The King's Fund

Ideas that change health care

Research paper

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A rapid view of access to care

An Inquiry into the Quality of General Practice in England

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The views expressed are those of the authors and not of the panel

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Contents

1 Introduction

This report is part of the Inquiry into the Quality of General Practice in England commissioned by The King's Fund. It considers access to general practice in England and how this can be measured. It also provides an indication of variations in access across the country.

In particular, it aims to:

- describe what good-quality access to GP care looks like
- propose what measures of good-quality access to GP care should be
- describe current access levels and variations
- identify existing measures of access and gaps in metrics
- describe government policy (and outcomes) where they bear on access
- provide an assessment of the role, and availability of data and data-collection methods through which to measure this
- provide a commentary on the challenges and implications faced by general practice in meeting the access to care agenda.

Ensuring good access to GP services has always been a key concern for the NHS in England. Much has been written about access to health care in general, and to primary care services in particular. Policy on access to primary care (and GPs in particular) has developed over time from concern about 'under-doctored areas' to include more sophisticated action on speed of access through, for example, targets on maximum waiting time for appointment.

However, how access is defined, what it means in practice and how it should be measured is a matter of some debate. Reflecting the literature on access, this review adopts a multidimensional framework for access, defining three broad domains – physical access, timely access and choice – and then defining 12 more detailed measures across these domains.

The review assesses the availability of data related to these measures, and presents illustrations of current variation across (mainly) GP practices on 26 access indicators, ranging from average size of the practice list, and various measures of proximity, to satisfaction with telephone access and ability to see a preferred GP. It concluded with a long list of 22 possible indicators of access, many of which are currently available through national and local surveys such as the GP Patient Survey (Department of Health 2010).

Nevertheless, while it is possible to set out metrics on access, these are essentially based on a traditional model of general practice characterised as a 'first port of call', gatekeeping or routing role, and a similarly traditional view of which services, care and health care advice are provided in surgeries by GPs and other primary care professionals.

This review proposes metrics that could bear on desirable aspects of access, but it also suggests that these should not be applied in a 'one size fits all' (for all time) way. Changes and developments in the nature and type of health care services, communication and medical technologies, along with variations in patient and societal preferences concerning

access, all suggest that detailed access metrics will need regular revision, and that much broader (and less specific) measures may need to be adopted to mirror changes in services, preferences and technologies.

This report begins with a discussion of how measures of access have developed, and goes on to provide a framework for measuring access. Section 3 provides an analysis of the current position in England in terms of some chosen measures of access. Section 4 discusses some international comparisons. Finally, Section 5 concludes with a discussion of the implications in terms of access for general practice in the future.

2 A framework for measuring access

This section provides a brief discussion of what access means, and how it has been interpreted in the past – particularly though the implementation of government policy – before suggesting a framework for measuring access to GP services.

Policy on access

Much has been written about access to health care in general, and to primary care services in particular. How access is defined, what it means in practice and how it should be measured is a matter of some debate – as other reports in the Inquiry into the Quality of General Practice in England commissioned by The King's Fund suggest.

Ensuring good access to GP services has always been a key concern for the NHS in England. Arber (1987) suggested that one aspect of good access was where 'patients can obtain appointments easily and quickly and where they, rather than the receptionist, decide when they should see the doctor'.

The simplest measure of access to GPs is the number of GPs per head of population. The implicit assumption underlying this measure is that a necessary (if insufficient) condition in meeting good access, as defined by Arber, is that there must be some minimum total number of GPs, distributed in such a way that enables practices to provide appointments in response to patients' needs.

It has long been recognised that there are parts of England that are 'under-served' in the sense that the number of GPs per head of population – particularly when population is adjusted for levels of need – is well below average. Indeed, a recent study has shown that even this simple measure of access does not give unequivocal results as it varies, sometimes substantially, according to the choice of GP supply measure, need adjustment and population base (Hole *et al* 2008). However, this is a crude measure of access and does not necessarily lead to good access as defined by Arber and others. Moreover, although there may have been difficulties in the past, there is currently little, if any, evidence that people are unable to register with a GP. However, where GPs are responsible for more people, it is clearly likely that access may be compromised, with less time and resources available per person than in a better-resourced practice.

More recently, other slightly more sophisticated measures of access have been introduced in England. For example, the NHS Plan (Department of Health 2000) pledged not only a substantial increase in the number of GPs but also policy to directly address timeliness of access, through new targets for the NHS. These included guaranteed access to a primary care professional – nurses and health care assistants within 24 hours and a primary care doctor within 48 hours – by the end of 2004. Also in 2004, the government introduced changes to the GP contract that provided extra payments for GP services linked to their achievement of quality standards, including access.

Quality is now monitored through the Quality and Outcomes Framework (QOF), introduced in 2004. The contract also introduced new arrangements for out-of-hours care, as under the new contract most GPs took less personal responsibility for the care of their own patients out of hours.

As it became clear how the access targets for GPs under the NHS

Plan were working in practice, in 2005 the access Patient Guarantee supplemented the 48-hour access, along with the ability to book more than two days ahead ('advanced access'), telephone access and the opportunity for a patient to see their preferred GP – all of which were included as part of the GP contract in 2006/7.

Alternative modes of provision had already been introduced since 2000, in an effort to improve access to some of the services provided by general practice – for example, walk-in centres and NHS Direct. More recently, the Department of Health has continued its effort to improve access, by extending opening hours, creating new practices (partly through competitive tendering), introducing new health centres in previously under-doctored areas, and the proposed abolition of practice boundaries, suggesting that patients will have a greater choice of GP practice in future.

However, for most people, being seen quickly is not the only concern. Other aspects of access are also valued, such as continuity with a specific professional or the ability to have an appointment at a convenient time. Several studies have shown that speed of access is perhaps less important than choice of appointment and professional. Thus a large national survey of patients' priorities and experiences of access to general practice revealed that patients in 'advanced access' practices obtained an appointment more quickly than those seen in control practices, but were no more likely to get an appointment when they wanted to be seen (Salisbury 2007).

This research also showed that for many people, being seen quickly was not the most important consideration. Obtaining an appointment on a day of choice was considered more important, and seeing a particular health professional was also a higher priority for some patient groups. This may necessitate booking in advance, which was more difficult in 'advanced access' practices. The finding that the speed of access was less important than choice of appointment and professional is not surprising given that more than two-thirds of patients were consulting about problems that they had experienced for several weeks or more (Salisbury 2007).

Similarly, Rubin found that the waiting time to make an appointment was important only if the appointment was for a child, or when attending for a new health problem. Other respondents would trade off a shorter waiting time and be willing to wait in order to either see their own choice of doctor or attend an appointment at their own choice of time. For respondents who worked, choice of time was six times more important than a shorter waiting time, and they were willing to wait up to one day extra for this. Those with a longstanding illness valued seeing their own GP more than seven times as much as having a shorter waiting time for an appointment, and would wait an extra day for an appointment with the GP of their choice, women would wait an extra two days, and older patients an extra 2.5 days (Rubin 2006).

The discussion of what access means in general was taken up in a recent series of articles in the Journal of Health Economics, Policy and Law (McIntyre *et al* 2009; Goddard 2009; Mooney 2009; Gulliford 2009). McIntyre and colleagues defined access to health care as…

> *… the empowerment of an individual to use health care and reflects an individual's capacity to benefit from services given the individual's circumstances and experiences in relation to the health care system.*
>
> (McIntyre *et al* 2009, p 181)

This discussion of access was based on three dimensions:

- availability (which they also call 'physical access') – includes both physical and time-dependent access, as well as elements of quality and quantity available.
- affordability or financial access – relates to the individual's ability to pay the full costs of care, including travel and lost earnings.
- acceptability or cultural access – defined as the fit between provider and patient attitudes towards, and expectations of, each other.

To a large extent, this last element is bound up with the quality of services provided, but where that quality is not purely objective and depends on the individual interactions. The translation of these elements into measurable dimensions of access is challenging.

A framework for measuring access

As we have seen, defining access is not straightforward, and is intimately bound up with the nature and quality of the service offered by general practice. For example, most people would not consider good access to a poor service to constitute 'good access'. In other words, access is instrumental rather than being of value in itself.

Although the literature on health care access suggests a range of measures of access, and some have become quantified measures used in policy, it is useful to consider what a more overarching framework of access might look like – one that allows consideration of all elements of access taken together. This section proposes a framework for measuring access that attempts to pull all elements together. This is then used in Section 3, to assess and compare current access levels across England.

The framework draws together some of the definitions and notions of access noted earlier, and takes a patient perspective. We therefore suggest that patients are likely to ask the following key questions about access:

- Is it easy to get to and into the surgery?
- Can I get an appointment to see an appropriate person when I want it?
- Can I see who I want to see?
- Can I get a good-quality consultation with appropriate specialist referral if required, and do I have access to a good range of on-site services?
- These can be are summarised as the following four dimensions:
- physical access to services, in the sense of distance to service and the logistics of the place of delivery
- timely access, in the sense of the services being offered at an appropriate time and place, and without undue delay
- access to a practice and GP of choice
- access to a range of quality services – in other words, appropriate levels of expertise as required, with a capability to refer on to specialist services.

In addition, there are system-wide dimensions to access: does the system provide access unconstrained by the social, educational, religious, cultural, language or other circumstances of the individual accessing services? These dimensions reflect more the notion of equity of access. However, a service that is not available because, for example, not all individuals can access the internet is failing some parts of the population on any measure of access. These issues of equity are addressed by other parts of the Inquiry into the Quality of General Practice in England commissioned by The King's Fund

The first three of the dimensions listed above should give rise to key metrics for measuring overall access. The fourth aspect reflects the instrumental nature of access: good access is access to high-quality and appropriate care. As with equity of access, this aspect of the quality and appropriateness of general practice services is dealt with by other parts of the Inquiry, and is not covered here.

Table 1 identifies the key aspects of access for the first four dimensions.

Table 1: Dimensions of access

Dimension of access	Example measures
Physical access	
Availability of GPs	GP registration Number of GPs per head population
Proximity	Distance from practice, travel times, public transport links, travel costs, safety or security of travel, car parking
Design of premises	Surgery design in terms of accessibility measures, quality of premises Satisfaction with ease of access to premises
Telephone access	Ease of, and satisfaction with, telephone access
Home visits	Does the practice carry out home visits on request?
Electronic access Email Website	Ease of, and satisfaction with, email access Existence of practice website with practice information and health information, appointments booking, etc
Timely access	
Appointments: • booking • hours	Availability of: • appointment within 48 hours • booking 2+ days ahead Satisfaction with opening hours Satisfaction with, and availability of, extended opening hours
Out-of-hours care	Availability of, and satisfaction with, out-of-hours care
Waiting times	Experience of waiting in GP surgeries Existence of a triage system
Prescriptions	Experience of waiting for repeat prescriptions Existence of electronic prescribing Availability of GP dispensing
Choice	

Choice of practice	Extent of choice of practice Proportion of population allocated to a given GP because of shortages
Choice of professional	Ability to see professional of choice – GP, named GP, practice nurse, etc

Patient preferences, values and trade-offs

An important issue to consider in formulating any normative metrics of good access to general practice is the value different people place on different dimensions of access detailed in Table 1. Moreover, there are likely to be trade-offs between these dimensions.

A study by Bower *et al* (2003) based on the general practice assessment study suggests that patients may have expectations of access that are in excess of government targets and also that they have high expectations of continuity of care. This analysis was based on responses to questions about their experiences of and satisfaction with:

- the waiting time for an appointment with a particular doctor
- the waiting time for an appointment with any doctor
- the waiting time for the consultation to begin
- continuity (in the sense of seeing the same doctor).

