Health Foundation long read (PDF version)

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Rethinking access to general practice: it's not all about supply

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Contents

Key points 3

Introduction 4

How good is access to general practice, and how is it changing? 6

How can the candidacy framework help us understand access to general practice? 10

How have previous governments tried to improve access? 13

Trade-offs between different components of access 15

Conclusion 15

Supporting information 17

Key points

We're working with THIS Institute to build a more holistic understanding of the challenges patients face in accessing GP services.

- In recent years, public satisfaction with access to general practice has plummeted. Patients are finding it harder to make appointments, and feeling increasingly dissatisfied with waiting times and the types of appointment offered.
- Despite having fewer GPs in England than there were in 2015, general practice is now delivering record numbers of appointments. A relatively high percentage of these – around 40% – occur on the day they are booked.
- Improving access to general practice has long been a priority for politicians. Numerous policies have attempted to improve access, but have usually focused on the 'supply' of appointments: things like how many GPs there are, the number of GP appointments available and how long people wait for them.
- Access to general practice is about more than just the supply of appointments. Broader factors matter too – like how people decide what to do about symptoms, their knowledge of health services and the barriers they face to reach services.
- The 'candidacy framework' is a broader way of understanding access by analysing how people identify themselves as 'candidates' for health care. Applying this framework specifically to primary care may help policymakers improve access to general practice.
- This long read is the first in a series of outputs from a collaboration between the Health Foundation and researchers at The Healthcare Improvement Studies Institute. The project draws on the candidacy framework to inform a more holistic understanding of general practice access issues.
- We set out headline data on access to general practice, describe previous attempts to unlock the access problem, and consider how a broader approach (using the candidacy framework) might drive improvement for patients and practices.

Introduction

This long read is the first in a series of outputs from a collaboration between the Health Foundation and researchers at The Healthcare Improvement Studies Institute. The project draws on the candidacy framework to inform a more holistic understanding of general practice access issues.

General practice is a critical part of the NHS. Offering 'cradle to grave' continuous care, GPs and their teams are responsible for managing acute illness and long-term conditions, and providing preventative care. GPs also have a key role in coordinating patient care and ensuring appropriate referrals to urgent and routine hospital care. Poor access to general practice has a range of negative impacts, including unmet care needs, avoidable harm (for example via delayed diagnoses or referrals) and inappropriate use of other NHS services.

For all its importance, general practice in England has an access problem. Or – more accurately – access problems. In recent years, patient satisfaction with access to general practice has plummeted. Dissatisfaction covers multiple domains, including the experience of making an appointment, waiting times for appointments and the type of appointment offered (eg whether it is in-person or telephone). Meanwhile, pressures in general practice are high. Despite government promises to recruit more GPs, the number of fully qualified, permanent full-time equivalent (FTE) GPs has fallen since 2015. But patient demand is rising fast, and appointment numbers are at record highs, putting further strain on remaining GPs.

Improving access to general practice is a priority for all political parties, and policy 'ideas' are emerging. The Labour party, for example, suggests expanding self-referral schemes for some conditions and creating new ways to access primary care via 'neighbourhood health centres'. The current government has tried to improve access via a mix of routes, including:

- increasing the number and range of health professionals working in general practice (giving patients access to professionals with different skillsets)
- requiring practices to work together to extend their opening times
- supporting practices to improve their telephony and triage systems.

But access is still a problem, and initiatives to improve it are unlikely to work unless they fully understand the problem they are trying to solve.

A major challenge is that access to general practice is traditionally seen through the lens of 'supply' – things like how many GPs there are, and the number of GP appointments available. These things are

critical, of course: access to general practice can't happen if there's no capacity. They are also things the NHS routinely measures.

