



Proposal to study a system of access in general practice involving a rapid telephone response by a GP

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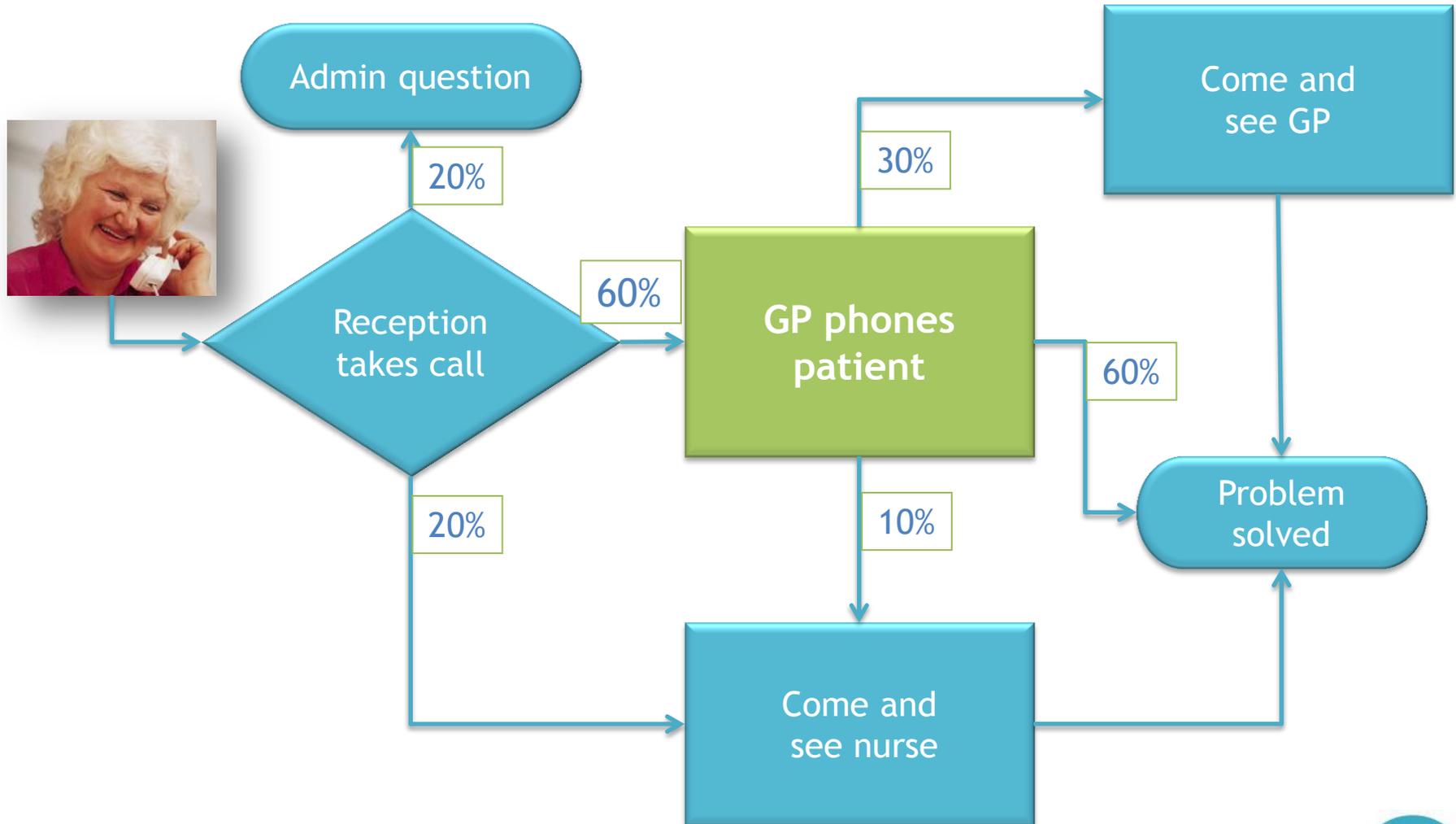
1. Studying the system as a whole
2. Design principles and variations
3. Measures available within practices
4. Questions which might be addressed
5. Note on intellectual property and interests