Bower *et al* used these data to pinpoint what levels of service patients might describe as satisfactory. However, as they point out, high standards relating to access and continuity derived from their analysis may not reflect explicit comparisons with other aspects of primary care. They claim that quality of care in primary care is a combination of access and effectiveness of the care provided. Surveys of primary care patients in Europe, (for example, as reported by Shoen *et al* 2007) suggest that interpersonal aspects may be more important than access issues such as waiting times for consultations.

Similarly, as mentioned ealrier, in a study looking at three dimensions of access (time to appointment, time of appointment, and choice of GP) it was found that speed of access is of limited importance to patients, and for many is outweighed by choice of GP or convenience of appointment (Rubin *et al* 2006). Waiting time seems to be important if the appointment is for a child, or when attending for a new health problem. However, most would trade off a shorter waiting time and be willing to wait in order to see their own choice of doctor or to attend an appointment at their own choice of time.

For people who work, choice of time was six times more important than a shorter waiting time and they were willing to wait up to an extra day for this. For people with a long-term illness, seeing their own GP was seven times more important than a shorter waiting time for an appointment and they would wait an extra day for an appointment with the GP of their choice.

Other studies (Salisbury *et al* 2007) have confirmed that for many patients, speed of access is not as important as convenience of appointment time and date. For example, where a patient has an urgent but non-emergency need and their surgery offers only same-day appointments in response to a telephone call on the day – or appointments at some point in the distant

future, the patient may feel forced to accept what they are given rather than being able to plan ahead. In a survey of patients in almost 50 GP practices, Sampson *et al* (2008) found that a 10 per cent increase in the proportion of same-day appointments was associated with an 8 per cent reduction in the proportion of patients who said they were satisfied with the appointments system.

This suggests that understanding patient preferences requires more direct studies of these issues. Surveys are needed that do not just measure access in a broad sense, but that focus on establishing trade-offs between the different aspects of access. These could be administered alongside discrete choice experiments, to provide some notion of how patients value the different attributes of access to care.

The fact that different dimensions of access are valued differently by different people (and by the same people at different times and in different circumstances) presents a real challenge to the formulation of concrete measures of good-quality access. More importantly, for general practice, it presents a challenge in how to design and deliver a truly personalised service that best responds to individuals' attitudes and concerns about access.

In summary, most of the measures of access that are currently available – and are described in the following section – have not been developed in a systematic way through consideration of an overall framework for access. Moreover, often one policy measure may stand in contradiction to another. For example, GP practices have increasingly been encouraged to expand and develop teams with wide skill sets, incorporating various health care and other professionals. Yet this has to be balanced against patient demands for continuity of care, and professional recognition that continuity is an essential requirement of good practice.

3 Available measures of access: levels and variation

Based on the dimensions of need set out in Table 1, this section reviews the metrics and data that are currently available for each access area, and reports on levels and variations for each measure by practice, PCT or local authority, where these are available. As the GP Patient Survey is a key national source of patient views about access, a summary of the survey including pros and cons is set out in the box below.

The GP Patient Survey

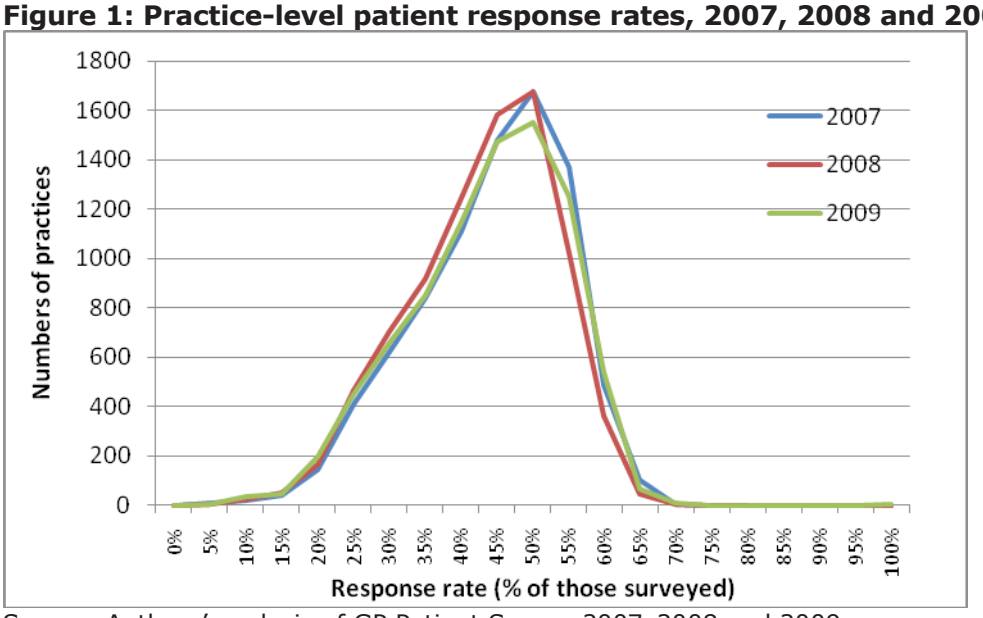
Background

The GP Patient Survey (Department of Health 2010) originated in the National Surveys of NHS Patients programme. This consisted of a series of surveys designed to help monitor NHS performance as seen from the patient's perspective, and was a commitment made in the White Paper *The New NHS – Modern, dependable* White Paper (Department of Health 1997), which proposed the introduction of annual surveys of patients and users to allow systematic comparisons of experiences over time and between different parts of the country. The 1998 General Practice Survey was the first in this series, and covered issues such as access and waiting times, patient–GP communication, patients' views of GPs and practice nurses, and the quality and range of such services as out-of-hours care and hospital referrals.

Coverage and response

The first GP Patient Survey was carried out in 2007, and was designed partly to trigger payments to GP practices, based on patient experiences of access to their general practitioners. A parallel survey covering around 250,000 patients who had been referred to hospital investigated patient experiences and attitudes to choice. The 2007 GP Patient Survey, run by Ipsos MORI, surveyed 4.9 million people, with around 2 million responses. In 2008 and 2009 the surveys obtained similar response rates – around 40 per cent of those surveyed – covering about 4 per cent of the entire English population. Response rates at practice level vary (*see* Figure 1).

Figure 1: Practice-level patient response rates, 2007, 2008 and 2009



Source: Authors' analysis of GP Patient Survey 2007, 2008 and 2009 (Department of Health 2010)

Pros and cons of the GP Patient Survey

The advantages of the survey are its scale (it is one of the largest surveys conducted in the public sector), coverage at practice level, and the fact that it is patient-based and conducted routinely. However, there are some disadvantages, including changes in questions and question wording from survey to survey, the potential for recall bias on the part of survey respondents, and the possibility of systematic bias in response rates at individual practice level.

On this last point, Table 2 shows the correlation between overall survey response rates and various demographic characteristics of those surveyed, at practice level. Practices with a higher proportion of unemployed in the surveyed group tended to have lower overall response rates and hence the possibility of bias or under-representation of the practice population as a whole.

Table 2: Correlation between respondents' characteristics and overall survey response rates

2009 GP Patient Survey	Correlation (Pearson: -1< r<+1)
Negative correlation with response rate	
% Unemployed	-0.59
% Non-white	-0.56
% Poor health	-0.48
% Learning difficulty	-0.41
% Permanently sick or disabled	-0.40
% Psychological or emotional condition	-0.40
% Fair health	-0.30
Positive correlation with response rate	
% Looking after the home	0.32
% Aged 85+	0.34
% Very good health	0.39
% Aged 75–84	0.42
% Fully retired from work	0.53
% Aged 65–74	0.54
% White British	0.56

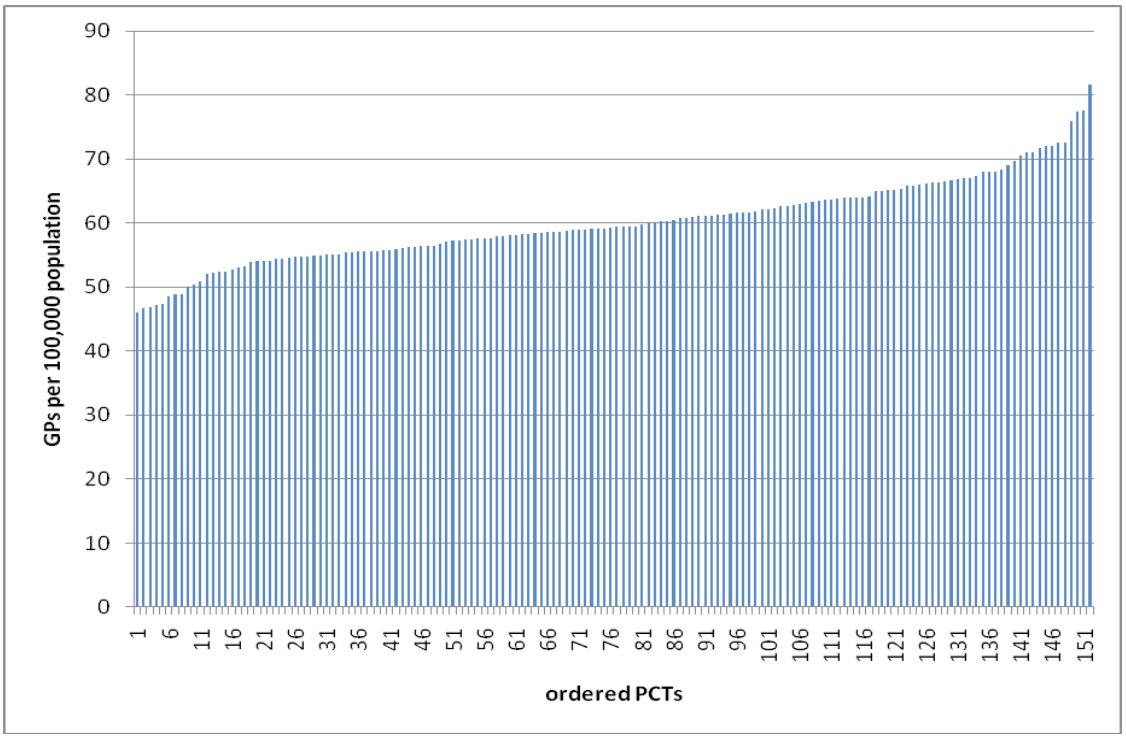
Source: The King's Fund 2010

Physical access

Availability of GPs

The simple measure of number of GPs per head of population has often been used as a crude measure of the availability of GPs, and as an indicator of access. There is considerable variation across the country, as shown in Figure 2.

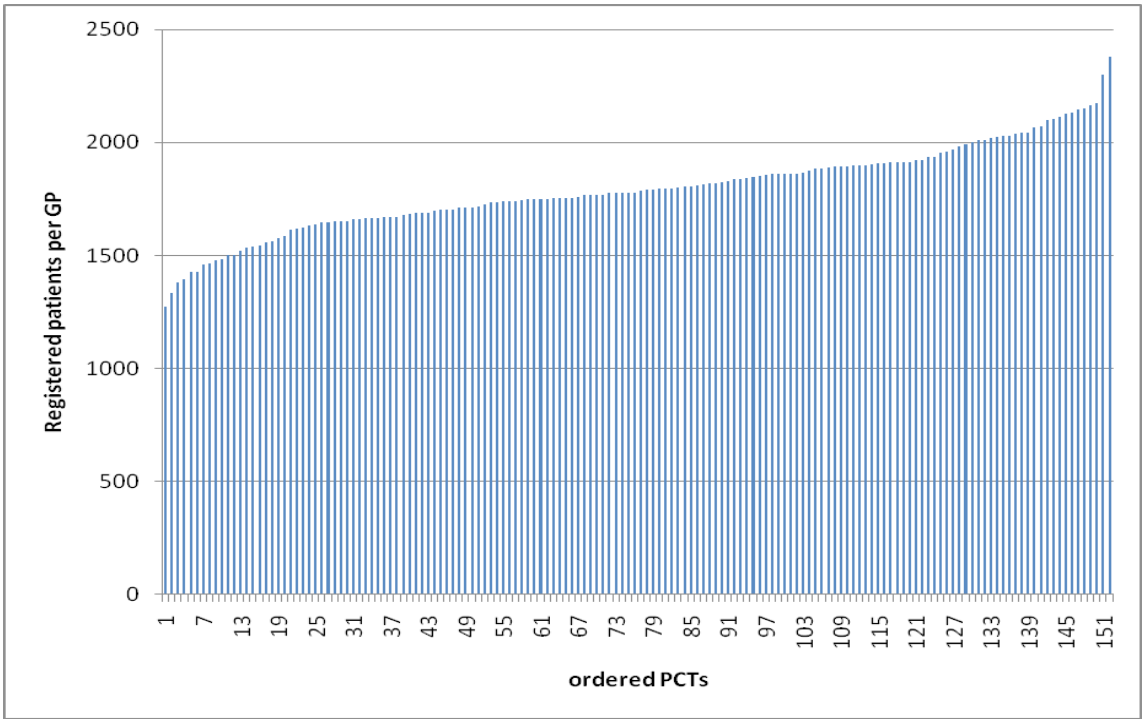
Figure 2: GPs per 100,000 population, by PCT



Source: Adapted from Information Centre (2009a)

Similarly, there are variations in average list sizes per GP (*see* Figure 3).