Yet thinking about access in this way can obscure broader factors that influence people's access to care – things like how people decide what to do about symptoms, their knowledge of health services and the barriers they may face in reaching services. Thinking too narrowly about access also risks undermining different dimensions of access that matter to patients beyond simply getting a GP appointment – including its speed, convenience, whether it's online or in-person, and more. The 'candidacy framework' – first developed by Mary Dixon-Woods and colleagues – is a broader way of understanding access to health care services.

This long read is the first in a series of outputs from a collaboration between the Health Foundation and researchers at The Healthcare Improvement Studies Institute (THIS Institute). We draw on the candidacy framework to build a more holistic understanding of general practice access issues. We first summarise headline data on access to general practice, introduce the candidacy framework, then analyse previous approaches to improving access, to inform future policy efforts.

We have also created an 'options list' (see Appendix 1), a resource that catalogues and categorises attempts to improve access to general practice with a view to informing future improvement efforts. The list includes interventions that have already been tried, are ongoing or have been proposed, and categorises them according to how they are intended to improve access to general practice.

How good is access to general practice, and how is it changing?

Available data paint a partial and sometimes contradictory picture of access to general practice. Viewed through some metrics, access to general practice is improving. General practice is delivering record numbers of appointments. The recruitment of an additional 34,000 health professionals, mainly via the Additional Roles Reimbursement Scheme, has broadened the range of staff and services for patients in their local GP surgeries. Around 40% of appointments occur on the day they are booked.

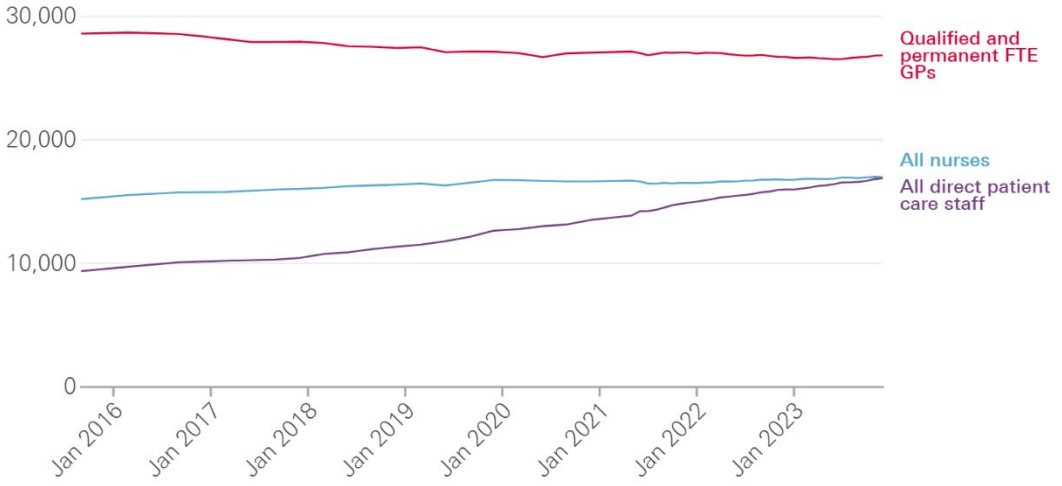
But survey data paint a uniform picture of falling public satisfaction with access (Figure 1). The 2023 GP patient survey – an annual survey sent to more than 2 million adults across England – finds that just over half (54.4%) reported a good overall experience of making an appointment, the lowest level in the 6 years the question has been asked. The percentage of people who got an appointment at a time they wanted (49.8%) is falling, as is the percentage who found it easy to get through to their practice by phone (49.8%).

Although the percentage of people who say they wanted their most recent appointment to be 'same-day' matches the percentage of same-day appointments recorded in national general practice activity data (both around 40%), waiting times for GP appointments remain a significant source of public dissatisfaction. Public perceptions data show that 65% of people think access to GP services has worsened in the past 12 months, and making it easier to get a GP appointment is one of the top three public priorities for the NHS.

