Rapid telephone access to your GP improves workload, linked to lower A&E attendance

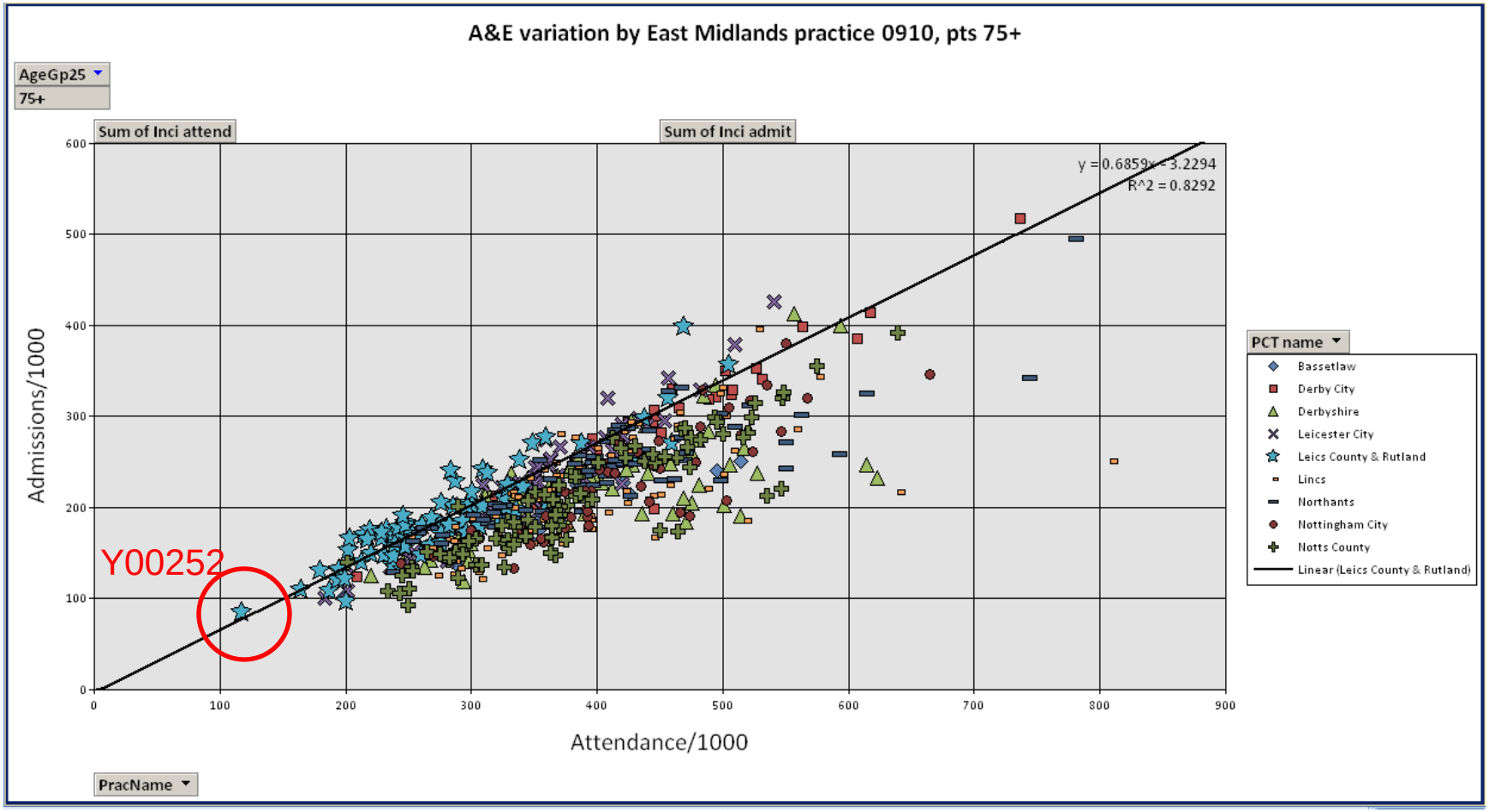
England national evidence
presented at Healthcare Innovation Expo,
London, 9-10 March 2011

Harry Longman
harry.longman@patient-access.org.uk
07939 148618

Hypothesis

- We have identified that:
  - There is wide variation in the use of A&E services between GP practices
  - This appears to be related to some local factors we currently understand, mainly deprivation and proximity to a hospital.
  - The majority of variation was unexplained
  - Our analysis suggests that practice operational features may explain a large part of this variation, and this could be transferable.

Earlier finding: outlying practice for low attendance and admissions for 75+ patients found to be using rapid telephone access to GP. Could this be a causal link, and transferable?



