” use of a GP telephone call in response to all or most new patient demand. This group became of particular interest because of further benefits cited by respondents. It appeared to be a distinctive innovation either invented or adopted by practices, with a defined start date. Various names were in use for the method, but the group later adopted the name “GP Access”.

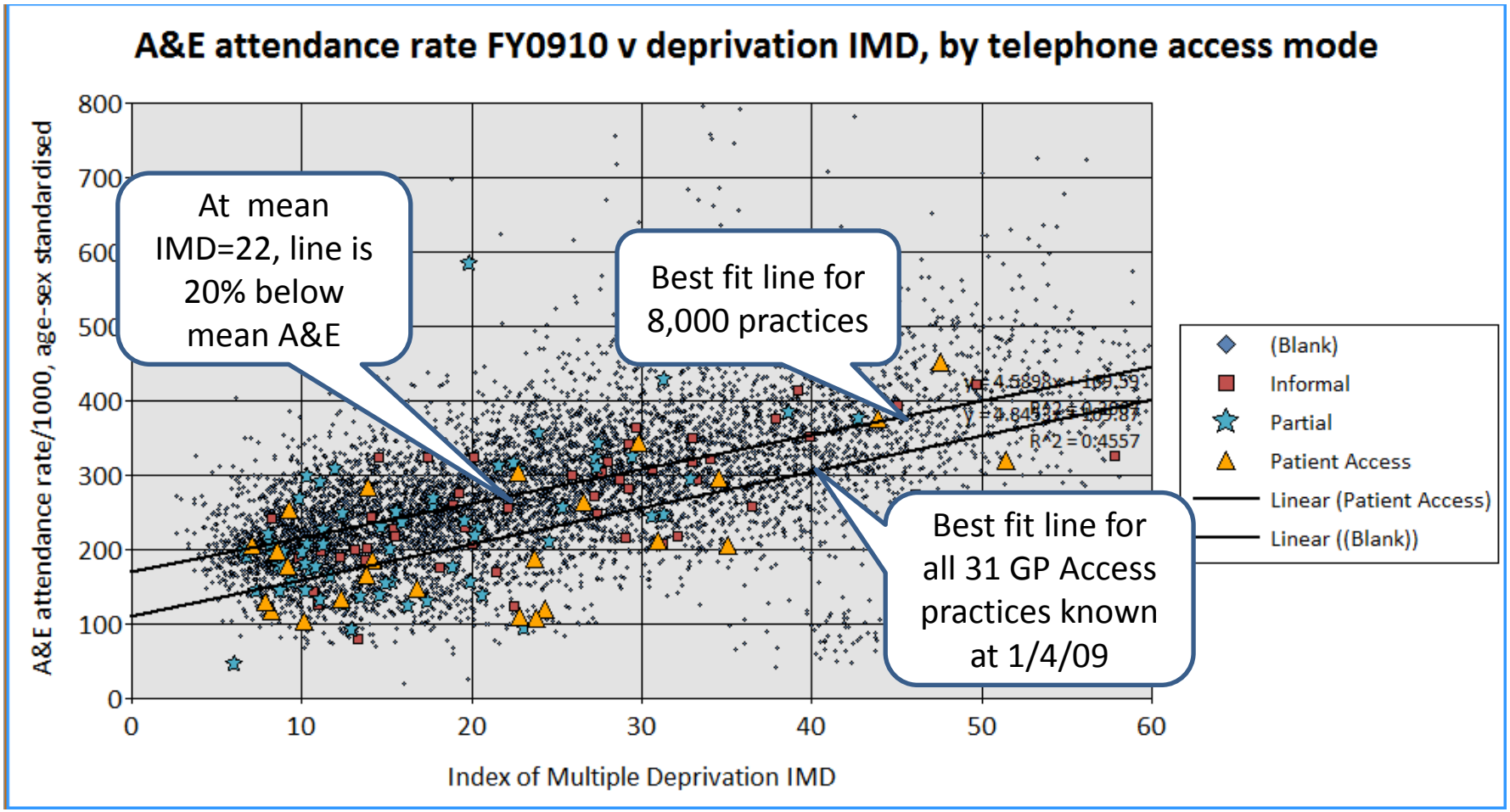
Numbers and sizes of 265 practices surveyed, by mode

