

Does Advanced Access work for patients and practices?

FAST access to care when it is needed is one of the hallmarks of a high quality healthcare system, but achieving this in an equitable fashion has long been a problem in the United Kingdom (UK), as in most other countries. Improving access to care is now a top priority for UK health policy. *The NHS plan* sets a target that by the end of 2004 all patients should be able to see a primary care professional within 24 hours and a general practitioner within 48 hours.¹ To support this objective, the government created a primary care access fund of £168 million, of which at least £48 million was dedicated to improving access to primary care. Each primary care trust (PCT) received funding for 2 years to employ a primary care access facilitator, supported by the National Primary Care Development Team (NPDT) within successive waves of a primary care collaborative. The organisational model strongly promoted by the NPDT is that of Advanced Access.^{2,3}

Advanced Access is based on five principles: understanding demand, shaping the handling of demand by providing alternatives to face-to-face consultations, matching capacity to demand (which may include changes to skill mix), developing contingency plans, and communicating continuously with staff and patients.² Practices use rapid 'plan-do-study-act' cycles to implement these changes. One key feature is that, in contrast to traditional appointment systems, most patients are seen on the day that they make the request and only a minority of appointments are available for booking in advance.³ However, under Advanced Access people should still be able to book ahead if they prefer.

The ideas behind Advanced Access originated in the United States (US), and draw on theories developed in industrial settings of ways to re-engineer systems to improve efficiency and reduce delays. The use of plan-do-study-act cycles is intended to create a culture of continuous quality improvement, which encourages innovation and learning from experience, and challenges established working practices.^{4,5} Proponents of Advanced Access have claimed that it leads to a range of other benefits, apart from reducing waiting times. These claims include improved patient and staff satisfaction, reduced non-attendance rates, a reduction in face-to-face consultations and improved continuity and quality of care.^{2,5,6}

However, concerns have been raised about the impact of Advanced Access on continuity of care, practice workload, and patient choice. Although patients value rapid access to care, an even higher priority for many people is being able to see a doctor that they know, can talk to, and trust.⁷ The relative importance of access versus seeing a particular health professional varies for different groups of patients and for different problems.^{8,9} An over-emphasis on rapid access to care may lead to a reduction in personal continuity of care, and make it difficult for people to see the doctor of their choice within a reasonable time. A qualitative paper

in this month's *Journal* illustrates these problems, and also highlights difficulties some people experience in making telephone contact at surgeries where most appointments are only available on the same day.¹⁰

Advanced Access is based on the idea that demand is largely predictable. If the pattern of demand is assessed, appointment systems are tailored appropriately to match demand, and any backlog is cleared, then delays for an appointment should not occur. However, it has long been believed that demand for health care is not fixed but is strongly related to supply (although this assumption has recently been questioned).¹¹ In a system without financial disincentives to consult, an important constraint on demand is the delay to gain access, during which many people find other ways of dealing with their problems or get better in the meantime. Advanced Access recognises that demand can be 'shaped' by changes in the way that care is delivered. But given what we know about the clinical iceberg of disease, if reducing delays leads to a lowering of the threshold for consulting, the impact on total workload in primary care could be large.

Reducing delays could have other subtle effects. It may lead to increased medicalisation of minor problems and social difficulties if it is easier to see a doctor than any other source of help. A perception that all medical problems should be dealt with immediately may undermine peoples' confidence that they can manage most symptoms themselves. There may also be an impact on doctors' behaviour and prescribing rates if people present with symptoms at a very early stage before it is clear if they represent a self-limiting illness.

However, this is just speculation. We simply do not know whether the benefits claimed by proponents of Advanced Access or the concerns raised by sceptics are justified. Considering the size of the investment in Advanced Access, the radical claims made for its benefits, and the strength with which it is being promoted by PCTs, it is remarkable that very little rigorous evaluation of this model has been undertaken. The articles most commonly cited about the benefits of Advanced Access in the US⁴ and the UK⁵ are entirely devoid of peer-reviewed references to substantiate the claims made. One paper from the US describes case studies of seven practices seeking to implement Advanced Access with variable degrees of success, but provides no empirical data or patient perspective.¹² In any event, it is debatable whether experiences in the US, which has a very different healthcare system, producing serious inequities of access, have much relevance to the organisation of primary health care under the National Health Service (NHS).

The evaluation of Advanced Access published this month provides the first peer-reviewed evidence from the UK about this approach, and is generally supportive. Using Advanced Access, two-thirds of practices in the National Primary Care

Collaborative reduced the wait for an appointment with a doctor and more than four-fifths of general practitioners felt that their participation in the collaborative had been worthwhile.¹³ But the research was commissioned within a very short time-scale and has a number of important limitations, as the authors recognise. No control practices were examined and little baseline data were available. The practices involved were not representative of all general practices, being more likely to be training practices and ex-fundholding practices, and less likely to be in urban or deprived areas. Data about appointment availability was collected by the practices themselves and is therefore of uncertain reliability. Most importantly, the evaluation did not include any information from patients about their experiences of the changes to access arrangements.

We need more research about the experience and priorities of patients in gaining access to primary care, including all patients, not just those successful in gaining access. Research should focus on the needs of particular groups of patients who may lose out under the new arrangements, and should explore the trade-offs that patients make between speed of access, choice of clinician and ability to book in advance. We need evidence about the impact on other health services (particularly out-of-hours services) and the concern that increased speed of access may increase demand and/or reduce continuity of care.

Perhaps the lack of evaluation of Advanced Access is not surprising. It is inconceivable that a new drug could be licensed for use in the UK without clear evidence of benefit or consideration of side effects, yet this is routine with regard to the introduction of major changes in organisation within the NHS. Another paper in this month's *Journal* describes a host of innovations to improve access with a very limited evidence base.¹⁴ There seems little consideration of the possibility that changes which seem a good idea at face value may not always be universally helpful or may have unintended adverse consequences. Although the NHS research and development programme has now funded research on Advanced Access that addresses many of the above questions, the organisational change itself has been promoted for more than 3 years, with considerable investment of resources.

The importance of independent and rigorous evaluation of new developments in the NHS *before* they are widely introduced is hardly an original observation but it needs to be made repeatedly and vigorously. Perhaps, as well as a clearer understanding of Advanced Access, we need a better

understanding of why the message about evidence-based policy is not getting through.¹⁵

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Conflict of interest

Chris Salisbury is receiving funding from the NHS Service Delivery and Organisation Research and Development Programme to undertake research on Advanced Access.

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The work of the National Patient Safety Agency to improve medication safety

PATIENT safety is defined as freedom from accidental injury due to medical care.¹ Two reports on patient safety in the National Health Service (NHS) have been published by the Department of Health: *An organisation with a memory*² and its follow-up, *Building a safer NHS for patients: implementing an organisation with a memory*.³

The reports highlighted research that indicated that

around 10% of patients admitted to United Kingdom (UK) acute hospitals experience some kind of incident that might threaten their safety,⁴ and that up to half of these could have been prevented. Findings in the United States,^{5,6} Australia,⁷ New Zealand,⁸ and Denmark⁹ have suggested similar error rates. The little data reported from primary care suggests similar rates of safety incidents.¹⁰