Forty-eight hour access to primary care: practice factors predicting patients’ perceptions

John L Campbell*, Jean Ramsayb, Judith Greenc and Kate Harveyd


**Background.** The government has proposed a 48-hour target for GP availability. Although many practices are moving towards delivering that goal, recent national patient surveys have reported a deterioration in patients’ reports of doctor availability. What practice factors contribute to patients’ perceptions of doctor availability?

**Method.** A cross sectional patient survey (11 000 patients from 54 inner London practices, 7247 (66%) respondents) using the General Practice Assessment Survey. We asked patients how soon they could be seen in their practice following non-urgent consultation requests and related their aggregated responses to the characteristics of their practice.

**Results.** Three factors relating to practice administration and appointments systems operation independently predicted patients’ reports of doctor availability. These were the proportion of patients asked to attend the surgery and wait to be seen, the proportion of patients seen using an emergency surgery arrangement, and the extent of practice computerization.

**Conclusion.** Some practices may have difficulty in meeting the target for GP availability. Meeting the target will involve careful review of practice administrative procedures.

**Keywords.** Access, administration, appointments, availability, General Practice Assessment Questionnaire, primary care, survey.

Introduction

The UK government have determined that “By 2004, patients will be able to see a primary care professional within 24 hours, and a GP within 48 hours”1. A recent major national survey of NHS patients has suggested a deterioration in patients’ perceptions of GP availability between 1998 and 20022 with an increase in the proportion of patients reporting they had to wait two or more days for an appointment with a GP of their choice (from 63% to 72%). This policy has been seen as contentious, and regarded by GPs’ representatives as further fuelling already high expectations amongst the population3 with regard to the accessibility of primary care services. The NHS Plan calls for a greater role for the patient’s voice in influencing the provision of services. Primary Care Trusts are increasingly using surveys of patients’ opinions as a method for achieving this objective, in line with the new contractual arrangements for UK GPs4. Smaller practices may have an advantage in regard to patients’ perceptions of doctor availability over larger practices5, but it is not known which features of practice structure might contribute to this perception. Many practices are now exploring alternative arrangements for providing access to their services6 although it is not known how the introduction of such changes relates to the expectations of patients regarding primary care accessibility3. The proposals outlined under the new contract for GPs7 tend to switch the emphasis from a clinician unit of care, to that of a practice. This study investigates practice factors determining the reported availability of GPs by patients in an inner city setting.

**Methods**

As part of a study examining the accessibility of primary care8, 7247 consecutive patients (66% response rate) attending one of 54 volunteer inner London practices (from 202 approached) completed a questionnaire incorporating items from the General Practice Assessment Survey9 addressing perceived GP availability.
Practice size and staffing

Subjects used an ordinal scale to report how quickly (on the basis of their previous experience) they were usually seen following a consultation request for which they were prepared to see any doctor in the practice (same day, next day, 2–3 days, 4–5 days, more than 5 days). Two measures of accessibility were determined for each practice: the proportion of respondents reporting that they were able to see a doctor (i) ‘the same or next day’, or (ii) ‘within 2–3 days’.

Practice characteristics were determined from a practice profile questionnaire. There was no practice clustering effect for the accessibility measures. Univariate associations between 16 variables from three broad areas of practice characteristic (size and staffing, appointment arrangements, population and environment) and the two measures of accessibility were calculated using Pearson’s tests of correlation if one of the variables was normally distributed, or Spearman’s if neither was normally distributed. For dichotomous variables, Mann–Whitney U was calculated (Table 1). Practices scored one each if reporting use of computer for: morbidity recording, routine consultations, acute prescribing, repeat prescribing, electronic links with health authority, call/recall programmes of care. A practice performance score (maximum possible score 6) was calculated for each practice (cervical cytology coverage amongst eligible women, immunisation rates at aged two and five years).8 Practice characteristic variables containing a univariate significance of $P \leq 0.1$ were entered into stepwise multiple regression analyses with the measures of accessibility as dependant variables. Local ethics approval was obtained for the study.