Classified from telephone interviews			
Mode of telephone access	**Count of practices**	**Average list size**	**Sum of patient lists**
Indistinguishable from traditional practices	76	6243	474528
Informal	62	4518	280154
Partial	84	7849	659360
Systematic	43	8200	336238

Characteristics of “systematic” mode

- Answered simply that the initial response to all or most patient demand was a GP phone call.
- Self awareness that they were different, unlike other practices they knew, viewed as outsiders, often penalised in PCT audits.
- Described how they had invented the system or adopted it from a specific source, with a date, ranging from 2000 to recent months.
- Described benefits to GPs in perceived control of workload through making their own appointments, able to prioritise most needy patients, better staff morale.
- Did not know of any reduction in A&E activity unaided, though a few reported this when asked.
- Diverse situations of size (2400 to 19,000), geography (Penzance to Middlesbrough), inner city to rural, deprivation, demographic and ethnicity across a broad spectrum.

“Systematic” mode: patients of these practices are about 20% less likely to attend A&E.

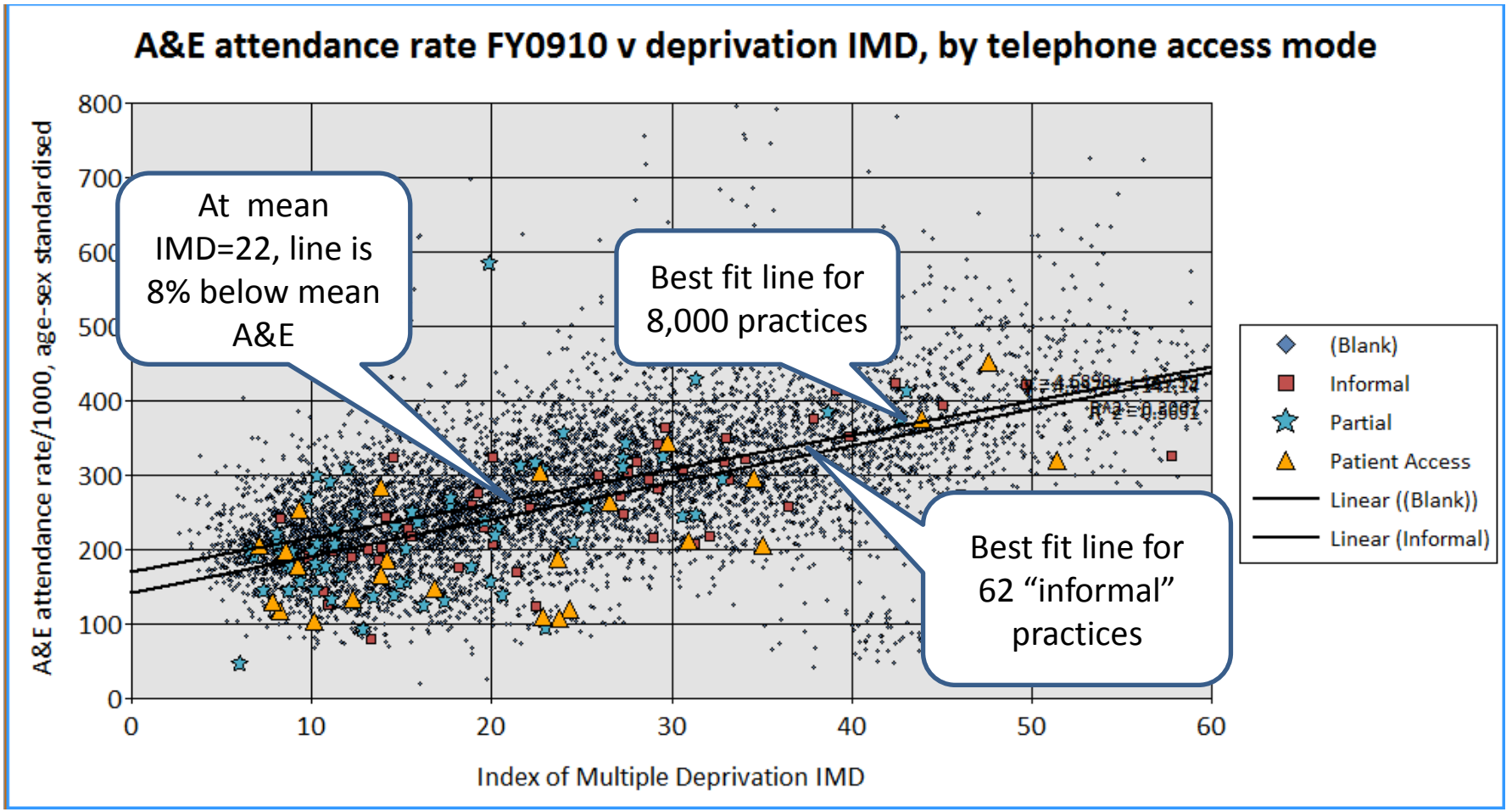


Design H Longman, A&E data calc EMQO from HESOnline FY0910, IMD from Solutions for Public Health/SEPHO

Characteristics of “Informal” mode

- Open lines for phone calls at any time (often interrupting face to face consultations), open doors for walk in patients. Respond to everything, as soon as possible.
- Smaller practices, usually 1-2 GPs, average 4500 list.
- Long established practices and long serving GPs, well regarded by their patients.
- Dedicated GPs, but stress commonly reported, long working hours, some about to retire.
- Broad spread of geography, demographic and deprivation.
- No particular start date for any system, custom and practice developed over years.
- Little management information.

“Informal” mode (phone and face to face) shows about 8% lower A&E use. Smaller lists.



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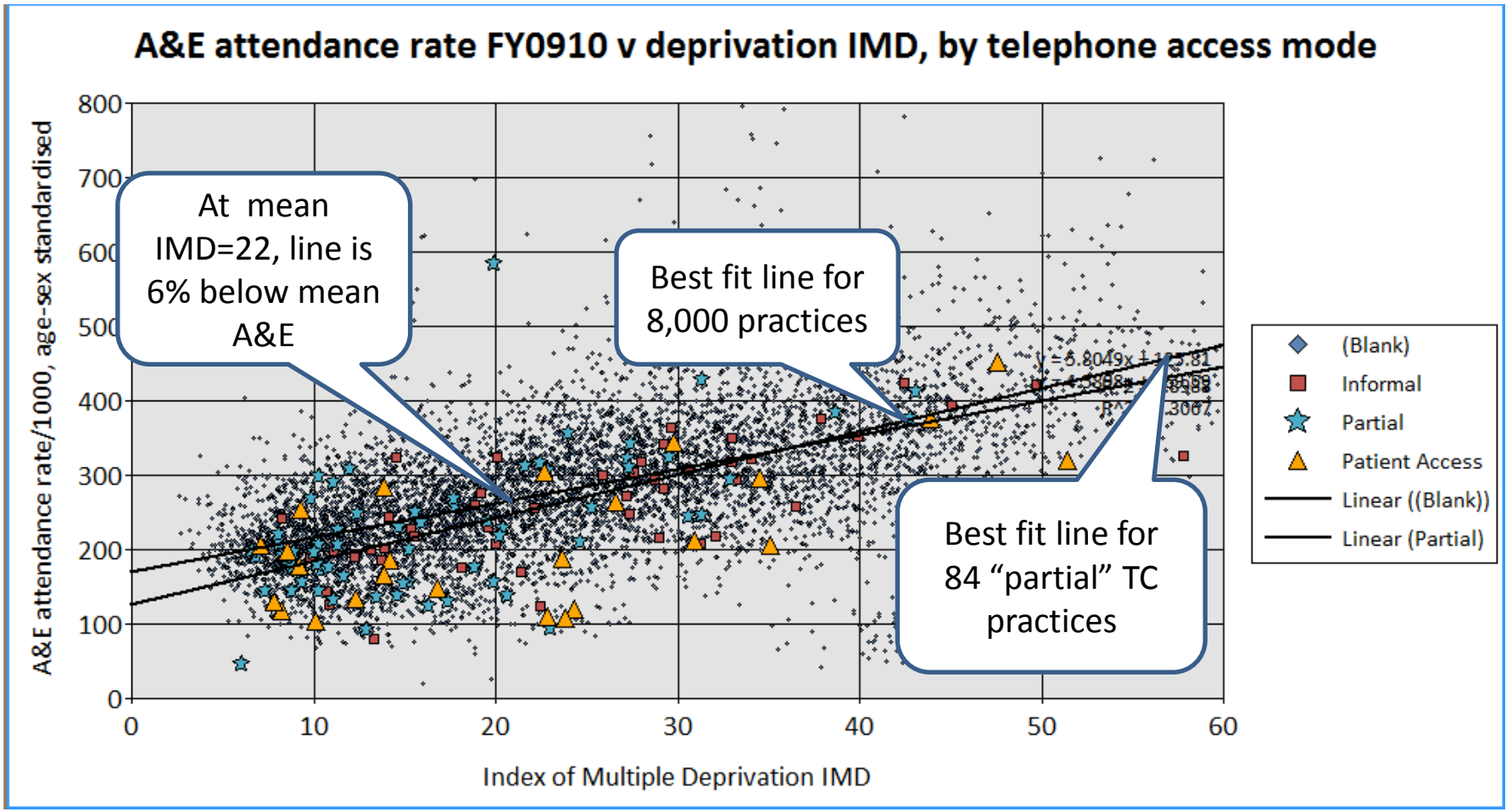
Characteristics of “partial” mode