Figure 1

There are fewer GPs than in 2015, but more nurses and other direct patient care staff

The number of full-time equivalent (FTE) qualified and permanent GPs, nurses and all other direct patient care staff in general practice per quarter



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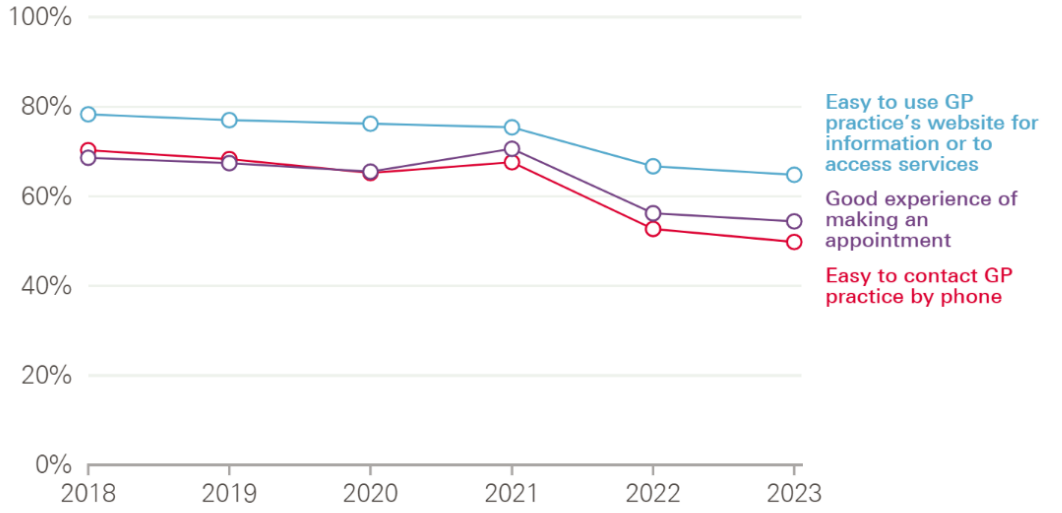
Source: Health Foundation analysis of NHS Digital: Appointments in General Practice, November 2023 • 'Direct patient care staff' include anyone who is directly involved in delivering patient care within general practice but who is not a nurse or GP. This may include paramedics, pharmacists, physiotherapists, health care assistants, phlebotomists, and podiatrists.

Since 2018, patients have reported decreasing satisfaction with making an appointment and contacting their GP practice

The percentage of patients reporting it is easy or fairly easy to reach their practice by phone and navigate the practice website, and those who report their overall experience of making an appointment as very good or fairly good



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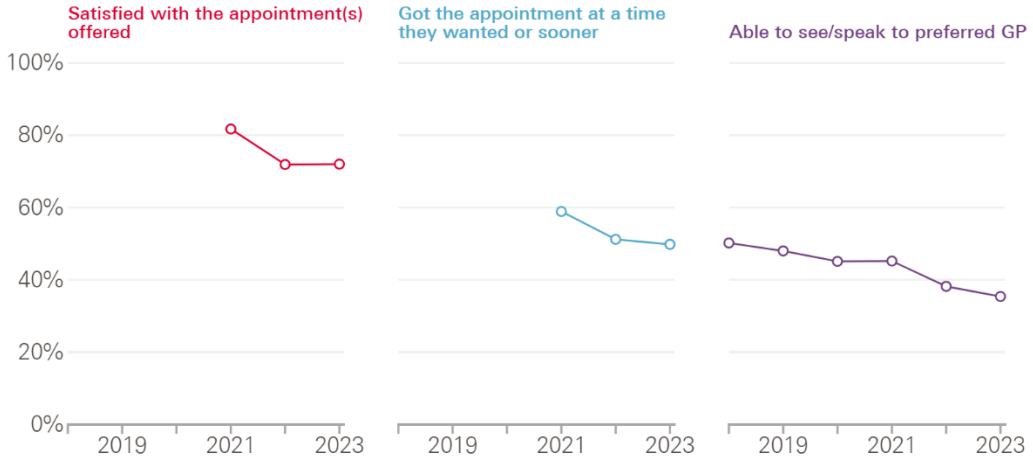
Source: NHS, GP patient survey