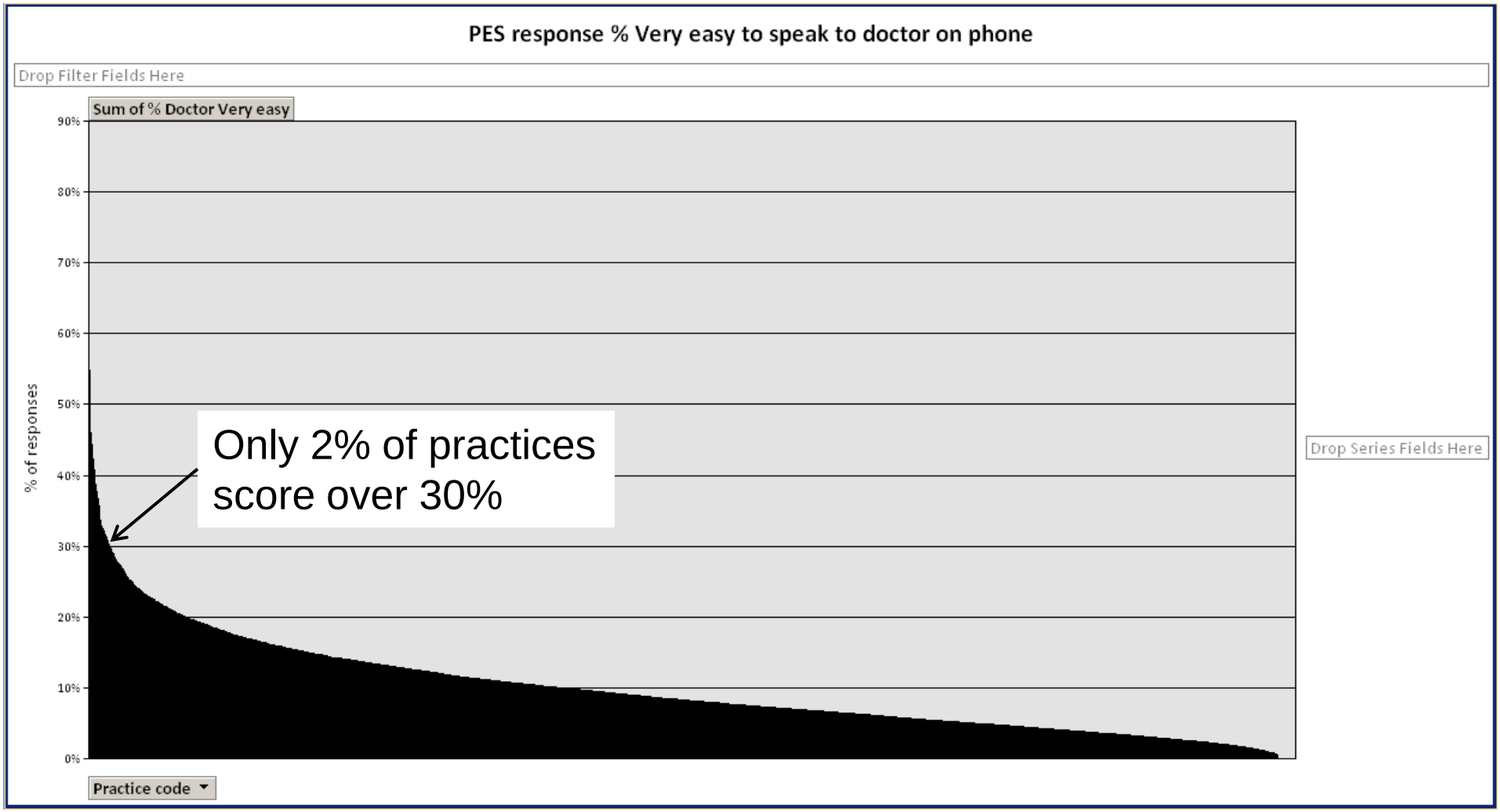
Correlation: R^2 = 0.829

Source: EMQO/HES, Exeter

Purpose of next steps

- Do other English GP practices operate a system of rapid telephone access for patients?
- What features do they have in common?
- What are the differences?
- What outcomes do they show?
- What further studies are needed?
- Where does this take the potential for wide scale dissemination?

From the Patient Experience survey, % “Very easy to speak to the doctor” is a useful differentiator (54% for Y00252)



Source: PES 2009-10 results online

Method

- Find most likely 2% of 8,300 practices from the 2009-10 Patient Experience Survey
- Phone them up, speak to receptionists, practice managers and partners. They are easy to phone!
- Ask how they work, what happens when a patient calls, how the patients like the service, how the doctors find it, whether it has affected secondary care.
- Classify each practice' method of telephone access
- Ask about their situation and patients' list
- Use NHS Comparators to understand secondary care usage, and SPH derived IMD to measure deprivation
- Assess likely impact of access system by practice and for the cohort of practices

Diversity of practices

- Most striking on the top 2% of practices is their diversity.
  - Inner city Manchester and Middlesbrough
  - Ex mining Barnsley and leafy Lechlade
  - Elderly Minehead and young family Taunton
  - Suburban Croydon and rural Cumbria
  - Multi-ethnic London and mono-ethnic Devon
  - Seaside Newquay and industrial Leeds
- List sizes from 1,000 to 20,000
- Deprivation IMD score from 8 to 51
- **Key finding: no practice can say "It won't work here"**

