THE UNIVERSITY of York
Centre for Reviews and Dissemination

Enhancing access in primary care settings

- GP surgeries across the country are implementing new strategies such as extended hours, telephone consultation and role substitution to meet rising demands.
- Evaluation of extended hours shows uptake varies depending on locality and that uptake on Sundays is lower than on extended week-days and Saturdays. Overall there is limited impact on A&E activity.
- Telephone consultation shifts the workload from face-to-face to telephone contact and increases the number of primary care contacts within 28 days of the initial consultation.
- Role substitution is being widely promoted but the extent to which this will reduce GP workload is unclear.
- The whole-system implications of extended hours, telephone consultation and role substitution need to be considered. Each strategy has the potential to reveal unmet need and displace activity rather than reduce workload.
- The lack of good quality evidence around these approaches highlights the need to monitor and evaluate the outcomes of implementation.

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Background

The rising demands on general practice services are well documented and practices across the country are implementing new strategies to meet these demands.[1] "Access" refers to the attempt to make primary healthcare services more responsive to the needs of the population, and encompasses the availability and proximity of health services, timely access, and the ability to see a preferred GP or nurse[2] and can involve a diverse range of initiatives.[1] The 2013 Prime Minister's Challenge Fund has supported a range of pilot initiatives across the country aiming to improve access to primary care services.[3] This briefing has been prepared in response to a request from Northumberland CCG and focuses on three approaches aimed directly at enhancing access to consultations in primary care settings: extended hours, telephone consultation/triage, and role substitution.

We have searched DARE, NHS EED, HTA, CDSR and NHS Evidence to identify relevant systematic reviews and economic evaluations. Websites of The King's Fund, Health Foundation, Nuffield Trust, NESTA, and RCGP were also searched for evaluations and case studies.

We have excluded the following interventions but can provide further information if any are of particular interest: outreach, pharmacy based minor ailments schemes, medication review by pharmacists, GPs with special interests, diagnostic services in primary care settings, and telemonitoring.

Extended hours

Seven-day GP appointments was a Conservative government election pledge in 2015 and there are several pilots of extended opening hours supported by the Prime Minister's Challenge Fund.[3,4] We did not find any systematic reviews specifically addressing extended hours in primary care. However, we identified one systematic review looking at interventions to reduce emergency department use that included interventions aimed at increasing access to primary care.[5] We identified an evaluation of six projects in Manchester focused on improving access and integration in primary care.[2]

The systematic review included 25 studies of interventions aimed at increasing access to primary care.[5] Interventions involved increasing the number of primary care medical doctors or primary care centres; out-of-hours primary care services; and telephone consultation and triage. Detail about the interventions is lacking and the impact on outcomes is mixed. While increasing the number of primary care doctors or settings may have a small impact on reducing emergency department attendance the evidence is predominantly from the USA, a very different primary care setting to the NHS. Evidence for out-of-hours services was mixed and telephone triage did not appear to impact emergency department use (telephone consultation/triage is discussed in more detail below).

In the Manchester evaluation, four of the six CCG project sites focused on delivering additional availability: providing additional weekday, evening and weekend appointments in locality-based host sites, and aiming to provide full patient record access (the remaining two projects addressed access for care home residents and people with complex needs).[2] Each project site took a slightly different approach (see table).

An additional 200-250 appointments per site per week were offered, with an average of 65.5% (range 55.3 to 83.7%) of available appointments booked. Uptake of weekday and Saturday appointments was greater than that for Sunday appointments in all four sites. Overall the impact on A&E activity was limited. The number of self-referrals to A&E appeared to decrease but this was largely off-set by increases in GP referrals. There appears to be no consistent impact on satisfaction in terms of access. The evaluation did not include a formal cost analysis; project sites were asked to provide a summary of their expenditure on set up costs and service delivery costs. Detailed information on the costs of intervention and on outcomes are not reported.[2]

Services with the best outcomes were supported by GP federations, offering the advantages of working at scale (flexible workforce, sharing back-office functions). However they also pose some

challenges in terms of ownership, management and funding, and a loss of practice identity and control. Integration of IT systems was necessary to allow sharing of data and patient records. This was a significant financial and technical challenge.[2]

Telephone consultation/triage

Telephone consultation has become increasingly popular as an approach to delivering flexible and faster access, however telephone consultation may not be suitable for some patients who may be more likely to seek further consultation.[6] We identified one Cochrane systematic review of telephone consultation and triage,[7] a recent large randomized controlled trial of telephone triage for managing same-day consultation requests,[8] and an associated process evaluation of the implementation of the intervention.[9]