Fewer patients are satisfied with the appointments offered, the timeliness of appointments and their ability to see their preferred GP

The percentage of patients who are very or fairly satisfied with the appointments offered, the timing of appointments and that they can speak to their preferred GP always, almost always or a lot of the time



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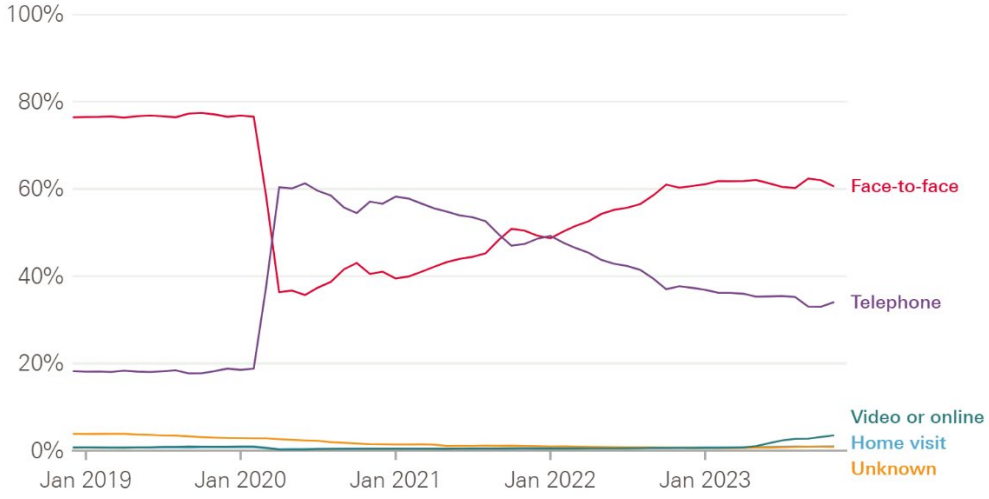
Source: NHS, GP patient survey. Data on satisfaction with appointment(s) offered and timing are only available from 2021

Face-to-face GP appointments have increased since the first COVID-19 lockdown, but there are still fewer than before the pandemic

The percentage of all appointments with GPs per month by the mode of appointment delivery



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Source: Health Foundation analysis of NHS Digital: Appointments in General Practice, November 2023 and June 2021

Note: interactive figure available at https://www.health.org.uk/publications/long-reads/rethinking-access-to-general-practice-it-s-not-all-about-supply

Some demographic groups have worse access than others. Health needs and consultation rates are higher in more socioeconomically deprived areas, but general practice in these areas is underfunded and under-doctored relative to need. Disabled people, carers, people from Bangladeshi and Pakistani ethnicities, people from socioeconomically deprived areas and people who identify as LGBTQI+ all report worse overall experience of accessing general practice. Patients in deprived areas tend to spend less time in GP consultations, and have seen a bigger increase in remote appointments (and decrease in face-to-face appointments).

More generally, the way that people book appointments, and the type of appointments they get, is changing. Although most people still make appointments over the phone, the proportion booking online or through an app is slowly increasing. In line with national guidance, many practices have implemented triage systems, often using online tools – these capture all requests for care and direct them to a clinician who decides the timing and type of appointment to be offered. And the rapid expansion of professional roles working in general practice (now often including paramedics, pharmacists, physios, link workers and physician associates) means that the proportion of appointments specifically with a GP is decreasing.