Telephone access classified 3 ways

Informal

- Single handers, some larger
- Long established, know patients well
- Available by any means, any time
- Dedicated and well loved individuals
- Some burning out
- 50 practices, 193,000 patients, avg list 3900

Partial system

- Range of sizes
- Offer telephone cons as an option
- May limit times of day
- May offer specific number of telephone slots
- May offer telephone only if no other appts.
- Often see benefits for pts and doctors
- 54 practices, 361,000 patients, avg list 6700

"GP telephone access"

- 2,000 to 20,000 list size
- Describe a structured system of access which starts with the doctor speaking to the patient
- Have run system for 1 to 10 years
- Most know they are different
- Most know the benefits for patients and doctors,
- Did not know A&E usually lower
- 38 practices, 275,000 patients, avg list 7400

38 “GP telephone access” practices found in England, at least 1 in every SHA

Count of GP telephone access practices by SHA

SHA	SHA name	Practices
Q30	North East SHA	1
Q31	North West SHA	4
Q32	Yorkshire and the Humber SHA	2
Q33	East Midlands SHA	7
Q34	West Midlands SHA	2
Q35	East SHA	3
Q36	London SHA	3
Q37	South East Coast SHA	1
Q38	South Central SHA	1
Q39	South West SHA	14

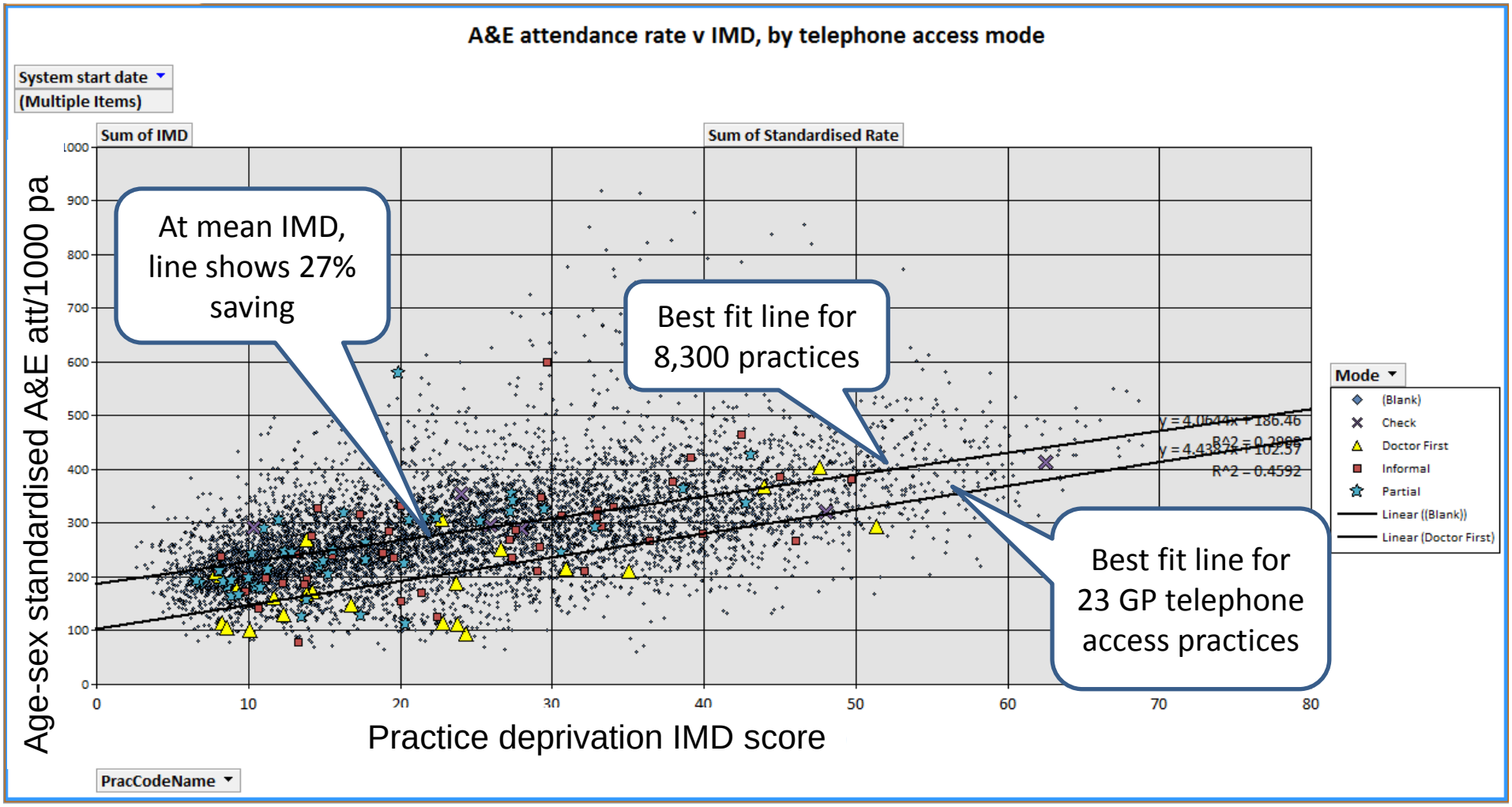
“GP telephone access” in three steps

1. **The patient phones the surgery**
   - Patients call the surgery in working hours, and are usually answered by a person, not a computer. The receptionist takes their number, the nature of the problem, and offers a call back. If the line is free they may be put straight through to the doctor.
   - The vast majority of demand is managed in this way, but patients are not forced into it if they need or want something different.
2. **The doctor speaks directly to the patient**
   - If the doctor is free, the call is put straight through. Or reception offers a call back.
   - Working down the flow of messages from reception, the doctor calls back the patients in order of priority. Through understanding demand by hour and by day, a response time typically well under an hour is achieved. Patients may request a later time to suit them.
3. **The problem is dealt with today**
   - Around half the telephone consultations complete the doctor’s work, with advice, prescription or other action. A face to face appointment may be needed, and is offered today. Most patients choose to come toda but another day can be arranged.

Consistent outcomes

1. **Patients love the service**
   - Patients views on the service are reported as overwhelmingly positive, for the speed, convenience and confidence of being able to speak to the doctor. Some have taken time to adapt, and a few do not accept it, but there is time and flexibility to allow for them.
   - Lists are growing at the expense of neighbouring practices.
2. **Doctors love the work**
   - Principle findings are the return of a sense of control over the workload, time saved in unnecessary face to face appointments, the ability to offer extended times to the most needy patients and better response to crises.
   - Practice managers are better able to respond to fluctuations in workload and capacity. DNA rates are almost nothing.
   - Receptionists love the calm and not having to fight off patients, as they can always offer access to the doctor
3. **A&E attendance is lower**
   - 38 practices have been identified as operating this service, for 275,000 patients. Of these, data of sufficient quality are available for 23. (15 are excluded for missing provider data, unknown deprivation score or insufficient period of operation). Their age-sex standardised A&E attendance rates have been compared with all other English practices.
   - The practices represent a geographic, demographic and socio-economic diversity as broad as that of England as a whole.
   - The deprivation adjusted mean attendance rate of 201 per 1000 patients per year is 27% below the mean of the remaining 8,300 practices.

A&E attendance rate: Per 1000 pts, standardised, adjusted for deprivation, shows average 27% lower for GP telephone access