The Cochrane systematic review included nine studies of a range of telephone consultation models provided by doctors, nurses or other health care workers, for example out-of-hours services, and telephone consultation for patients requesting same-day appointments.[7] Just over half of the studies were conducted in UK primary care settings. The overall quality of the evidence was poor, with a lack of reporting on some important outcomes, but the review authors concluded that telephone consultation (of any type) may reduce immediate GP or home visits, and that around half of calls could be handled by telephone advice alone. However, there was some concern that telephone consultation may simply delay GP visits as two studies reported increased return consultations.[7]

A recently published randomized controlled trial, involving 42 practices (20, 990 patients) in four centres in the UK, compared GP-led or nurse-led telephone triage with usual care for patients seeking same-day consultations in primary care.[8] The trial found telephone consultation by GPs or nurses was associated with an increase in the number of primary care contacts within 28 days of the telephone consultation, the majority of which occurred on the same day as the initial consultation. Estimated costs were broadly similar for both telephone consultation groups and usual care. Telephone consultation did not appear to reduce GP workload, but rather changed the nature of the workload from face-to-face to telephone contacts. Telephone consultation appeared to be safe; the number of emergency admissions was small, although there was a non-significant increase in the risk of admission in the GP- and nurse-led consultation groups compared with usual care. Patients receiving nurse telephone consultations were generally less satisfied than patients receiving GP consultations or usual care.[8]

The process evaluation of the trial found telephone consultation was responded to well by staff in some practices but not in others.[9] The reasonable allocation of resources and support, so that staff were not overloaded was central to successful implementation. Effective communication was required to facilitate the change in culture; telephone consultation in some cases was seen as a challenge to good clinical care.[9]

An ongoing study funded by NIHR, RAND Europe and University of Cambridge, due for completion in September 2017, is exploring the impact of telephone triage as an alternative to face-to-face contact in general practice. The study aims to evaluate the effects of triage on patient experience and health service use, explore how appropriate the approach is for hard-to-reach groups and determine the cost consequences.[10]

Role substitution

Shifting some of aspects of general practice work from doctors to nurses or clinical pharmacists is another approach to dealing with increasing pressures in primary care. We found two relevant systematic reviews addressing role substitution; a Cochrane review evaluating nurse-doctor substitution in primary care settings[11] and a review of pharmacist services provided in general practice clinics.[12]

The Cochrane review included 16 studies evaluating three different approaches to nurse-doctor substitution: nurse responsibility for first contact and ongoing care for all presenting patients; nurse responsibility for first contact of patients wanting urgent consultations during routine practice hours or out-of-hours; and nurse responsibility for ongoing care of patients with chronic conditions.[11] The review found similar health outcomes for patients in the short-term whether they saw a nurse or GP in all three models of care. Patient satisfaction was higher when nurses rather than doctors provided first contact for urgent consultations. Doctor workload was reduced in the few studies that reported the outcome. While there was no appreciable difference in resource use between nurses and doctors, nurse productivity appeared to be lower, with longer consultations and a greater rate of recall than doctor consultations. Additional training and experience may help to counter the difference in productivity, however very few of the studies clearly reported the level of training nurses received to undertake these enhanced consultation roles.[11]

Clinical pharmacist services delivered in primary settings were evaluated in 38 randomised controlled trials included in a recent systematic review.[12] The majority of the included studies were conducted in the USA and Canada, with six studies conducted in the UK. Pharmacist services included medication review, education, lifestyle advice, adherence assessment, monitoring and adjusting therapy, predominantly for patients with long-term conditions such as diabetes and hypertension. Positive effects were seen for medication adherence, resolution of medication-related problems and quality of life. There were limited or no effects on patient satisfaction and costs.[12] NHS England has announced a three-year pilot scheme to embed pharmacists in general practice clinics helping to manage long-term conditions and providing advice for those patients with multiple medications.[13] Plans are in place to evaluate the scheme to establish its feasibility and overall impact on GP workload.

Implications

Careful workforce planning and evaluation of demand are essential. Recent reports that many seven-day GP access pilots are reducing their extended hours, particularly on Sundays,[4] adds to the findings from the Manchester evaluation that demand for extended hours varies from location to location, and demand for Sunday appointments is low.[2]

It is currently unclear whether primary care appointments are a substitute for, or complement to, A&E attendance. Providing additional appointments may be uncovering significant unmet need, limiting the potential impact on reducing help-seeking at A&E. Appointments may be at the wrong place or wrong time – with people reluctant to travel further distances to other GP surgeries operating in hub or rota solutions covering wider populations. Additional availability may also displace activity from earlier in the day – spreading out activity over a longer period of time. Providing additional services may lower the threshold for seeking help.[2]

Telephone consultation and nurse-doctor substitution for a variety of consultations could be helpful additional approaches to delivering effective primary care but the whole-system implications need to be considered.[8] There is the possibility that such approaches may merely shift GP activity resulting in no change in overall workload. Identifying patient groups who may benefit most from telephone consultation and/or nurse consultation, such as those with long-term conditions, may be one way of maximising the effectiveness of these approaches.