Changes to the type of appointment offered – and public perceptions of these changes – are complex. The percentage of in-person appointments with GPs decreased significantly at the start of the COVID-19 pandemic, and around 40% of GP appointments are now by phone. Data about public perceptions of the shift to remote access give mixed messages. Analysis of practices using online triage systems suggests that most patients prefer a telephone appointment, but making it easier to get in-person appointments is a popular choice when people are asked about priorities for the NHS. GPs have also faced sustained media criticism about how hard it can be to get in-person appointments.

Other direct patient care staff in general practice, such as nurses and health care assistants, are more likely than GPs to have in-person appointments – probably reflecting the physical nature of the tasks they undertake (eg taking bloods and changing dressings). But there are also concerns that the addition of new roles into general practice is contributing to declining patient satisfaction. Patients are sometimes unsure what type of health care professional they have seen, and say they prefer to see a GP.

Data about access to general practice also have limitations. National appointments datasets cover limited domains and are only as accurate as the information contained in general practice IT systems. Survey data have other limitations (changes to question wording, or mixing questions about hospital and GP waiting times, make it hard to understand what is really happening). Public perceptions data are also shaped by researchers' views on what is interesting, relevant and worthy of asking – so how broadly we think about access to general practice affects the data available.

Especially lacking is the kind of data that could help us understand how recent changes in the general practice workforce have affected access. For example, access to 'general practice' is no longer the same as 'access to 'GPs', but survey questions rarely distinguish the two. Overall, the full range of influences on access isn't always visible when thinking about why problems occur and, relatedly, what might be done about them.

How can the candidacy framework help us understand access to general practice?

One way of thinking about access in a more rounded way is by considering how patients, professionals, the systems they work in and broader structural factors interact to shape people's access to care. The candidacy framework was developed to provide a holistic perspective on access to health care by analysing how people identify themselves as 'candidates' for health care. The framework is characterised by seven features: identification of candidacy, navigation, permeability of services, appearances at health services, adjudications, offers and resistance, and operating conditions.

Although the framework was originally developed to understand access to health care by vulnerable groups, it offers a helpful way of thinking about some major influences on people's access to general practice too – as well as how ease of access can vary between patient groups and GP practices. For example, people need to identify themselves as candidates for care in the first place, and people have varying perceptions of what warrants medical attention in general practice, versus managed at home or elsewhere – see, for instance, *Wasting the doctor's time* (Llanwarne et al, 2017), *The iceberg of illness and trivial consultations* (Hannay D, 1980), and *Illness identity as an important component of candidacy* (Macdonald et al, 2016).

Table 1 summarises features of candidacy, giving examples of how each might apply to general practice.

Table 1: Features of candidacy, with potential applications to general practice

Domain of candidacy	What this means	Example of how this may translate to general practice
Identification	How people recognise their symptoms as needing medical attention or intervention.	People have different thresholds for deciding to seek care from general practice. Some of these are socially patterned (for example, smoking and obesity are more common in deprived areas, and people may delay seeking

		care because they fear being judged by staff).
Navigation	Using services requires knowledge of what is available, and having the practical resources to use them.	Frequent changes to how people make appointments (eg online booking systems, mandatory triage), as well as an increasing range of professionals available, might make it more difficult for people to know how to get an appointment and which health professional to ask for. Attending appointments requires people to have certain resources such as transport to GP surgeries, a reliable telephone connection or internet access. These resources are not equally distributed throughout the population.
Permeability	How many and what type of criteria people must meet to use services affects how easy they are to use. Permeability also includes cultural alignment between services and individuals.	General practice (the first point of contact for most health problems) has become more closed – less 'permeable' – in recent years. Changes to how appointments are requested and conducted, the criteria patients must meet to get offered the appointment type of their choice, and system pressures have all contributed to this decline in permeability.
Appearances	Appearing at services involves people making a claim to candidacy and requires a set of competencies and comfort with the social and cultural aspects of how services are organised.	Some people may be more able than others to use their 'voice' to present their needs. For example, some people may be more articulate, more confident and more persistent, ensuring their candidacy gets recognised and their related needs are heard.
Adjudications	Once patients have asserted their candidacy by presenting to health services, professional judgements ('adjudications') about candidacy strongly influence people's access to care. These judgements depend on a broad mix of factors, including operating	Adjudications in general practice can draw on generalist expertise and contextual knowledge of the patient over time, and are significantly influenced by the role of GPs as gatekeepers for secondary health care.