Figure 3: Average list size per GP, by PCT, 2008



Source: Adapted from Information Centre (2009a)

Although the availability of GPs and their caseload may seem obvious

factors bearing on access, a study for Tower Hamlets PCT by McKinsey and Company found that among practices in Tower Hamlets there was little relationship between the ability to provide appointments within 48 hours and the list size or number of GPs per practice (Department of Health 2009b).

Another consideration is the ease with which people can register with a GP, as well as whether there is any choice available. These issues are considered in 'Choice of GP', p 35).

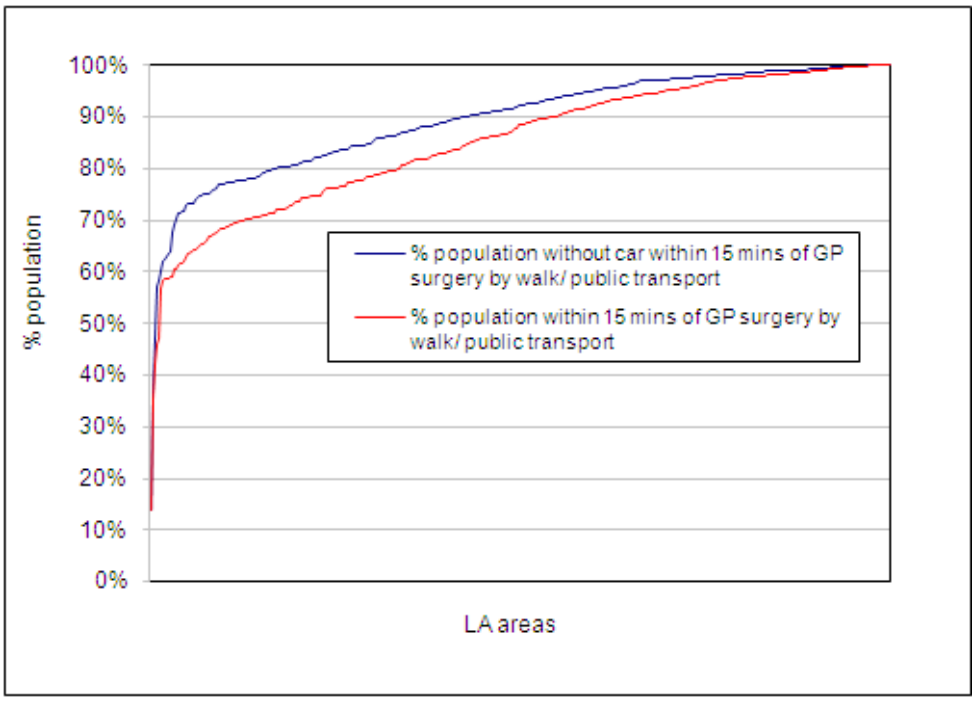
Proximity

A key consideration is the ease with which patients can attend a GP's surgery. Department of Transport data are available on time taken to travel to surgeries, by various modes of transport, for local authorities in England. (The GP Patient Survey reports on patients' travel times from home to surgery.) These data show a wide range of variation. Figures 4 and 5 and Table 3 show the proportion of households in 2008 in each local authority area in England that could reach a GP surgery within 15 minutes, and 30 minutes, by walking or public transport. They show that the same proportion was made up of households that did not have a car and who were hence more likely to rely on other forms of transport.

While for most areas the proportion of households that could reach a GP surgery in 15 minutes was over 90 per cent – Table 3 shows the median values as 89 and 92 per cent – there remained areas where the proportion was quite low. Thus, in the worst 25 per cent of areas, between 14 and 76 per cent of the total population were within 15 minutes of a GP practice. Access to GP surgeries was available to most households within 30 minutes, with a few exceptions.

Figures 4 and 5 also show that people who did not own cars tended to live in areas that were close to GP surgeries. This may reflect their dependence on walking or public transport. A key issue is the level of disability among these populations, as well as the terrain over which people must travel – particularly hills. For example, older people may find it more difficult to travel further to GP surgeries (whether on foot or by public transport), and this factor should be reflected in any indicators that are developed.

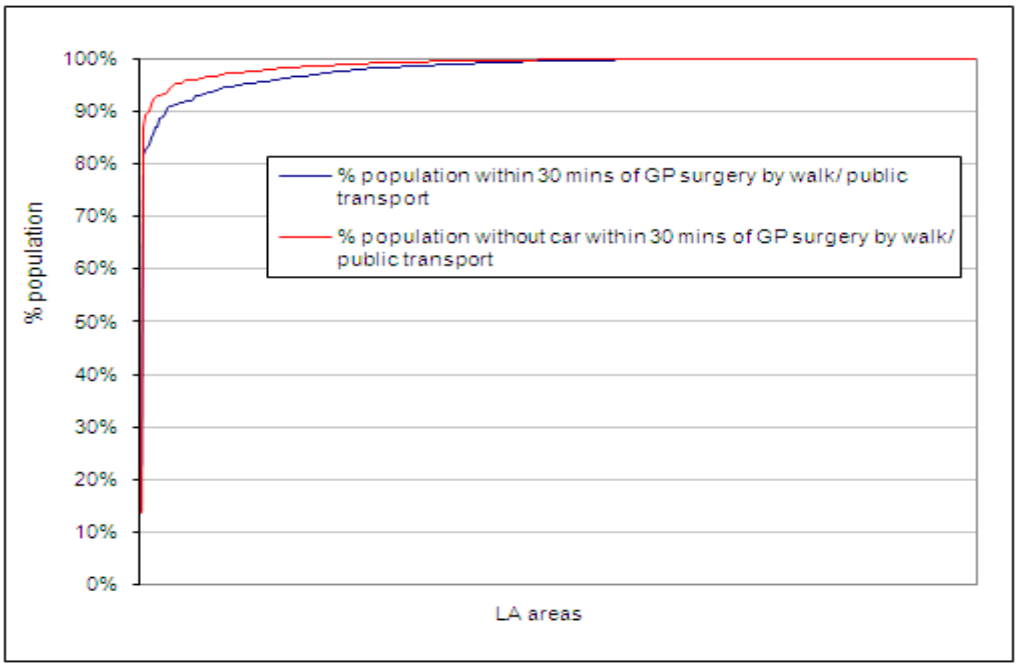
Figure 4: Proximity to GP surgery by walking or public transport by local authority area, 2008



Source: Authors' analysis of Department for Transport (2008)

When it comes to access by car, in all local authority areas (with just one exception) it was possible for households to access a GP surgery by car within 30 minutes, and in only five areas was this not possible within 15 minutes. Data are also available on proximity of access by cycle. As might be expected, these show a picture somewhere between the two other modes of travel. As a measure of proximity of access, walking or public transport seem most relevant, and there remains a considerable degree of inequity of provision when looking at this indicator.

Figure 5: Proximity to GP surgery by walking or public transport, by local authority area, 2008



Source: Authors' analysis of Department for Transport (2008)

Table 3: Quartile representation of spatial access to GP surgeries, 2008

Measure	% population within 15 minutes' walk or public transport of GP surgery	% population without car within 15 minutes' walk or public transport of GP surgery
Median	89%	92%
Upper quartile	97–100%	98–100%
Lower quartile	14–76%	14–83%

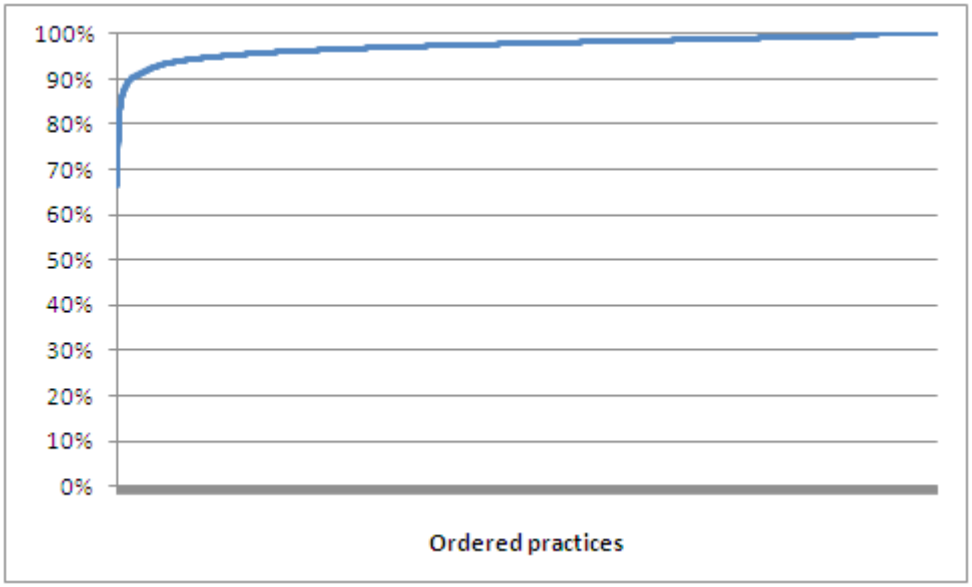
Source: Authors' analysis of Department for Transport (2008)

Considerably more research and analysis could be carried out at a local level to address, among other things, issues such as practicality of transport links given GP surgery opening hours, safety or security of travel, and parking issues. There are examples available of this type of analysis for local areas that reflect some of these factors (DHC 2005).

Design of premises

Another important issue is the ease with which people can enter and use a GP surgery. On this point, the GP Patient Survey in both 2008 and 2009 asked about the ease of getting into surgery. Figure 6 shows the proportion stating that access was very or quite easy. (The national average and overall distribution were almost identical for the 2008 survey.)

Figure 6: Proportion stating that it was very or fairly easy to get into the surgery, 2009



Source: Authors' analysis of GP Patient Survey 2009

It is clear that physical access into GP surgeries was easy for the vast majority of respondents. Nevertheless, it is worth noting that for 10 per cent or more patients, at around 170 practices, even such basic access was not easy.

There is a legal duty to ensure that there is access for people with disabilities, in order to comply with the 1995 Disability Discrimination Act. A survey of health authorities in 2001 showed that at that time only 23 per cent of practice premises were fully accessible to disabled people (Audit Commission 2002). To be compliant with the Act, this figure must now be 100 per cent.