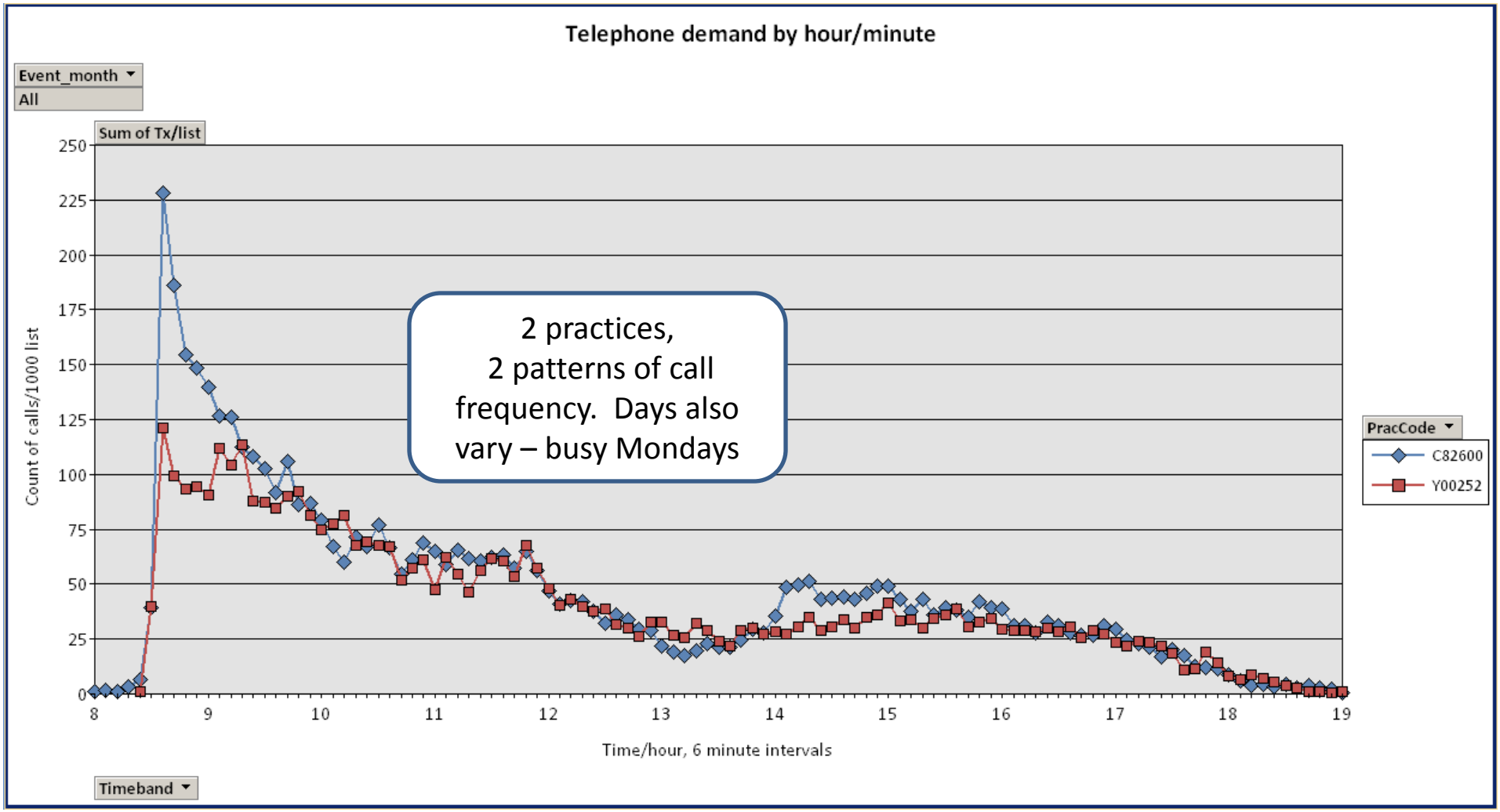


Sources: IMD from SPH, A&E rates from NHS Comparators, practices from HL Feb-Mar 2011. 15 further practices lack data quality

Understanding and responding to demand:

practices order their day around their own pattern

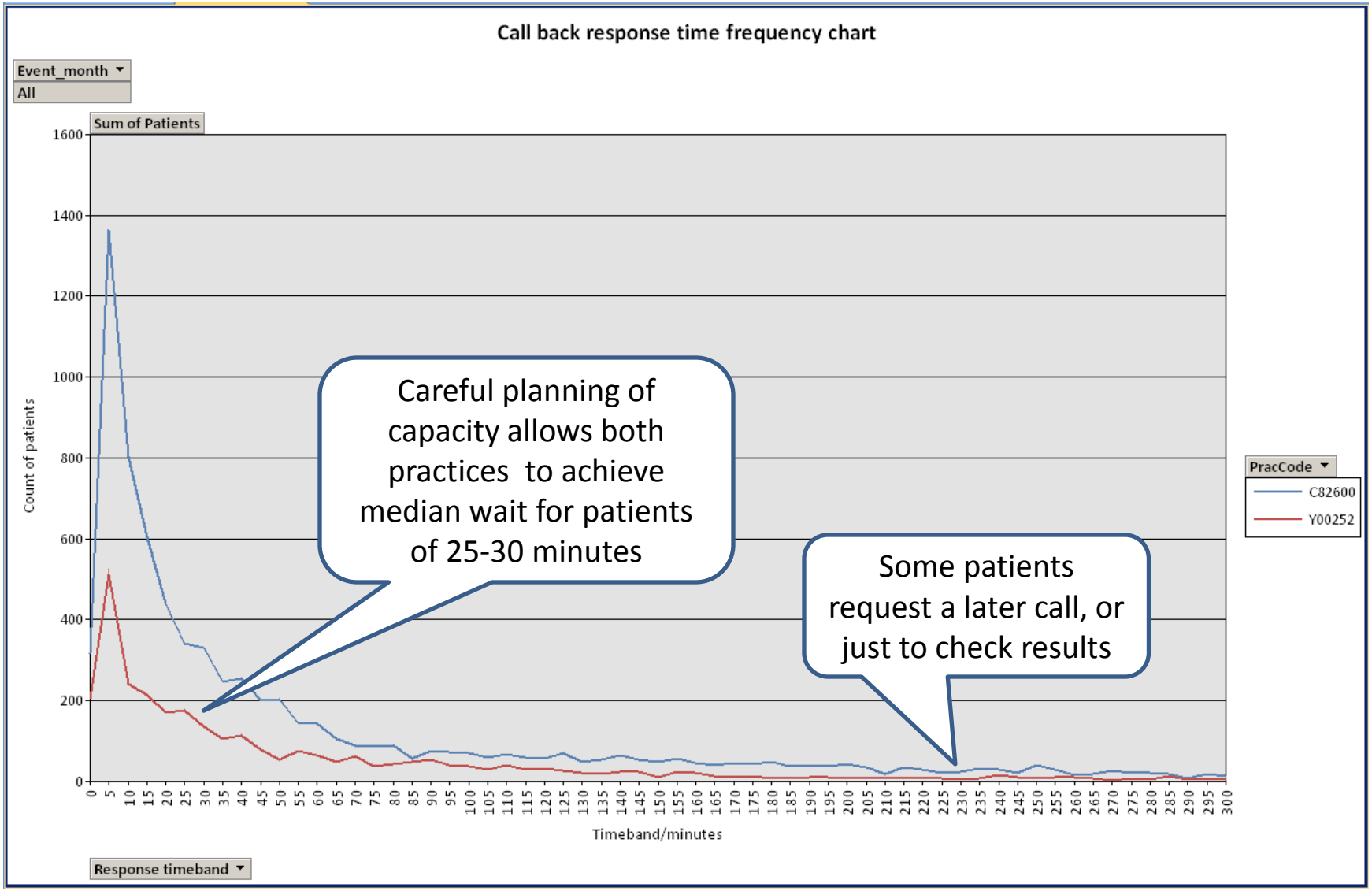
Frequency diagram through the day, 6 minute intervals, demand/1000 list size