	conditions and resource constraints.	
Offers and resistance	Individuals may accept or refuse offers of care. Refusals may sometimes occur because people wish to resist the nature of the care offered.	Responses to a patient's claim to candidacy can result in 'offers' for active management, including referrals, prescriptions and investigations. In general practice, these offers often also relate to advice and reassurance in the context of a longstanding professional–patient relationship. Patients may accept or decline the offers made to them, meaning utilisation is not always a useful measure of access.
Operating conditions	Perceived or actual availability of services has a major impact on how individuals view their candidacy for services.	When the public are highly aware of pressures in the NHS (eg media reporting of winter pressures), people may alter their thresholds for seeking care.

The candidacy framework draws attention to how access to general practice is not simply a matter of supply or speed of appointments. Access is also a function of how people perceive their symptoms, identify GP services as being able to meet them, have the resources (cognitive, physical, and others) to find their way to them, and can present their needs in a way that can be adjudicated upon and subsequently processed, all in complex and resource-constrained environments.

Although GP services are free at the point of care in the UK, many barriers to access exist – additional to those outlined above – and these may be especially consequential for some groups. Narrow interpretations of access risk obscuring important barriers, and how access might differ between and across patient groups. In contrast, candidacy frames access as a highly dynamic process.

Viewing access through the wider lens offered by candidacy could help policymakers think more broadly about where improvements to access are most needed, understand why many existing attempts have failed and identify alternative solutions. It may also help avoid 'zombie' solutions – repeating efforts that have often been tried before, in different guises.

How have previous governments tried to improve access?

Policymakers considering ways to improve access to general practice can also learn from a back catalogue of previous attempts. Appendix 1 sets out a comprehensive list of more than 400 ideas and efforts to improve access to general practice in the UK in the last 40 years. The list is arranged into six categories (see Table 2) and includes attempts ranging from national level improvement projects right down to local practice quality improvement projects.

Table 2: Categorisation of current and past approaches to improving access to general practice

Category of approach	**Examples**
Appointment innovations	• Using triage to optimise appointment allocation • Using telehealth to expand the types of appointments offered to people
Giving patients direct access to services that remove the need to access general practice	• Self-referral to physiotherapy, psychological services and some types of specialist care (eg sexual health) • Expanding services offered by community pharmacists (eg including blood pressure checks, oral contraceptive reviews)
Increasing the number and range of professionals available to see patients within general practice	• NHS England's Additional Roles Reimbursement Scheme (which is funding additional health professionals such as pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics, to grow capacity in general practice via primary care networks) • Programmes to enhance recruitment to GP training (eg the RCGP #ChooseGP scheme)
Offering contacts beyond core hours, core settings and core services	• Practices providing appointments on weekday evenings or at weekends • Walk-in centres and urgent care clinics
Supporting patient engagement, empowerment and education	• Online advice tools and AI-supported symptom checkers

	• Improving local transport links to practices • Making practice registration processes easier
Supporting the internal and wider structures of general practice	• Horizontal integration with other local practices, mergers and the formation of federations • Vertical integration of general practices with hospital trusts and secondary care • Allowing commercial for-profit providers to bid for primary care contracts in cases where practices cannot be sustained by previous GPs • National programmes to reduce bureaucracy in general practice

Coalition, Labour and Conservative governments have all tried measures such as extending the opening hours of GP surgeries, expanding the range of places to access GP services (eg via walk-in or urgent care centres) and offering patients greater choice over where and how they access general. Other approaches to improving access characterise specific political eras.