In the past, the government has focused on measures of the quality of GP premises. It defined basic or minimum standards for GP practice premises – for example, to include facilities such as washbasins in treatment rooms, and to have rooms that ensured patient privacy. However, often these were not met, and there was a great deal of variation across the country. In 1990/91, 7 per cent of premises in England did not meet the minimum standards, and the situation in London was much worse, with more than 20 per cent failing (Boyle and Smaje 1993). In 1994/5, 26 per cent of premises in London were below standard, compared with just 2 per cent in the rest of England (Boyle and Hamblin 1997).

By 2001/2, the position in England as a whole had actually worsened to a failure rate of 9 per cent (Audit Commission 2002), and although in 2003/4 this had reduced to less than 8 per cent, London remained as high as 19 per cent at that time (Department of Health 2005). (The Department of Health stopped collecting these data in 2004/5.)

Telephone access

Telephone access to GP services has more than doubled in the past 40 years, from 4 per cent of consultations in 1971 to 9 per cent in 2004/5 in Great Britain (Office for National Statistics 2006). The latest evidence for England suggests that the telephone consultation rate had increased to 12 per cent by 2008/9 (Hippisley-Cox and Vinogradova 2009).

Evidence is sparse on whether patients are happy with this increase in telephone consultation, as opposed to face-to-face encounters. A systematic review of the impact of telephone consultation suggested that there was a lack of data on patient satisfaction and safety (Bunn *et al* 2005). A small study of the use of GP co-operatives suggested that although patients welcomed the speed and ease of access by telephone, they were often unhappy as they would have preferred a home visit, or they felt that communication by telephone was inadequate, resulting in doctors not being able to understand the severity of the problems patients described.

Many patients reported physical reasons (for example, mobility or difficulty breathing) or social reasons (such as lack of money or access to transport) for not being able to attend a primary care centre or GP surgery (Payne *et al* 2001).

Figure 7 provides an indication of levels of patient satisfaction with telephone access to GP surgeries. However, these views are more likely to focus on ease of access rather than some of the factors discussed above.

Figure 7: Proportion of people who are satisfied with telephone access to GP surgeries, by surgery, 2008

Source: Authors' analysis of GP Patient Survey 2008

Table 4 shows that in 1998 the proportion of people who were satisfied with access by telephone was greater than 91 per cent for more than half of practices. For the best 25 per cent of practices, more than 96 per cent were satisfied, while for the worst quarter of practices only between 22 and 82 per cent were satisfied.

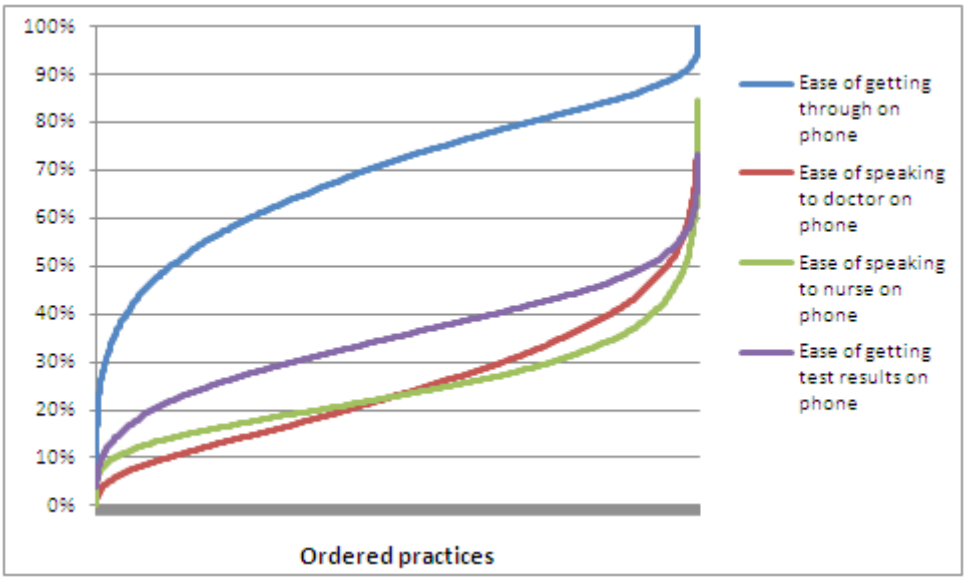
Table 4: Quartile representation of proportion of people who are satisfied with telephone access to GP surgeries, by surgery, 2008

Measure	Proportion satisfied
Median	91%
Upper quartile	96–100%
Lower quartile	22–82%

Source: Authors' analysis of GP Patient Survey 2008

Figure 8 is based on a different question in the 2009 GP Patient Survey. It indicates how easily patients were able to contact their GP practice by telephone, as well as ease of access by phone to a doctor or nurse, and to test results. This alternative view of telephone access (rather than satisfaction) suggests a rather poorer service: median 'easy' access to the practice via telephone was around 75 per cent, to a doctor or practice nurse around 25 per cent, and for test results around 35 per cent. Similar proportions were evident in the 2008 GP Patient Survey.

Figure 8: Proportion stating that it was very or fairly easy to get access via telephone to the surgery, to professionals and to test results, 2009



Source: Authors' analysis of GP Patient Survey 2009

Home visits

In the past, a relatively high number of consultations with GPs used to take place in the patient's own home. However, this practice has dropped off considerably in recent years. In 1971, 22 per cent of consultations took place in the home, compared with just 4per cent in 2004/5 (Office for National Statistics 2006). The latest evidence suggests that by 2008/9 the proportion of home visits had dropped further, to 3 per cent (Hippisley-Cox and Vinogradova 2009). These figures could be viewed as indicating reduced ease of access to GP services. A Dutch study (Giesen *et al* 2007) has shown that waiting times for GP co-operatives in the Netherlands are on average around 30 minutes, with almost 90 per cent being seen within an hour. Waiting times for home visits increase with increasing distance from the GP co-operative, but are also influenced by factors such as traffic intensity, the level of demand for home visits and urgency.

All GP practices provide home visits, and indeed have an obligation under the current GP contract to do so. In fact, the contract states that GPs must use their reasonable clinical judgement as to whether a patient needs to be seen and, if so, to decide the most appropriate place for the consultation.

Electronic access

- Key issues with respect to electronic access to GPs include:
- whether the GP practice has a website
- whether patients can book GP appointments online
- whether patients can order prescriptions online
- whether patients can consult their medical records online
- whether patients can consult or communicate with their GP practice by email.

National data are not collected on these issues, although there may be some ad hoc local studies and surveys. Certainly most practices seem to have a website, and some of the modes of access listed above are available in some areas of the country. The Commonwealth Fund study referred to later (*see* Table 17) shows that in 2007:

11 per cent of people in the United Kingdom said that they were able to communicate with their GP practice by email

32 per cent of those who could not said that they would like to

9 per cent said they could access their medical records by computer (although this number seems unrealistically high)

36 per cent of those who could not said they would like to be able to do so.

Timely access

Appointments

People want to be able to see their GP at a time of day convenient to them, and usually without too much delay. The government has identified three measures of access relating to timeliness on which GPs should be assessed:

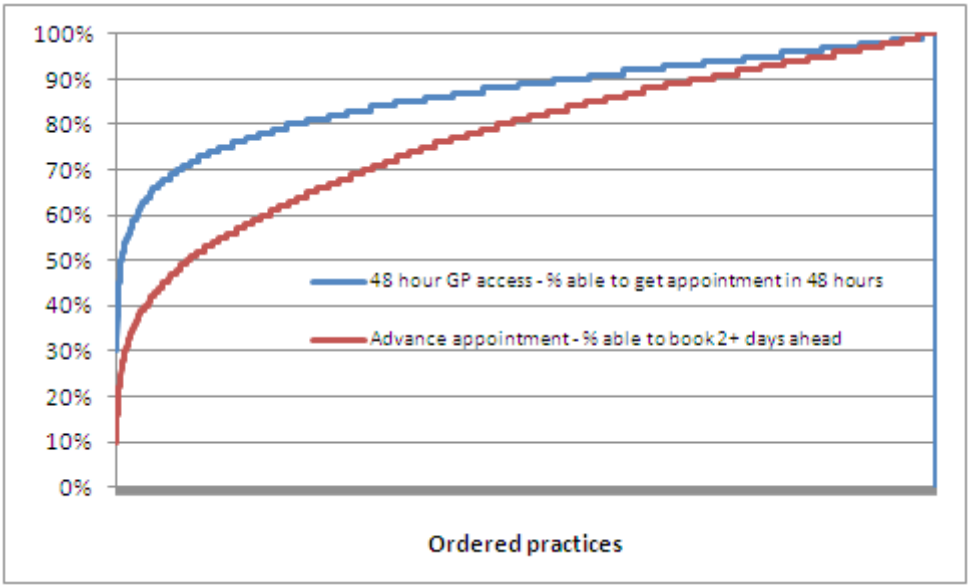
- ability to get an appointment with a GP within 48 hours
- ability to book at appointment more than two days ahead
- satisfaction with GP opening hours.

The first two of these measures may be useful but do not really get to the crux of the matter of convenience. The third is probably most relevant, although it is necessary to understand the reasons for dissatisfaction.

Figure 9 and Table 5 show the distribution of the first two measures of timely access across GP practices in England in 2007 (Information Centre 2008). For England as a whole, the median scores for the above indicators were 89 per cent and 81 per cent respectively. However, there was considerable variation between GP practices. So, looking at variation in the proportion of people able to get an appointment quickly (within 48 hours), for the worst 25 per cent of practices, between 30 and 82 per cent of patients reported that they could not get an appointment. Similarly, there was substantial variation in the ability of practices to provide a booked appointment more than two days in advance, with for the worst 25 per cent of practices between 10 and 66 per cent of patients reporting they could not get an appointment (*see* Table 5).

If these proportions were translated into absolute numbers for the population of England, the implication is that as many as 5.6 million people would have been unable to get an appointment with a GP within 48 hours, and as many as 9.8 million would not have been able to book an appointment more than two days ahead.

Figure 9: Timely access to GP surgeries, by surgery, 2008



Source: Authors' analysis of GP Patient Survey 2008

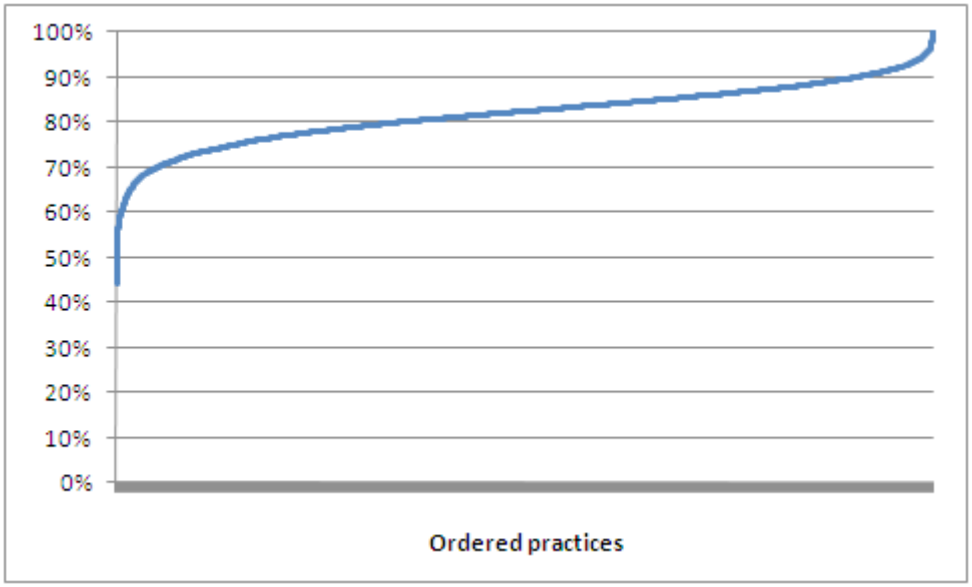
Table 5: Quartile representation of timely access to GP surgeries, by surgery, 2008

Measure	% able to get appointment < 48 hours	% able to appointment 2+ days ahead
Median	89%	81%
Upper quartile	94–100%	91–100%
Lower quartile	30–81%	10–66%

Source: Authors' analysis of GP Survey 2008

There is much less variation between practices in the proportion of people who say they are satisfied with GP opening hours. Figure 10 shows responses to the 2009 GP Patient Survey. (The national average and variation across practices has remained essentially unchanged between 2007 and 2009.) For England as a whole, the median was 83 per cent, ranging from a minimum of 44 per cent to a maximum of 100 per cent. Nevertheless, in the worst 25 per cent of practices only 44–78 per cent of people were satisfied with opening hours.