- “It’s complicated” in answer to the question of what happens when a patient calls.
- Negotiation on what the patient wants, what is available and when. May request a telephone call, or be given one if no appointments available, or asked to call at a specific time.
- Diverse set of arrangements, formally defined and known to receptionists, eg 6 slots per doctor per day, calls made after surgery at 12.00, doctor takes calls 11.30 to 12.30.
- GP phone call reported as popular with patients, saves face to face appointments, slots taken up early in the day, saving time for both patients and doctors.
- Significant pressure on appointments often reported, with frequent adjustment of system in attempts to overcome problems.
- Range of practice sizes near to average, diverse settings.

“Partial” mode, with some GP telephone consultations available, shows about 6% lower A&E



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4. Discussion

- Arrangements for access to GPs by phone shows wide variation between practices.
- Among those most easily reached by patients, useful classifications can be made even though modes are not discreet.
- A “systematic” group emerged, reporting a number of in-practice benefits as well as an association with 20% lower A&E usage. A t-test shows this is significant, p=0.0014 (S Swift).
- This mode has the characteristics of an innovation, rather than a continuum with others.

5. Conclusions

- Ease of access to a GP by phone is linked to lower use of A&E, irrespective of deprivation.
- An innovation where every patient is called by the GP is significantly more promising than a range of partial and informal systems, even where the PES scores are similar on perceived ease of speaking to GP.
- The innovation has been invented a number of times, and has also been transferred and adopted by others.
- Invented by GPs to solve a different problem, addressing workload and demand in primary care, the method is highly promising for reducing inappropriate emergency demand in secondary care.

6. Further study questions

Further work has already begun to map the detail of the method, measure some operational features in practices and demonstrate how these change in adopting practices. Many new questions arise, including for example:

- Can a causal link be made between the innovative method and lower A&E demand? Plausibly, it could be because access to GP is perceived to be sufficiently fast and convenient that the anxious patient is more likely to call the GP than self refer to A&E. A prospective design or interrupted time series could be used.
- To what extent is there an ideal form of the innovation which could be universally applied? What criteria could be used to answer the question?
- How could an intervention with new practices be developed and optimised?
- Are there measurable clinical effects for patients with this service, positive or negative?
- What are the long term effects on demand in these practices, and how do they differ by context?
- What is the effect on accessibility to primary care for underserved groups which might include racial or linguistic groups, and men?
- Are there practices, doctors, patients or populations for whom the model is inappropriate?