Between 1997 and 2010, Labour's approach to improving the NHS involved widespread introduction of centrally managed targets. In 2000, this included a target that patients should be able to see a primary care professional within 24 hours, and a GP within 48 hours. Coalition and Conservative governments focused more on growing the primary care workforce, initially (and unsuccessfully) by boosting GP numbers, and latterly by recruiting additional 'direct patient care' staff (who are not GPs) to work in primary care.

The success of these policies has been mixed. In 2013, the Prime Minister's Challenge Fund (which incentivised participating practices to pilot new ways to improve access, with relatively modest investment of £50m) helped show what can work and how strategies can be tailored to local needs. More recently, recruitment of direct patient care staff to work in general practice (via the additional roles reimbursement scheme) exceeded initial targets, enabling 50 million extra appointments per year in general practice. Some approaches have had mixed effects. Extending practice opening hours can increase appointment availability, but these appointments may be underutilised. Anticipated benefits (such as reducing use of emergency departments) may not be realised, and new services (such as walk-in centres) may generate supply-induced demand and be poor value for money.

Labour's 24/48 hour access target – in place from 2000 to 2010 – is arguably a textbook example of unintended policy consequences. Flaws with methodology meant that data collection was unreliable, and – as some practices limited advance appointment slots to better meet targets –

patients experienced problems booking appointments more than 3 days ahead. People's ability to see their preferred GP declined, and – despite politicians claiming that targets had been met – overall satisfaction with GP opening hours fell between 1998 and 2004.

Efforts to improve access to general practice have focused on some domains of candidacy more than others. A range of policies have attempted to boost access by making services easier to navigate, or more permeable. But there have been fewer attempts to improve access by focusing on aspects of patient experience – for example, how people identify themselves as candidates for care, or how staff decide on care pathways.

Trade-offs between different components of access

Policies to improve access to general practice may also involve trade-offs between different components of access. Access to the same GP over time – often referred to as relational continuity – is associated with a range of positive outcomes, including lower mortality, unplanned hospitalisations and use of emergency services. But evidence (eg from Nuffield Trust and others) suggests that policy initiatives to improve quick access to general practice may have weakened relational continuity.

Similarly, broadening the range of health professionals working in general practice might increase appointment capacity, but could also reduce continuity of care with GPs for patients who need it, erode people's ability to assess which symptoms warrant medical attention and which do not, or make navigation harder for some people. Increasing digital routes to access may help some patients but risk excluding others, reducing the permeability of services.

Conclusion

Problems with access to general practice are longstanding and complex. Rising GP workload, and the corresponding decline in permanent FTE GPs, is a fundamental problem. Improving access will be difficult unless the overall resourcing of general practice – including funding, as well as the total number and range of staff – matches patient need.

In the context of ongoing GP shortages, recent increases in the different types of patient-facing staff have contributed to increased supply of appointments in general practice. But ongoing declines in public satisfaction and heated debate about the acceptability, scope and regulation of some new roles suggest that boosting supply in this way is not solving all access challenges.

Improving access to general practice depends on having a good understanding of what needs to be fixed. Policies that take a narrow approach are likely to make things worse. Viewing access through a wider lens (for example, using the candidacy framework) can help policymakers think more broadly

about what might be blocking improvement, consider trade-offs between 'domains' of access and reduce the chances of unintended consequences.

Drawing on the candidacy framework, the IMPRESS project – a collaboration between the Health Foundation and researchers at THIS Institute – aims to build a more nuanced and holistic understanding of general practice access issues. We're working together to develop 'CandidacyGP+', a new framework tailored specifically for general practice. This will give more nuanced insight into access challenges, in turn helping inform better ways to improve access to general practice – which we know is a priority for patients, practitioners and policymakers alike.

Supporting information

This long read was published originally on 5 March 2024 at the following address:

https://www.health.org.uk/publications/long-reads/rethinking-access-to-general-practice-it-s-not-all-about-supply