Figure 10: Proportion of people who are satisfied with GP surgery opening hours, by surgery, 2009



Source: Authors' analysis of GP Patient Survey 2009

When asked in the 2007 GP Patient Survey about the reason for dissatisfaction with opening hours, a majority of people said it was because surgeries were not open on Saturdays (median 44 per cent), with a high number also saying that surgeries are not open enough in the evenings (31 per cent). Smaller proportions of people said surgeries were open early enough in the morning (5 per cent) or around lunchtime (7 per cent), with a small number complaining about the lack of Sunday opening. Again, as with satisfaction with opening times, these proportions remained little changed in the subsequent 2008 and 2009 GP Patient Survey.

It is possible to look at the relationship between levels of dissatisfaction with GP opening hours and a range of individual characteristics, including age, ethnicity and work status. Findings are provided in Table 6. (Breakdowns by other characteristics are available – for example, urban versus rural, or levels of deprivation, but interesting differences are not observed.) People under 45 years of age tended to be more dissatisfied than people aged over 65.

A major cause of dissatisfaction among people under 45 years was not enough evening GP appointments, while people aged between 45 and 64 years seemed to favour Saturday opening, as did people over 65 years of age. There were some differences arising from ethnicity, with 77 per cent of non-white British being dissatisfied with opening hours compared with 83 per cent of white British.

The most significant differences emerge when work status is taken into account. People who worked full time tended to be considerably less satisfied (average of 74 per cent compared with an England average of 82 per cent), while people with what are described as 'other work patterns' (possibly implying more control over their work time) were least dissatisfied. Full-time workers were most concerned with availability of evening appointments and, to a lesser extent, early morning ones. Part-time workers were significantly more concerned with lunchtime opening than the average, although they also concerned with Saturday opening and, to a lesser extent, opening in the evenings. People with other work patterns, while least dissatisfied, seemed to be very interested in the availability of Saturday appointments.

As might be expected, full-time workers who commuted more than 30 minutes expressed more dissatisfaction with GP appointment hours (66 per cent satisfied) than those who commuted 30 minutes or less (78 per cent). Full-time workers who worked office hours also tended to be more dissatisfied (72 per cent satisfied) than those who did not (78 per cent). Finally, as would certainly be expected, full-time workers who were unable to take time off to see their GP expressed most dissatisfaction of all with GP appointment hours (just 53 per cent satisfied), and a high proportion of those wanted late evening and Saturday surgeries.

Table 6: Differences in levels of and reasons for satisfaction with GP surgery opening hours, by age, ethnicity and work status, 2008

	% satisfied	Reasons for dissatisfaction					
		Not open early enough in morning	Not open around lunchtime	Not open late enough in evening	Not open on Saturday	Not open on Sunday	Other reason
England average	82%	6%	9%	31%	44%	1%	8%
Age							
Aged < 45	77%	8%	10%	39%	33%	2%	8%
Aged 45 - 64	81%	6%	8%	32%	46%	1%	7%
Aged 65+	90%	2%	11%	8%	68%	2%	8%
Ethnicity							
White British	83%	6%	9%	31%	45%	1%	7%
Non-white British	77%	8%	11%	31%	40%	3%	8%
Work status							
Full-time	74%	8%	6%	43%	36%	1%	6%
Part-time	83%	6%	13%	26%	45%	1%	9%
Other work patterns	88%	3%	14%	14%	57%	2%	10%
Full-time commuting < =30 min	78%	7%	8%	40%	37%	1%	7%
Full-time workers commuting >30 min	66%	9%	4%	46%	35%	1%	5%
Full-time working weekday office hours	72%	9%	5%	46%	35%	1%	5%
Full-time working hours other than weekday office hours	78%	6%	9%	36%	39%	2%	9%
Full-time able to take time away to see GP	81%	9%	7%	40%	37%	1%	6%
Full-time not able to take time away to see GP	53%	7%	4%	48%	35%	1%	5%

Source: Authors' analysis of GP Survey 2009

These findings imply that any suggested changes to GP practice opening hours should at least take account of the characteristics of local populations: one model is unlikely to fit all.

The GP survey in 2008 and 2009 asked similar sets of questions on levels of satisfaction with GP opening hours. In England as a whole in 2008, around two-thirds of respondents said that within the previous six months they had tried to see their GP fairly quickly. This question is intended to reflect similar concerns to those about being able to see a GP within 48 hours. In 50 per cent of practices, as many as 87 per cent of patients said they had been able to see a GP fairly quickly. However, in the worse 25 per cent of practices between 21 and 73 per cent of patients said they had not been able to see a GP fairly quickly.

This compares with a median of 89 per cent in 2007/8 for a similar (but not precisely the same) question, and between 19 and 70 per cent in the worst 25 per cent of practices. (Between 30 and 81 per cent said they had been able to see a GP within 48 hours.) Figure 11 shows the distribution of people who said they had been able to see a GP fairly quickly.

Figure 11: Proportion of people who said they had been able to see a GP fairly quickly, by surgery, 2008 and 2009

Source: Authors' analysis of GP Patient Survey 2008 and 2009

Respondents were also asked why they had not been able to see their GP fairly quickly. By far the greatest proportion said it was because there had been no appointments (median 79 per cent), while some said it was because the times did not suit (13 per cent), some said that the appointment offered was with a doctor they did not want to see (13 per cent), and a small proportion (2 per cent) said that the appointment offered was with a nurse. These proportions were similar in the subsequent survey, in 2009.

The 2008 and 2009 surveys also asked respondents if they had been able to book ahead for an appointment with a GP (reflecting similar concerns to the question on booking two or more days in advance, asked in the 2007 survey).

Figure 12 shows the distribution of people who said they had been able to book ahead to see a GP. In 50 per cent of practices in 2008, around 80 per cent of patients said they had been able to book ahead to see a GP. However, in the worst 25 per cent of practices between 33 and 83 per cent of patients said they had not been able to book ahead to see a GP. This compares with a median of 81 per cent in 2007 for a similar (but not precisely the same) question, and between 34 and 90 per cent in the worst 25 per cent of practices. (Between 10 and 66 per cent said they had been able to book in advance.)

As the figure also shows, the situation in the 2009 survey seems to indicate a slight reduction in the proportion of people saying they had been able to book ahead.

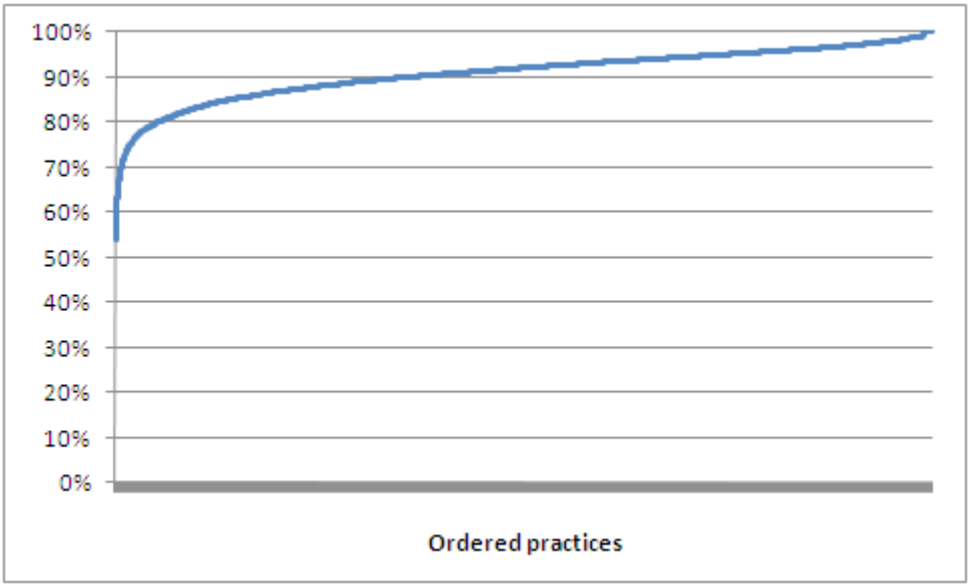
Figure 12: Proportion of people who said they had been able to book ahead for an appointment with a GP, by surgery, 2008 and 2009

Source: Authors' analysis of GP Patient Survey 2008 and 2009

Through the Quality and Outcomes Framework, practices are also monitored on their ability to offer a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week. In 2008/9 most practices were meeting this criterion (98.5 per cent), although 125 were failing to do so (Information Centre 2009d).

In terms of ease of obtaining an appointment with other staff, the GP Patient Survey in 2008 and 2009 asked about appointments with practice nurses. Figure 13, for 2008, shows the distribution of responses by GP practice of those stating that it was very or fairly easy to get an appointment with a practice nurse, The median is just over 90 per cent and the lower and upper quartiles between 55 and 85 per cent. The distribution was similar in 2009.

Figure 13: Proportion stating that it had been easy to get an appointment with practice nurse, 2008



Source: Authors' analysis of GP Patient Survey 2008

Extended hours

In 2006 the Department of Health announced that GP pay would be affected by the results of patient surveys on access. The Extended Access Direct Enhanced Service rewards practices that offer additional consultation time. By January 2009, around 70 per cent of practices offered extended opening hours. The 2008/9 NHS Operating Framework (Department of Health 2007) confirmed a commitment to longer opening hours for GP practices, as follows:

The Government has given a commitment that early action to improve the responsiveness of services will focus on improving routine access to GP services in the evening and at weekends. PCTs need to ensure that at least 50 per cent of GP practices in their area offer extended opening to their patients, with the additional opening hours based on patients' expressed views and preferences on access.

Patients seem relatively satisfied with the opening hours of their GPs. However, in 2009 when asked whether they would like to see opening hours extended, a majority (55 per cent) were in favour, and there was considerable variation between practices, as shown in Figure 14.

Figure 14: Proportion of people who would like to see their GP surgery opening hours extended, by surgery, 2009

Source: Authors' analysis of GP Patient Survey 2009

It can be seen from the lower quartile in Table 7 that in most practices (almost 75 per cent) a majority of people would like to have an extension to GP surgery opening hours. In the 25 per cent of practices most in favour, between 58 and 89 per cent of people wanted an extension. Of course, it should be recognised that this question is expressed in such as way that gives people a choice of a costless extension of hours, so it is not surprising that so many are in favour. More pertinent might be a question designed to elicit what value would be put upon such an extension.

Table 7: Quartile representation of proportion of people who would like to see their GP surgery opening hours extended, by surgery, 2009

Measure	% people who would like to see surgery opening hours extended
Median	55%
Upper quartile	58–89%
Lower quartile	5–45%

Source: Authors' analysis of GP Survey 2009

When asked what additional times they would like to see the GP surgery open, a majority of people chose Saturday (53 per cent). The next most popular choice was after 6.30pm (26 per cent).

The Commonwealth Fund study referred to later (*see* Table 17) shows that in 2007, 21 per cent of people in the United Kingdom said that their GP practice was open before 8.30am, 23 per cent said that it was open after 6pm, and, 11 per cent said that it had some weekend hours. However, 39 per cent of people said their GP practice had no early morning, evening or weekend hours.