Source: practice EMIS records Sept – Dec 2010

Patients: what response time can I expect? Half an hour

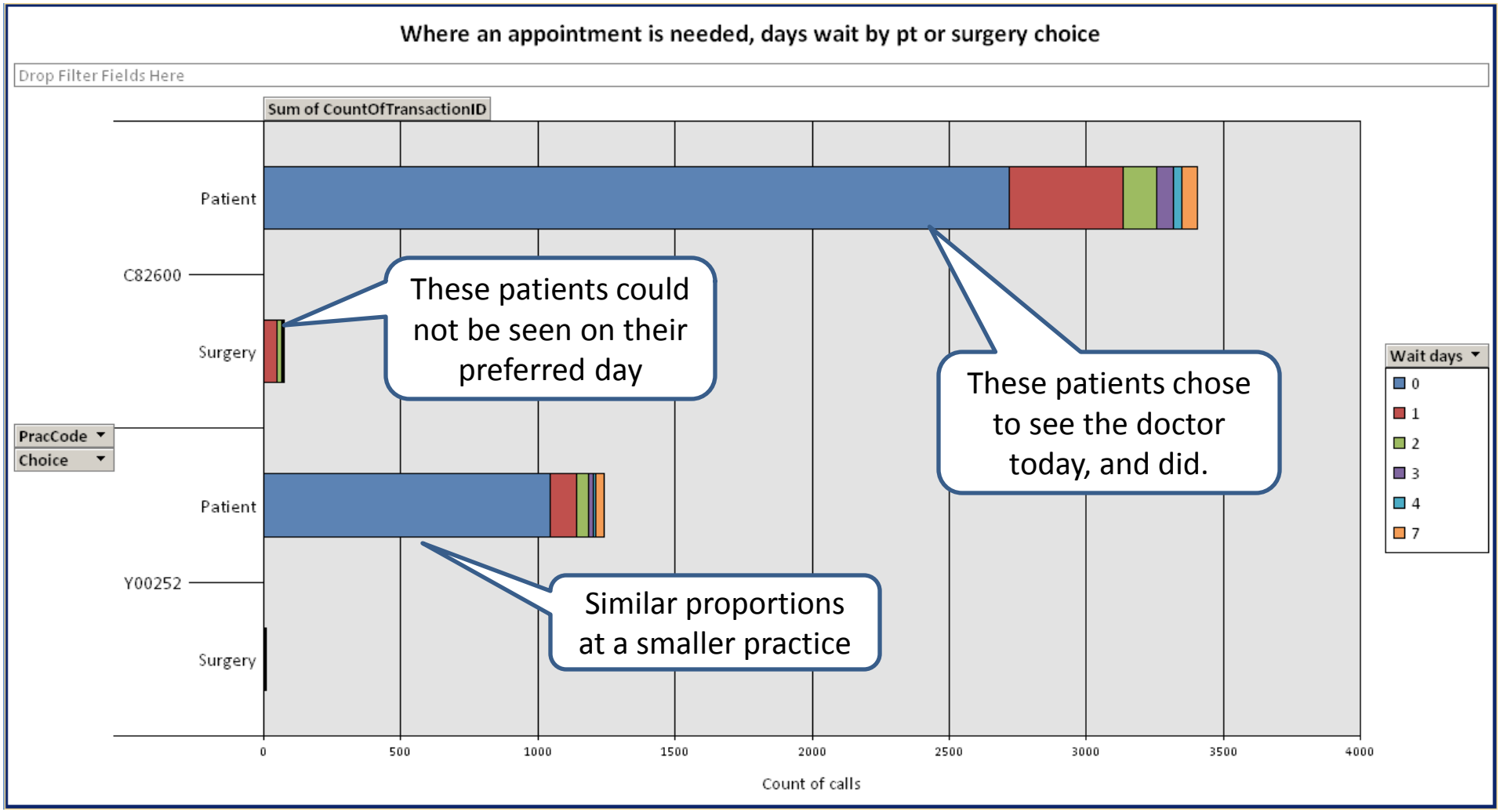
Operational data from two practices running the system.
Frequency diagram of response times, median 28 minutes