Additional material, case studies, research so far at gpaccess.uk

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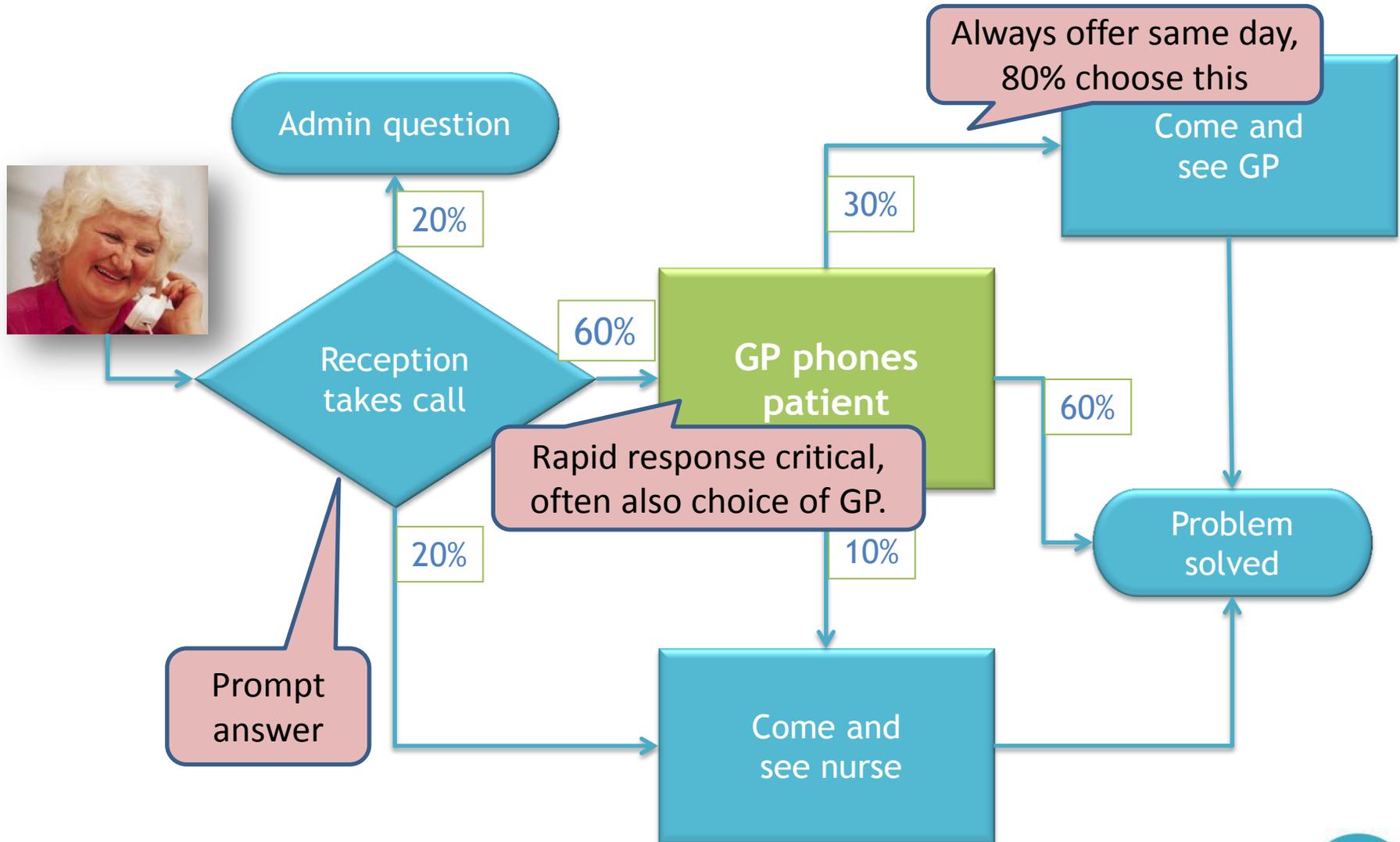