Out-of-hours care

Most GPs – around 90 per cent, according to the National Audit Office (2006) – do not offer out-of-hours care to their own patients, although some may still be part of out-of-hours services in their local areas. These services are contracted for by PCTs, and are offered by a variety of providers – often in the private sector. For members of the public the concern is not with how out-of-hours services are provided per se, or which part of the NHS has responsibility for such services, but the more concrete issues of, for example, how to even contact such services – particularly given recent changes.

It is also worth noting that, again from the public's point of view, the only difference between the service they expect between out-of-hours and 'in-hours' GP services is the time of day. Figure 15 shows that a rather lower proportion than might be desired do not know how to contact out-of-hours services in their area: in both 2008 and 2009, only around 65 per cent of people in 50 per cent of practices knew how to contact the service.

Figure 15: Proportion of people who know how to contact out-of-hours services, 2008 and 2009

Source: Authors' analysis of GP Patient Survey 2008 and 2009

Figure 16 shows the considerable variation in the proportion of people who had found it easy to contact out-of-hours GP services by telephone in 2008 and 2009. Table 8, for 2008, shows that in 50 per cent of practices just 39 per cent or less of people felt it was very easy, and less than 41 per cent fairly easy. For the worst 25 per cent of practices, between 0 per cent and 31 per cent of people thought it was very easy and between 0 per cent and 35 per cent that it was fairly easy – although, taken together, up to 73 per cent of people felt it was either very or fairly easy.

Figure 16: Proportion of people who found it very or fairly easy to contact out-of-hours GP services by telephone, 2008 and 2009

Source: Authors' analysis of GP Patient Survey 2008 and 2009

Table 8: Quartile representation of proportion of people who found it very or fairly easy to contact out-of-hours GP services by telephone, 2009

Measure	% of people who found it very or fairly easy to contact out-of-hours GP services by telephone		
	Very easy	Fairly easy	Very easy or fairly easy
Median	39%	41%	80%
Upper quartile	48–92%	47–74%	86–100%
Lower quartile	0–31%	0–35%	0–73%

Source: Authors' analysis of GP Survey 2009

Figure 17 shows once again considerable variation in the proportion of people who felt that they had to wait too long for out-of-hour GP services. Table 9 shows that in over 50 per cent of practices, 31 per cent or more people felt they had waited too long for care. For the worst 25 per cent of practices, between 39 and 80 per cent of people felt they had waited too long for care. All figures were again similar in 2009.

Figure 17: Proportion of people who felt that care from out-of-hours GP services took about the right time, 2008 and 2009

Source: Authors' analysis of GP Patient Survey 2008 and 2009

Table 9: Quartile representation of proportion of people who felt that care from out-of-hours GP services took too long, 2009

Measure	% of people who felt that care from out-of-hours GP services took too long
Median	31%
Upper quartile	39–80%
Lower quartile	0–23%

Source: Authors' analysis of GP Survey 2009

Figure 18 shows considerable variation in the proportion of people who state that the care they received from out-of-hours GP services was good. Table 10 shows that in 50 per cent of practices, 65 per cent or less of people felt they had received good care. For the worst 25 per cent of practices, between 0 and 55 per cent thought care was good. Again, there was little change in 2009.

Figure 18: Proportion of people who felt that care from out-of-hours GP services was good, 2008 and 2009

Source: Authors' analysis of GP Survey 2008 and 2009

Table 10: Quartile representation of proportion of people who felt that care from out-of-hours GP services was good or very good, 2008

Measure	% of people who felt that care from out-of-hours GP services was:		
	Very good	Good	Very good or good
Median	28%	37%	66%
Upper quartile	35–70%	43–75%	73–100%
Lower quartile	0–21%	0–31%	0–58%

Source: Authors' analysis of GP Patient Survey 2008

Overall, it is probably fair to say that there is a considerable level of dissatisfaction with out-of-hours care, and a wide variation in perceived performance against the public's perception that out-of-hours care should be of the same standard as normal in-hours care.

Waiting times

The length of time people have to wait to see the GP when they have an appointment can be a cause of concern to some, and is also a measure of ease of access. Table 11 shows that in 2009 most people waited between 5 and 15 minutes for their appointment (median 53 per cent), with a sizeable minority waiting up to 30 minutes (median 18 per cent) and a number waiting over 30 minutes (median 4 per cent). There appears to be wide variation between practices. Within one practice, as many as 74 per cent of patients reported waiting more than 30 minutes.

Table 11: Quartile representation of length of time people wait in surgery when they have GP appointment, England, 2009

Measure	Length of time people wait in GP surgery				
	Normally seen at appointment time	Less than 5 minutes	5–15 minutes	16–30 minutes	More than 30 minutes
Median	10%	9%	52%	17%	3%
Upper quartile	14–54%	13–37%	57–72%	24–46%	7–73%
Lower quartile	0–7%	0–6%	0–44%	0–10%	0–1%

Source: Authors' analysis of GP Survey 2009.

Perhaps more interesting is what people actually think about the length of time they wait. Table 12 shows that most people do not believe that they have to wait too long (median 74 per cent). However, a substantial number of people do feel they wait a bit too long (median 21 per cent) and a significant number say that they wait far too long (median 5 per cent). Table 13, from the 2009 survey, shows a slight improvement.

Table 12: Quartile representation of people's impression of how long they wait in the GP surgery, England, 2008

Measure	What is your impression of the time you wait in GP surgery?		
	I don't normally have to wait too long	I have to wait a bit too long	I have to wait far too long
Median	74%	21%	5%
Upper quartile	83–100%	28–56%	9–55%
Lower quartile	15–64%	0–15%	0–3%

Source: Authors' analysis of GP survey 2008

Table 13: Quartile representation of people's impression of how long they wait in the GP surgery, England, 2009

Measure	What is your impression of the time you wait in GP surgery?		
	I don't normally have to wait too long	I have to wait a bit too long	I have to wait far too long
Median	69%	20%	5%
Upper quartile	77–100%	26–47%	8–52%
Lower quartile	16–59%	0–14%	0–2%

Source: Authors' analysis of GP Survey 2009

Is there any relationship between the impression that people have about how long they wait and the actual time they wait? It is possible to consider this on a practice-by-practice basis. Perhaps not unexpectedly, there is a strong correlation (0.93) between practices where people wait more than 30 minutes for an appointment and those where people say they wait far too long. Similarly, there is a strong correlation (0.88) between practices where people wait between 16 and 30 minutes for an appointment and those where people say they wait a bit too long.

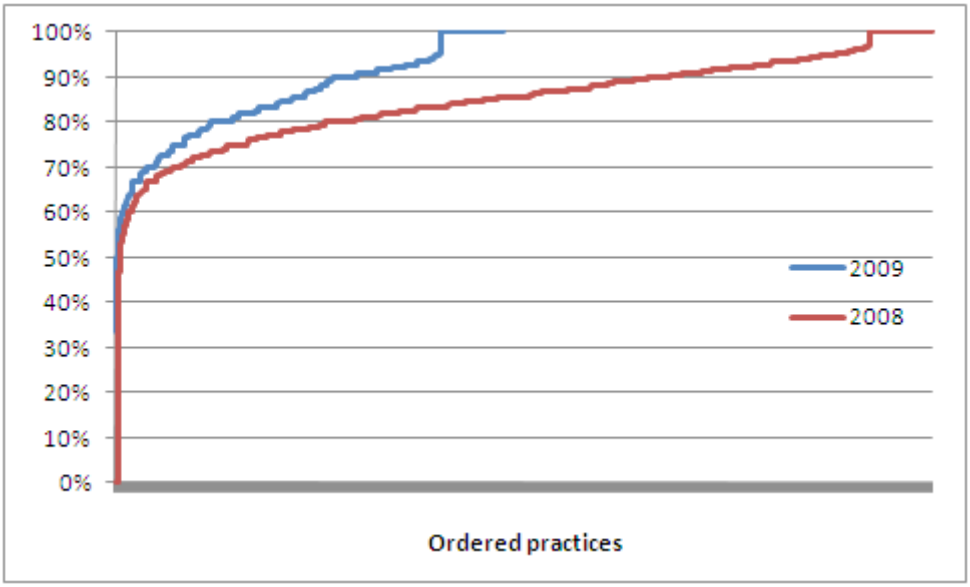
On the other hand, there is also a correlation (0.79) between practices where people wait less than five minutes for an appointment and those where people say they do not normally have to wait too long. There is also a lesser correlation (0.52) when people wait between five and 15 minutes. This then begins to provide some insight into individuals' views about what is an acceptable length of time to wait in a GP surgery: certainly, less than five minutes – and for some people, as long as 15 minutes – is acceptable.

Prescriptions

Ease of access to repeat prescriptions has improved considerably in recent years. Moreover, there has been an extension in the professions – for example, nurses and pharmacists – that can prescribe certain drugs. As part of improved access to prescription drugs, the Electronic Prescription Service (part of the national development of IT systems in the NHS) is intended to allow the person prescribing to send prescriptions electronically to the dispenser and then to the Prescription Pricing Authority, reducing reliance on paper prescriptions. Initially, the service was intended to be fully operational by the end of 2007. However, by March 2009, although 80 per cent of GP practices and pharmacies had the technology to operate the service, only just over 30 per cent of prescriptions were issued electronically (Department of Health 2009a).

Through the QOF, practices are also monitored on their ability to meet a target on repeat prescribing: that the number of hours between the patient requesting a prescription and its availability for collection should be 48 hours or less (excluding weekends and bank or local holidays). In 2008/9, almost 99 per cent of practices met this criterion, with just 99 practices failing to do so.

Figure 19: Proportion saying easy to obtain medicines following prescription from out-of-hours service, 2008 and 2009



Source: Authors' analysis of GP Survey 2008 and 2009

Choice

Registration

One key factor determining access is the ability to register with a GP. In the past, in some parts of the country there have been difficulties with registering, and significant numbers of people have been allocated to a GP practice without being given any choice. Meanwhile, in some areas – either because of shortages of GPs or due to administrative interpretations of distances that people could reside from surgeries – people have had access to no practice at all.

This situation has changed. Individual citizens now have three rights with respect to what is called 'informed choice' under the new NHS Constitution:

the right to choose one's GP practice. The practice in question must accept a patient unless there are reasonable grounds for refusal, in which case it must inform them of the reasons for this

to express a preference for a particular doctor within their GP practice, with which the practice must try to comply

to make choices about their NHS health care, with options available depending on individual need. This is reflected in the new GP contract.

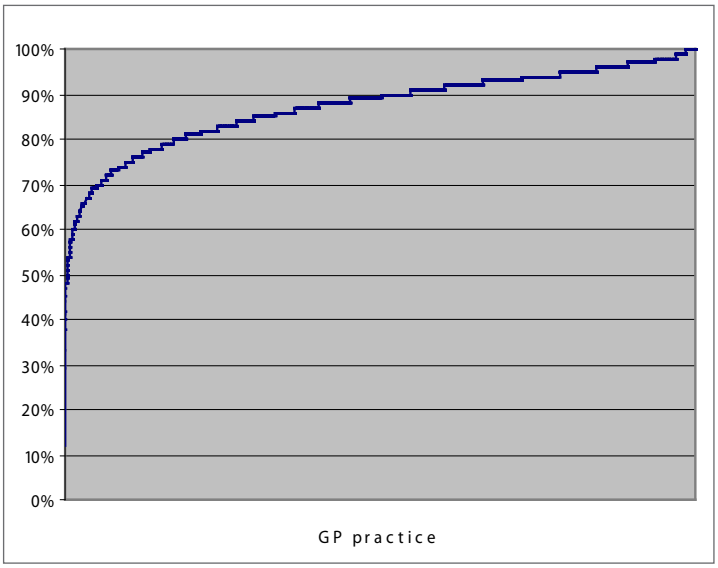
People can move from one practice to another without giving a reason, although the new practice can refuse their application. Similarly, a GP can ask a patient to find another GP – in other words, can remove the patient from the list. This should usually happen only if there has been an irretrievable breakdown in the doctor–patient relationship: in the most extreme cases, where the patient is violent, threatening or abusive, or if the patient has moved outside of the practice's geographical area. In 2007/8, just 1,142 people switched GP at their own request, compared to more than 75,000 people who were transferred at the request of the GP. The former figure will not include switches within a practice from one GP

to another, and neither figure reflects the total turnover in a practice's population – in other words, the number of new patient registrations plus the number of patient deductions as a proportion of the total practice population, which can vary anywhere from 2 per cent to 20 per cent of the total (Information Centre 2009b).