The lack of good quality evidence for the interventions considered in this briefing highlights the need to test and evaluate different initiatives, allowing sufficient time and support to evaluate not only what works but how and why.[1]

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Summary of four Manchester extended hours pilot sites[2]

The table outlines details of the extended hours provision in four Manchester CCGs

Site	Detail of additional availability	Impact
Bury (6 GP practices; registered patients of GPs in one CCG section; c. 32,894)	Additional availability appointments: 6.30 to 8.30pm Mon-Fri (18 x 10 min appointments/ day) and 8am-6pm Sat-Sun (120 x 10 min appointments/day) Urgent and routine appointments provided from one of the participating practices Quota for allocation of appointments according to list size Two GPs and receptionists All practices used Vision: allowing access to full record, data-sharing agreement on a read-write basis via a smartcard Referrals not made directly; summary of appointment faxed back to regular practice with recommendation 100-hour community pharmacy located on site Project planned development of other services such as community care plans, specialist outreach clinics, single care record and community engagement via champions group. However these were not up and running when evaluation was undertaken	4% reduction in total A&E activity 3% reduction in minor A&E attendances (non-significant) Reduction in out of hours (OOH) GP usage and walk-in centre activity Positive and statistically significant impact on patient satisfaction related to access

Site	Detail of additional availability	Impact
Central Manchester (33 GP practices; registered patients of GPs in entire CCG area; c. 203,982)	Responsiveness appointments provided within regular practice hours Additional availability appointments, provided at 4 'host' practices: 6-8pm Mon-Fri, 9-11am Sat-Sun (12 x 10 min appointments/day) Quota for allocation of appointments according to list size used until 1pm, then appointment opened up to any practice Patients contacted own practice, if no capacity an appointment was booked at their host practice One GP and two receptionists Staffed by local GPs and locums; receptionists from host practices provided cover All practices ran EMIS: allowing access to full record, data-sharing agreement on a read-only basis Referrals not made directly; summary of appointment faxed back to regular practice with recommendation 100-hour community pharmacy located near to host sites Host practices requested blood tests directly with results sent to patient's practice Project involved extension of other existing services including specialist advice lines, homelessness service, dementia enhanced service, long-term conditions enhanced service, living with pain service and community pharmacy respiratory project. GP in-reach was discontinued	Small non-significant reduction in A&E activity 14% statistically significant reduction in minor A&E attendances No significant change in OOH or walk in centre activity

Site	Detail of additional availability	Impact
Heywood (6 GP practices; registered patients of GPs in entire CCG area ; c. 30,890)	Additional availability appointments provided by one of the participating practices: 4-9pm Mon-Fri (28 x 15 min appointments/day), 10am to 8pm Sat (51 x 15 min appointments) and Sun (34 x 15 min appointments) Began with appointment quotas but switched to first-come first-served after 6 weeks Appointment booked by practice calling OOH provider who filled allocated slots One GP and one Nurse; changed to two GPs after six weeks OOH provider supplied GPs and receptionists Practices used either EMIS or Vision; host practice accessed summary care record on Adastra on a read-only basis Urgent referrals made directly from additional availability service, non-urgent communicated back to regular GP with recommendation Regular hours pharmacy located near host site Evening pathology collection Project involved other services including: GP-led care planning; multi-skilled care worker-led care planning; and hospital navigator service	No significant impact on total A&E activity No significant impact on total minor attendances No significant impact on total on OOH or walk in centre usage No significant improvement in patient experience or satisfaction

Site	Detail of additional availability	Impact
Middleton (8 GP practices; registered patients of GPs in one CCG locality c. 51,680)	Additional availability appointments run from one of the participating practices: 6.30-9.30pm Mon-Fri, 6-9pm Sat-Sun (18 x 10 min appointments/ day) Appointments available on a first come, first served basis. Web-based diary allowed GP surgeries access to appointments between 8.30am and 6pm, OOH provider had access to same diary 24/7. Triaged A&E attenders could also be booked in to the service by A&E staff One GP OOH provider supplied GPs and receptionists All practices ran EMIS web: allowing access to full record, data-sharing agreement on a read-only basis Referrals not made directly from the additional availability service. A summary of the appointment communicated back to the regular practice with recommendation 100-hour pharmacy located near host site Project involved development of other services including: mental health crisis clinics; community pharmacy consultations (not fully operational); care tracker (not fully operational); web consultations(not fully operational)	3% reduction in total A&E activity (unclear whether this attributable to additional availability appointments) No significant impact on minor A&E attendances Negative effect on patient experience and satisfaction