1. The system should be studied as a whole, as it is used and adapted by practices



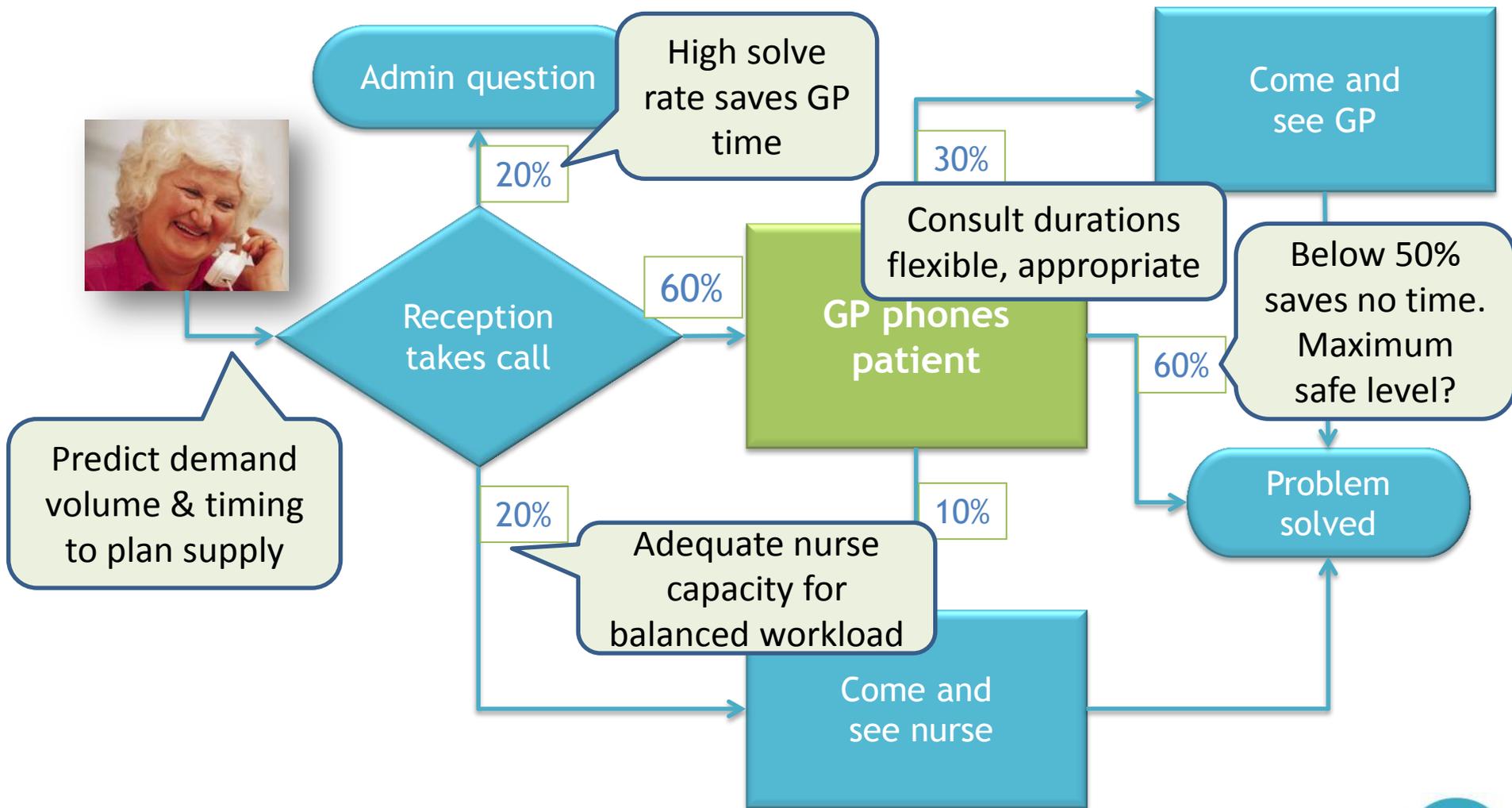
PA Navigator measures the flows, which vary by GP & practice.