Source: practice EMIS records Sept – Dec 2010

If I need to see the doctor, when will it be? Today

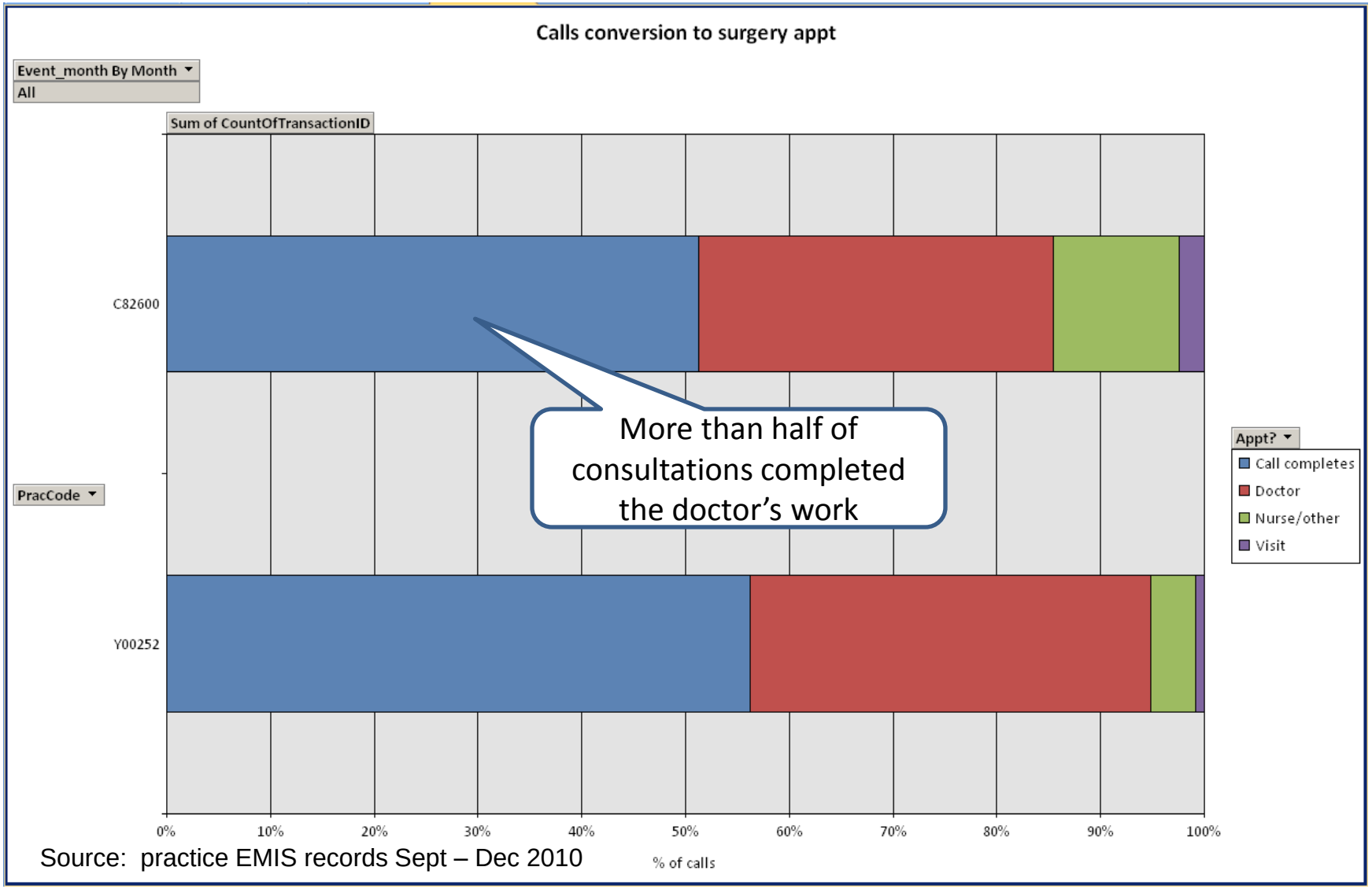
80% of patients say same day (blue bar). 98+% get day of choice