**Results**

Contributing practices were representative of practices in the two inner London Health Authority areas in respect of the number of whole time equivalent GPs providing care. Adult respondents were similar to non-respondents in respect of age, with females having a slightly higher response rate than men. Two out of three patients (66.9%, SE 2.8) reported that a doctor was available for consultation the same or next day following a consultation request with any doctor, compared with 89.3% (SE 1.6) reporting availability within 3 days of such a request. Two practice variables independently predicted the proportion of practice patients reporting that a doctor was available the same or next day following a consultation request: the proportion of patients asked to attend the surgery and wait to be seen ($R^2$ change 0.25, $P < 0.001$) and the extent of practice computerisation ($R^2$ change 0.10, $P = 0.01$). The proportion of patients reporting that a doctor was available within 3 days following a consultation request was independently predicted by the extent of practice computerization ($R^2$ change 0.13, $P = 0.011$) and the

**TABLE 1** Practice characteristics ($n = 54$) and univariate association (see text) between practice characteristics and the proportion of practice questionnaire respondents reporting that they were able to see a doctor the same or following day, or within 3 days of a consultation request

<table>
<thead>
<tr>
<th>Mean ± SE unless otherwise stated</th>
<th>Availability of doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Same/next day</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Practice size and staffing</strong></td>
<td></td>
</tr>
<tr>
<td>List size</td>
<td>5956 ± 438</td>
</tr>
<tr>
<td>Single handed or group practice, n (%) of sample single handed</td>
<td>18 (33)</td>
</tr>
<tr>
<td>Number of patients per doctor</td>
<td>2209 ± 67</td>
</tr>
<tr>
<td>Number of administrative staff /1000 patients</td>
<td>1.02 ± 0.05</td>
</tr>
<tr>
<td><strong>Appointment system</strong></td>
<td></td>
</tr>
<tr>
<td>Proportion of patients seen with an appointment (estimated %)</td>
<td>72 ± 4</td>
</tr>
<tr>
<td>Proportion of patients told to come and wait (estimated %)</td>
<td>17 ± 4</td>
</tr>
<tr>
<td>Proportion of patients seen with block booking (estimated %)</td>
<td>0.6 ± 0.4</td>
</tr>
<tr>
<td>Proportion of patients seen in an emergency surgery (estimated %)</td>
<td>11 ± 2</td>
</tr>
<tr>
<td><strong>Practice population and environment</strong></td>
<td></td>
</tr>
<tr>
<td>Proportion of list attracting any deprivation payment (%)</td>
<td>84.7 ± 3.1</td>
</tr>
<tr>
<td>Proportion of list attracting high deprivation payment (%)</td>
<td>13.2 ± 3.7</td>
</tr>
<tr>
<td>Proportion of list aged under 5 years (%)</td>
<td>7.6 ± 0.4</td>
</tr>
<tr>
<td>Proportion of list aged over 65 years (%)</td>
<td>11.0 ± 0.5</td>
</tr>
<tr>
<td>Extent of computerization</td>
<td>4.6 ± 0.2</td>
</tr>
<tr>
<td>Training status n (%)</td>
<td>18 (33)</td>
</tr>
<tr>
<td>Practice performance score</td>
<td>4.1 ± 0.3</td>
</tr>
<tr>
<td>Publicized time for telephone consultations n (%)</td>
<td>13 (24)</td>
</tr>
</tbody>
</table>
proportion of patients seen using an emergency surgery arrangement (R² change 0.08, P = 0.037).

Discussion

Data collection was carried out using the General Practice Assessment Survey⁹ instrument, the precursor of the General Practice Assessment Questionnaire¹⁰—the latter being approved for use by practices in the new contract for GPs. Implementing a 48-hour target for GP availability is a challenging exercise.⁶ In this study, patients from more computerized practices, and practices seeing higher proportions of patients in emergency surgery arrangements had poorer perceptions of GP availability than patients from less computerized practices, and practices offering patients the possibility of turning up and waiting to be seen. It is not known whether these factors would predict patients’ perceptions of access outside of London although the views expressed by the London patients seemed to relate to the more general concerns of patients reported in the NHS Plan.

Although there was an association between practice list size and patients’ reports of the availability of a doctor the same or next day following a consultation request, this effect was not seen when the data were corrected for other variables using regression analysis. Findings from this present study add support to the earlier suggestion⁵ that practice administration and the operation of appointment systems may be of importance in influencing patients’ perceptions of doctor availability. Further research is required to explore the observed association between the extent of computerization within practices and availability of services. It is not clear whether this reflects a difference in culture between practices, or whether practices with more extensive computerization have more efficient technical support for appointments systems arrangements.

If these patients’ reports reflect actual GP availability, some practices may have difficulty meeting the proposed availability targets. Further work, probably of a qualitative nature, would be required to explore what factors contribute to patients’ perceptions of doctor availability. Access arrangements in a primary care setting are changing rapidly with multiple points of access to NHS care, and care from a wider range of health professionals than previously. Meeting and maintaining the proposed target will not only involve review of the skill mix of the health professionals providing care, but also careful review of practice administrative structures and procedures.

Acknowledgements

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Declaration

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Ethical approval: local ethics approval was obtained for the study.

Conflicts of interest: none.

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