Measurement is crucial to good performance. All interrelated – red mainly patient satisfaction, green mainly efficiency



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2. Design principles

1. Principles are around purpose – “how can we help all our patients, all day every day?” and do so with minimum rework.
2. The thinking behind the design replaces the traditional supply led model (filling GP slots) with a demand led model, predicting the nature, timing and volume of demand and organising supply to match it as closely as possible.
3. GP telephone consulting or triage has been found to be an effective means for running the system, but is not an end in itself.
4. The GP inventors of the system found that GPs are most effective at deciding appropriate treatment, so receptionists are used for signposting not for triage, and nurses for certain presentations only, not undifferentiated demand.
5. Variations have developed from different innovators, through trial and error, custom and practice, and in response to local conditions whether population, staff, facilities etc.
6. While the method can be simply and adequately described, there is no single agreed detailed specification and none is envisaged.

Some design variations between practices

1. Patient call - normally this is by phone, but can be accepted online. Walk-ins are discouraged, but where this is the only practical route eg deaf, these are accepted.
2. Receptionist response - generally not "scripted", ask how to help. Try to find out nature of problem, to help GP and to allow best direction. If possible, solve the problem without further handoff. Maybe 20% or so. Good information is crucial to doing this well.
3. Directed to nurse - where appropriate, book appt f2f. May be LTC clinic, list of conditions set by GPs. Variation - walk in nurse led clinic at Stour, successful model, further examples unknown
4. Most demand, put on list for GP to call back. Normal practice to state problem, but pt may say "It's personal". Important to try for preferred GP where one is named.
NB it is NOT normally possible for pt to book ahead f2f with GP through reception, unless a specific small subset of demand, eg antenatal checks. A GP may decide to bring the patient in without a call, if the problem note and history mean a call would be redundant.
5. Organisation of call back list - variations mainly around 2 types or a hybrid between them.
Shared list - one list from which all GPs pick patients. May have GP initials by patient to indicate preference.
Separate list - each GP on duty for callbacks that session is given a list of patients. Typically as preferred by patient for continuity, coupled with equal numbers where no preference given.
6. While we know that both access and continuity can be improved, there may be a trade off between these at some level - an interesting question.
7. Bringing in patients: if the GP decides the patient should come in, the offer is made for the patient to choose when. Our evidence shows over 80% choose the same day. This may be to see the same GP or another, or a different clinician eg NP or nurse.

3. Measures available within practices

1. Measurement has been central to understanding, evaluating and improving the system, both extracted from clinical systems and from online data capture.
2. Measures centre on aspects most important to patients, ie response speed and continuity, on efficiency and resource use
3. Routine operational measures
 1. Demand – by hour, day, week etc
 2. Response & waiting times – by minute, by day
 3. Capacity – by time period, clinician, phone/f2f
 4. Efficiency – eg consultation duration, bring in rate, DNAs
 5. Continuity – UPC measure
4. Qualitative surveys
 1. Patients, before & after intervention
 2. Staff, before, during and after intervention
5. Possible extensions
 1. Inter practice comparisons
 2. Age/sex of patients consulted
 3. Clinical audit
 4. Longer term clinical outcomes

4. Questions which might be addressed

1. The method
 1. Are there optimal designs, overall or related to practice characteristics?
 2. How could they be evaluated?
 3. Clinical safety – what are the effects?
2. Effects on secondary care
 1. A&E attendances
 2. Emergency admissions
 3. Referrals and elective demand
 4. OOH demand
3. Operational characteristics and any “dose response” effect on the above, eg
 1. Speed of response by GP to initial call
 2. Continuity – same episode and longer term
 3. Ratio of face to face/telephone consultations
4. The intervention
 1. What makes it effective, what factors predict success or failure?
 2. How should it be evaluated and over what period?
 3. How could it be improved?
 4. What is the effect of training?
5. Could a pilot group of practices provide a model for large scale evaluation?

5. Note on intellectual property and interests

1. No IP is claimed over the method of access or its variations. A similar idea has been invented at least 20 times independently, among the earliest known being C Barlow, Quorn 2000 and S Coupe, Stour 2001.
2. The name “GP Access” was adopted in 2014, since before that time a number of local names had been in use describing a similar model.
3. GP Access Ltd (formerly Patient Access Ltd) was set up in 2011 by H Longman in association with some of the GP inventors. Its object is “to transform access to medical care”. Material produced such as the launch programme are copyright, much of it placed in the public domain via the website gpaccess.uk
4. Other authors have no current financial interest in the organisation, but have provided advice free of charge.