Choice of GP when making an appointment

Another important consideration for better access is the extent to which people can see the same GP when they want to. This tends to lead to improved continuity of care and showed up as a significant factor in several countries that were surveyed on patient satisfaction with access to health care (Schoen *et al* 2007).

Figure 20: Proportion of patients who are able to see the GP of their choice, by GP surgery, 2007



Source: Authors' analysis of GP Survey 2007

Figure 21 indicates variation between practices in the proportion of patients who are able to see the GP of their choice. As Table 14 shows, although for around 50 per cent of practices 89 per cent of patients reported being able to see a GP of their choice, for the worst 25 per cent of practices only between 12 and 83 per cent of people could do so.

Table 14: Quartile representation of proportion of patients who are able to see the GP of their choice, by GP surgery, 2007

Measure	% people able to see GP of their choice
Median	89%
Upper quartile	94–100%
Lower quartile	12–83%

Source: Authors' analysis of GP Survey 2007

Somewhat different results emerged from the patient survey of 2008/9. Figure 20 shows considerable variation between practices. In over 50 per cent of practices, only around 64 per cent of patients said they were able to see their preferred GP. In the worst 25 per cent of practices, between 7 and 55 per cent said they were able to see their preferred GP. However, in a minority of practices patients revealed that there was no choice, as there was usually only one doctor in the surgery.

The survey also asked patients who preferred to see a particular GP how often they managed to see this GP: 57 per cent said always or almost always, 20 per cent said a lot of the time, 19 per cent said some of the time and just 4 per cent said never or almost never.

[FIGURE] 21 Proportion of patients who said they were able to see their preferred GP, by GP surgery, 2009

Source: Authors' analysis of GP Survey 2009

Table 15: Quartile representation of proportion of patients who said they were able to see their preferred GP, by GP surgery, 2009

Measure	% people able to see preferred GP
Median	64%
Upper quartile	71–94%
Lower quartile	7–55%

Source: Authors' analysis of GP Survey 2009

Quality and extent of services

The issue of the quality of services available is addressed elsewhere in the Inquiry into the Quality of General Practice in England commissioned by The King's Fund, so detailed analysis is not presented in this report. Nevertheless, a number of key considerations referred to in Section 1 (see xxxxx) have formed part of the targets for GP practices in England in recent years. The outcomes for these targets are reported below.

In addition, the number of complaints about services is a form of indicator of quality, as well as of patient satisfaction. In 2008/9 there were approximately 39,500 written complaints relating to general practice, 74 per cent of which related to medical issues and 23 per cent to GP administration. This is an increase of around 11 per cent on the number of complaints in 2007/8. When these complaints are broken down further, 32 per cent relate to clinical issues, 24 per cent to communications or attitude, 13 per cent to practice or surgery management, 16 per cent to general practice administration and just 2 per cent to premises (Information Centre 2009c).

Length of GP consultation

The length of time available for a consultation is clearly an important consideration. The QOF data referred to earlier provides one measure of this. Practices report on the average length of routine booked appointments, or (in the case of practices that operate open surgeries – where patients turn up without appointments and wait to be seen) average face-to-face time spent with the patient. For routine appointments, the Department of Health has stated that the average is expected to be at least 10 minutes, and for open surgeries at least eight minutes. In 2008/9, over 98 per cent of practices achieved this aim, although almost 150 practices did not (Information Centre 2009e).

A survey in 2008/9 asked people whether they felt their GP gave them enough time in a consultation. Most people thought that the length of consultation was either very good (median 57 per cent) or good (median 34 per cent). However, a significant number of people – in one practice, as many as 16 per cent – felt that the amount of time was either poor or very poor, as illustrated in Figure 22.

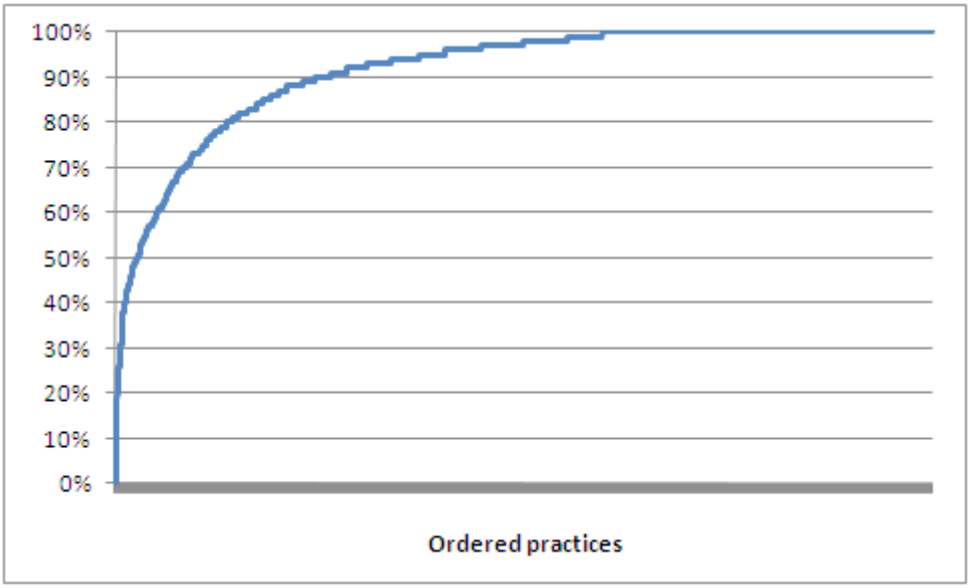
Figure 22: Proportion of patients who rated their doctor as 'good' in terms of time devoted to consultation, 2009

Source: Authors' analysis of GP Survey 2009

Choice of hospital or specialist

One key consideration is the extension of patient access, through increased choice, when a GP makes a specialist referral. When a specialist referral is being considered, the GP should offer the patient the choice of hospital. This indicator is monitored by government. Currently there is considerable variation in performance on this measure across GP surgeries, as illustrated in Figure 23.

Figure 23: Proportion of people offered a choice of hospital when referred for specialist consultation, by GP surgery, 2007



Source: Authors' analysis of GP Survey 2007

NB: Question not asked in 2008 or 2009 surveys

Table 16 shows that in 2007 around 50 per cent of GP practices patients were offered a choice of specialist consultation less than 51 per cent of the time. Moreover, for the worst 25 per cent of practices only between 6 and 42 per cent of people were offered a choice.

Table 16: Quartile representation of proportion of people offered a choice of hospital when referred for specialist consultation, by GP surgery, 2007

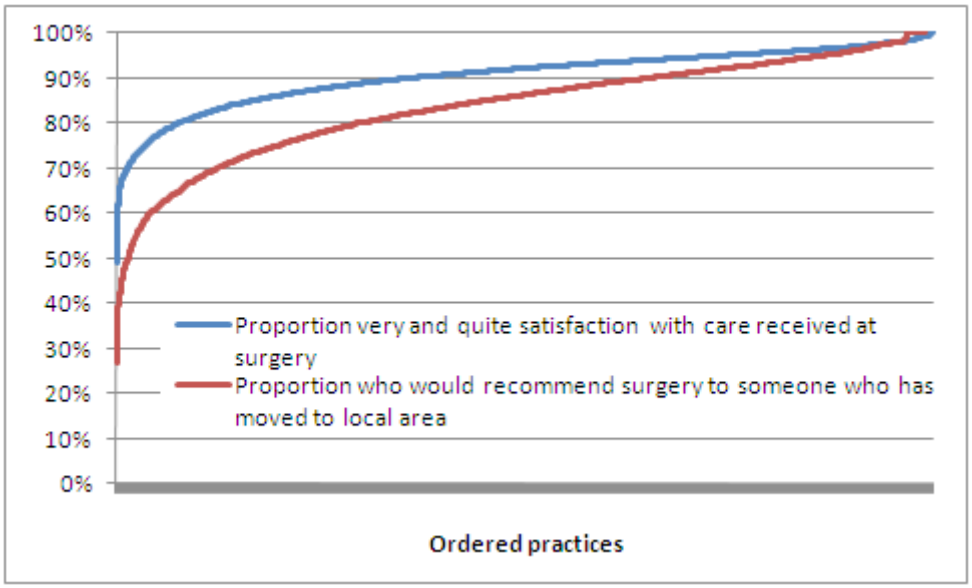
Measure	% people offered choice of hospital when referred for specialist consultation
Median	51%
Upper quartile	62–95%
Lower quartile	6–42%

Source: Authors' analysis of GP Survey 2007

Satisfaction with GP care

The GP Patient Survey in 2008/9 asked people how satisfied they were with the care received at their GP surgery. In most practices, most people were either very satisfied (median 58 per cent) or fairly satisfied (median 34 per cent). However, a significant number were not satisfied. Figure 24 shows the proportion of people who said they were fairly or very dissatisfied with the care they received at their GP surgery. Although on average around only 2 per cent of patients were dissatisfied on this basis, in the worst 25 per cent of surgeries 4 per cent or more were dissatisfied, and in one surgery the figure rose to as much as 28 per cent.

Figure 24: Proportion of patients who say they very or quite satisfied with care received at their surgery, and proportion who would recommend surgery to someone new to the area, 2009



Source: Authors' analysis of GP Survey 2009

4 International comparisons

The importance of a good system of initial contact with health services has been recognised in most countries. A recent survey of adult health care experiences in seven countries, including the United Kingdom (Schoen *et al* 2007), builds on previous surveys for the Commonwealth Fund (Schoen *et al* 2004, 2005). It includes a range of questions related to issues of access to GP services. For most of these, equivalent information is available collected locally for England. Table 17 provides a comparative view of the United Kingdom against the six other countries based on this set of questions.

Schoen *et al* (2006) also reported on doctors' views about access to primary care for the same seven countries. Interestingly, in the United Kingdom – and the same is true of other countries – there GPs respond differently to patients when it comes to GP surgery opening hours. While only 23 per cent of patients report having access to evening surgeries, GPs themselves report the level of access as 39 per cent. Similarly, only 21 per cent of patients report access to early morning surgeries but 33 per cent of GPs do. On the other hand, 11 per cent of patients report access to weekend surgeries compared with just 5 per cent of GP s claiming that their practice has weekend hours.

A more recent survey of primary care doctors by the same researchers (Schoen *et al* 2009) sought views on the use of IT in primary care to improve patient access. According to this survey, 96 per cent of doctors in the United Kingdom used electronic medical records in their practice – an increase from 89 per cent in 2006. In addition, 89 per cent had electronic access to patient test results, 89 per cent use electronic prescribing, 97 per cent enter clinical notes electronically, and 93 per cent received electronic alerts about potential problems with drug doses or interactions. On the other hand, only 35 per cent were able to order laboratory tests electronically.

The survey also looked at patient access to out-of-hours care, and patient difficulties in paying for out-of-pocket costs, such as for drugs. It found that 89 per cent of doctors in the United Kingdom reported that their practice has arrangements for their patients to see a doctor or a nurse outside normal hours. Only 14 per cent of doctors saw difficulties in paying for drugs or other care as a problem for patients.