Source: practice EMIS records Sept – Dec 2010

Doctors: How many of the patients will I need to see? Under half

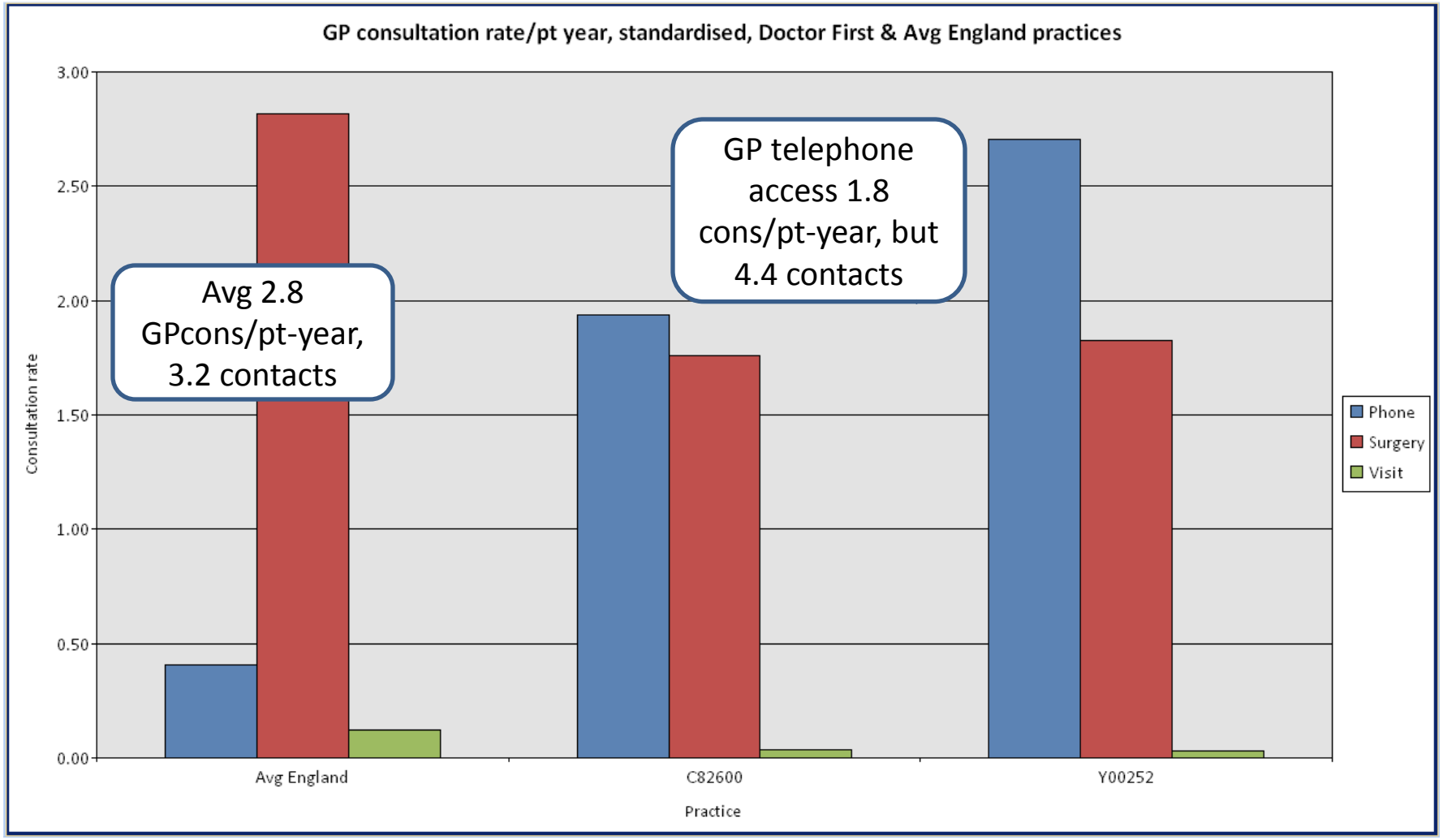
Blue bar, over 50%, dealt with in one go over the phone.
Red bar, come and see doctor, green bar see nurse.



Source: practice EMIS records Sept – Dec 2010

Doctors are more accessible to more patients, but see 37% fewer

Independent comparison with 500 practices in England shows relative change in GP consultation, 6x multiple by phone and approx 37% reduction in surgery face to face



Source: Qresearch report on GP consultation rates, 2008, 2009. Practice records from full year 2010

Note: Suspected under reporting of phone consultations at practice C82600

Some variations

- **How do doctors run sessions?**
  - All doctors take calls at any time in the day, and book appts mostly for their own patients (but can be to another by request or need)
  - OR one duty or triage doctor books appts for the others, taking turns by session
  - Some limit the time for the phone service, but capture 80% of demand
- **When are call backs made?**
  - Some put the doctor straight through if the line is free, or wait on hold
  - Call backs are as soon as possible, unless later by request
  - A few give patients a time when they will be called
- **Are patients allowed to book appts?**
  - Most practices don't encourage or even allow this
  - A few allow patients to book without speaking to the doctor (and numbers doing so are falling)
  - Exceptions are made eg for the deaf, tracheotomies, mental incapacity, those without a phone.
  - If more than 20% of appts booked outside this method, classified as "partial"

Access routes found not to produce the same benefits and flexibility

Many of these are used by others surveyed, but had been rejected after trial by the "GP telephone access" practices

- Appts offered as face to face, with telephone a last resort when no slots left
- Patient has to ring before 11am to speak to a doctor today
- Patient asked to ring the practice at a set time
- Patient is offered one of a fixed number of telephone consultation slots, by request.
- Nurse or receptionist triage by telephone
- Patients may see a doctor today if they arrive in person and queue at the walk-in clinic.

Conclusions

- **At least 38 practices operate a similar system**
  - Wide range of size, geography and demography
- **Key common features for >80% of demand**
  - Patient phones the surgery
  - Doctor speaks directly to the patient
  - Problem is dealt with today
- **Outcomes are common and predictable**
  - Patients get better, faster access
  - Doctors workload is improved
  - A&E attendance is reduced

New next steps

- Create a community of practitioners led by GPs
- Look for more similar practices
  - Ongoing task, maybe a few dozen more?
- Community to develop guidance
  - Training and reassurance for new starters
- Build the evidence base and publish
  - Time series study of effect
- Consider further research