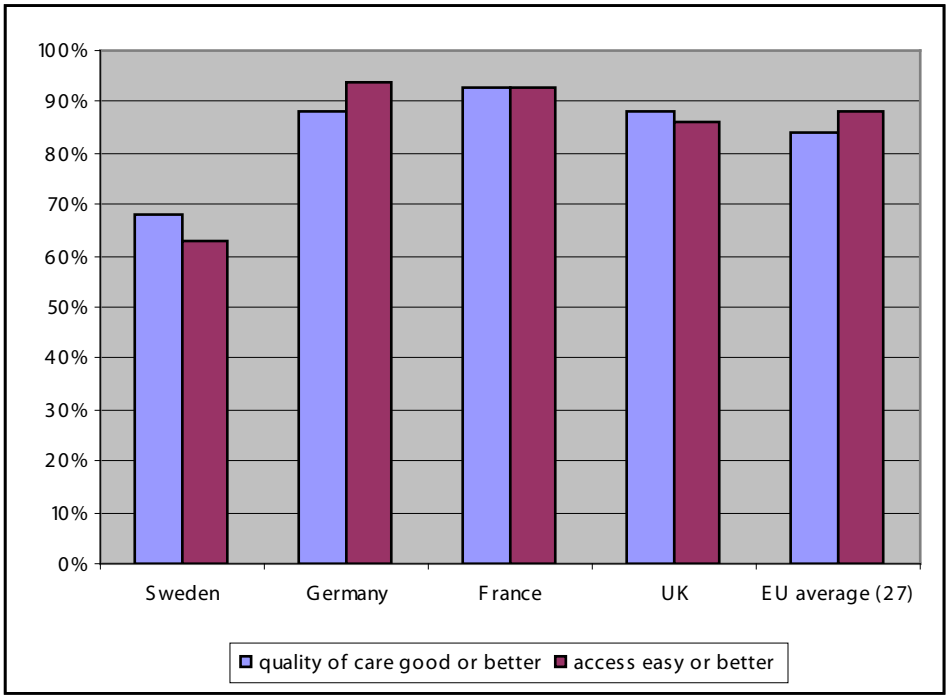
Table 17: Some international measures of access to GP services, 2007

Question	Answer	Australia	Canada	Germany	Netherlands	NZ	UK	US
		%	%	%	%	%	%	%
When you need care, how important is it that you have one practice or clinic where doctors and nurses know you, and provide and co-ordinate the care you need?	Very important	80	78	78	74	78	84	80
Do you have a doctor or GP you usually see?	Yes	88	84	92	100	89	89	80
Does the GP practice have early morning hours (before 8.30am)?	Yes	25	19	53	63	21	21	33
Does the GP practice have evening hours (after 6pm)?	Yes	37	31	39	5	26	23	25
Does the GP practice have some weekend hours?	Yes	58	21	15	8	34	11	28
Does the GP practice have no early morning, evening or weekend hours?	Yes	21	40	20	22	31	39	35
How easy is it to contact the doctor by phone during regular practice hours?	Very/ somewhat easy	86	78	66	75	88	80	81
Can you communicate with your doctor or practice by email?	Yes	15	9	16	15	22	11	20
And if no, would you like to do so?	Yes	34	40	18	38	40	32	43
Can you access medical records by computer including the internet?	Yes	12	5	18	7	11	9	10
And if no, would you like to do so?	Yes	35	43	30	49	44	36	37
How often does your doctor, or the doctor at the place you usually go to, know important information about your medical history?	Always	69	67	78	71	69	63	62
How often does your doctor, or someone in your doctor's practice, help you co-ordinate care from other doctors or places?	Always	51	47	45	31	49	38	47
Do you have a regular doctor or place that is very or somewhat easy to contact by phone, always or often knows your medical history, and always or often helps co-ordinate care – this is referred to as having a 'medical home'?	Yes	59	48	45	47	61	47	50
How quickly could you get an appointment with your doctor last time you were sick or needed care?	Same day	42	22	55	49	53	41	30
Next day	Next day	20	14	10	21	22	17	19
Two or more days	> = 2 days	36	56	30	22	21	38	45
How easy or difficult is it to get care on nights, weekends or holidays without going to an emergency room (A&E)?	Very/ somewhat easy	32	30	47	47	46	38	30
How often does the doctor explain things in a way that you can understand?	Always	79	75	71	71	80	71	70
How often does the doctor spend enough time with you?	Always	73	59	70	71	69	59	56
How often does the doctor tell you about treatment options and involve you in decisions about best treatment?	Always	66	62	62	60	67	54	61
How highly do you rate the overall quality of care received from your doctor?	Excellent/ Very good	76	73	52	58	78	65	70
Last time you saw a specialist did your regular doctor help you decide who to see?	Yes	63	63	57	35	55	45	63
Last time you saw a specialist did your regular doctor provide the specialist with information about your condition or problem?	Yes	81	76	57	65	73	70	72
Was there a time in the past year when you did not see a doctor, did not get recommended care, skipped doses or did not fill a prescription because of cost?	Yes	28	14	20	5	28	9	42

Source: Adapted from Schoen *et al* (2007)

Figure 25 compares the views of people in the United Kingdom with those of people in other EU countries about the quality of GP services, and ease of access to those services. In the case of UK citizens, 88 per cent stated that the quality of their GP or family doctor services was good, compared with 93 per cent in France, 88 per cent in Germany and just 68 per cent in Sweden. Considering ease of access, UK citizens believed they had relatively easy access to GPs (86 per cent). This compared with 93 per cent in France, 94 per cent in Germany and just 63 per cent in Sweden.

[FIGURE] 25 Comparison of views of citizens of quality and ease of access to GP services, UK and other EU countries, 2007



Source: Eurobarometer (2007)

5 Conclusions

This report has described a number of measures of access, based on a suggested framework for considering different aspects or dimensions of access. In general, most people, most of the time, report good access on key dimensions (such as proximity to a practice), but on all dimensions of access, across practices and PCTs, variations in access are evident.

On the basis of the suggested framework, Table 18 suggests 23 measures of access. Data on most measures are currently available from existing sources. However, for some (for example, compliance with the 1995 Disability Discrimination Act in relation to design of buildings, and the ability to book appointments online or communicate with GPs via email) there is no existing source of information.

Table 18: Measures of quality access

	Access dimension	Indicator	Source of data
Physical access	Availability	1 GPs per 100,000 population by PCT	Information Centre
		2 List size per GP	Information Centre
	Proximity	3 Percentage of population within 15 minutes of a surgery by walking or public transport	Department for Transport travel times survey
		4 Percentage of population without a car within 15 minutes of a surgery by walking or public transport	Department for Transport travel times survey
	Premises	5 Compliance with the 1995 Disability Discrimination Act	New measure – no source
		6 Proportion of people very or fairly satisfied with practice environment and facilities	New measure – no source
	Telephone	7 Proportion of people who found it very or fairly easy to get through on the telephone to GP surgeries, by surgery	GP Patient Access Survey
		8 Proportion of people who found it very or fairly easy to speak to their GP on the telephone, by surgery	GP Patient Access Survey
	Digital	9 Can patients book appointments online?	New measure – no source
		10 Can patients communicate directly with GP or practice staff via email?	New measure – no source
	Home visits	11 Home visit requests refused by GP, as a percentage of all consultations	New measure – no source

Source: The King's Fund (2010)

Timely access	Appointments	12 Proportion of people able to get an appointment with a GP within 48 hours	GP Patient Survey
		13 Proportion of people able to book at appointment more than two days ahead	GP Patient Survey
		14 Proportion of people satisfied with surgery opening hours	GP Patient Survey
	Out-of-hours care	15 Proportion of people who felt that care from out-of-hours GP services took too long	GP Patient Survey
		16 Proportion of people who felt that care from out-of-hours GP services was good or very good	GP Patient Survey
	Waiting times	17 Proportion of people who state that they wait a bit or far too long in surgery	GP Patient Survey
		18 Proportion of people able to see a GP fairly quickly	GP Patient Survey
	Prescriptions	19 Does practice have or make use of the Electronic Prescription Service?	New measure –no source
		20 Maximum of 48 hours from patient request for a prescription to availability for collection by the patient	Quality and Outcomes Framework
Choice	Choice of practice	21 Is the practice open or closed to new registrations?	New measure: NHS Choices website, local data
	Choice of professional	22 Proportion of patients who said they had been able to see the GP of their choice	GP Patient Survey

Source: The King's Fund (2010)

In addition, it is worth considering further analysis of existing data sets.

- Although data are not available over a long time period, and there has been a tendency for the GP Patient survey questions to change, some analysis of trends in patient views of access may be possible.

- There are more detailed, unpublished survey data underlying the published GP Patient survey data. These could be analysed in more depth at a national or regional level, to gain a better understanding of what drives people's views on access.

- Detailed analysis of a range of indicators across individual GP surgeries may suggest answers to issues such as the persistence of poor access performance and its causes.

Research studies cited above suggest that people's preferences vary. For example, some place greater weight on quick access to any GP or professional, while others focus on continuity with a particular GP. The government has already responded to the first group, through separate facilities – that is, walk-in centres and telephone advice. However, GP practices need to respond to different demands within the same management structure.

This means that further investigation is needed of patient and public preferences around access – that is, how different groups value (relative to each other) all the dimensions of access set out above. This should provide a basis for determining how best to respond to the full range of patients' preferences, as well as helping with prioritising efforts and resources on the most valued dimensions of access.

Establishing the right metrics on access is only the first step in the process of improving practice performance. The Department of Health's recent guide to PCTs and, by extension, GP practices – Primary Care and Community Services: Improving GP access and responsiveness (Department of Health 2009b) – provides a useful plan of action of how to improve access, together with a local case study example. Establishing quantitatively GP practices' baseline performance on access, using measures similar to those in Table 18, is essential to demonstrate where problems lie, as well where good practice exists, and hence the potential for improvement among practices that score less well.

While the Department of Health's guide focuses on measures from the GP Patient Survey, it also recommends the use of other locally collected survey data, including qualitative information gathered from focus groups and reviews of the experience of GPs and practice staff. More research is needed to determine how such information is best combined with quantitative data derived from the metrics in Table 18.

However, while it is possible to set out metrics on access, these are based essentially on a traditional model of general practice characterised as a first port of call, gate-keeping or routing role, and a similarly fairly traditional view of what services, care and health care advice are provided in surgeries by GPs and other primary care professionals.

When thinking about good-quality access in future, a challenge is to consider how access relates to changes in the way health care services might be provided (and located) as a result of, for example, changes in technology, or in patients' expectations, attitudes and tastes, as well as due to the inevitable exigencies of financial pressures on health

care generally. In this sense, access should not be seen as an isolated aspect of the quality of primary care – it is instrumental. The important question is: access to what?

Changes not only in the way people access health care, but in the nature and type of service they access has been evident over the past decade. For example, new routes into the health care system have been established. To an extent, NHS Direct, NHS Choices and walk-in centres have changed the relationship between patients and the NHS, and have provided alternative first ports of call.

Meanwhile, over the past 30 years or more there have been various, if somewhat sporadic, developments in novel forms of access. These include direct access to GP-led outpatient clinics and hospital-based diagnostic services, and consultant-provided treatments in GP surgeries – as well as an expansion in the range of services most GP practices provide. What is more, if the new government presses ahead with the previous government's Closer to Home agenda, we will see growing expectations of what services GP practices should routinely provide, and hence of what 'good access' means.

As we have mentioned, developments in communication technologies bear on access too. For example, the 2007 Commonwealth Fund survey suggests that many people see the internet and email as an important component of access, and that this proportion is likely to grow.

In summary, while this report has suggested possible metrics bearing on desirable aspects of access, we would also suggest that these should not be applied in a 'one size fits all' (for all time) way. We are seeing ongoing changes and developments in the nature and type of health care services, communication and medical technologies, and variations in patients' and society's preferences about access. As such, detailed access metrics (such as those we outlined above) will need regular revision, and much broader (and less specific) measures may eventually be adopted as services, preferences and technologies change.

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