evidence for
better health care

nuffieldtrust

Meeting need or fuelling demand?

Improved access to primary care and supply-induced demand

Briefing

Rebecca Rosen

June 2014

In partnership with

NHS England

Improving access to general practice and other primary care services is a key concern for policy-makers and practitioners. Both the Coalition Government and the Opposition have made this a priority for reforming the NHS. In October 2013, the Prime Minister launched his Challenge Fund, which is financing innovative pilot schemes across the country designed to improve access to general practice; and in a speech in May 2014, Labour Leader Ed Miliband outlined a range of new options for improving access to family doctor services, including plans to re-introduce the 48-hour GP access target.

NHS England commissioned this work by the Nuffield Trust to ensure that the successful pilots from the Prime Minister's Challenge Fund were in a position to learn from past experience and research. The briefing examines how far increased access to general practice and other primary care services will deal with unmet need, or whether these efforts will serve to stimulate additional use of services that would not have otherwise occurred. This is known as 'supply-induced demand'.

We examine what supply-induced demand is, distinguishing between demand for services that is stimulated by easier access to new forms of primary care (described as 'induced demand') and clinical practice in direct access primary care that stimulates additional use of other services (described as 'induced utilisation'). We also consider the role that service providers can play in modifying supply-induced demand, and whether it is possible to alter patient behaviours and demand for different forms of primary care services. Finally, we identify some important considerations for those evaluating the impact of the Prime Minister's Challenge Fund.

Key points

- Inadequate capacity in general practice not only leads to unmet health needs, but to an increase in demand for A&E and walk-in centres. Schemes such as the Prime Minister's Challenge Fund are looking at ways to improve access to general practice and wider primary care services.
- Additional NHS services are often not substitutive and tend to increase overall service use. Services that seek only to extend access to general practice across longer hours may end up resolving clinical problems and generating additional demand in approximately equal measure and at high cost.
- Effective triage and integrated unscheduled care services are important ways to ensure that patients access a service that can meet their needs in the minimum number of contacts possible, and with access to a known clinician when appropriate. However, the ability to address all needs during a single contact is influenced by factors such as regulatory restrictions, the 'philosophy' of the service, and the time available per patient seen.
- The links between the unscheduled care provider and usual doctor are critical, and a key design challenge for emerging services is around defining what the initial assessment should include, along with timely handover of clinical data to support efficient onward care.
- The way people use unscheduled care services is shaped by their beliefs about health and their expectations of the health services. The extent to which these beliefs can be changed is debatable.
- The results of education campaigns to change behaviours and expectations are mixed, and for a campaign to be effective it must be targeted in a variety of ways that will be noticed by the public and sustained over a long period of time.
- Evaluation of the Prime Minister's Challenge Fund services should have clear aims and be considered within a local context. Service providers should be explicit about expected outcomes to allow rigorous evaluation of cost-effectiveness. Service user and staff perspectives should be taken into account.

Find out more online at:
www.nuffieldtrust.org.uk/publications/meeting-need-fuelling-demand

Introduction

Media coverage of how people struggle to access their GP is widespread. There is significant public frustration about the difficulties of getting through to GP surgeries and booking an appointment at a convenient time.

Although data from the national GP survey (Ipsos MORI, 2013) show that 75 per cent of patients report their overall experience of getting an appointment as good, 13 per cent had to call back nearer the day they wanted an appointment. Ten per cent of people describe their overall experience of making an appointment as poor and ten per cent of patients who cannot get a convenient appointment do not then see or speak to anybody else about their health concerns.

In October 2013, David Cameron launched the Prime Minister's Challenge Fund to address these problems; inviting GPs around the country to submit innovative proposals for improving access to general practice and wider primary care (NHS England, 2013).

Over 250 proposals were submitted, with 20 selected to become Prime Minister's Challenge Fund pilots. In some cases, these services extend the hours of access to general practice. Others will broaden the ways in which patients can contact GPs and other primary care providers, with plans to use skype, telephone, texting and email consultations. Some will provide standalone access to general practice, while others will seek to link unscheduled access with ongoing care from the usual doctor. But there is no guarantee that this additional offer will be used by the patients who have difficulty getting an appointment when they want one. Indeed, it is possible that these easy-to-access extended hours services will generate consultations that would not otherwise have taken place and result in an overall increase in demand for health care with minimal gain in terms of improved health of individuals.

This briefing examines the issue of supply-induced demand and considers whether we can measure how far increased access to general practice will deal with unmet need, or whether it will stimulate additional use of services that would not have occurred otherwise. The briefing is based on discussions at a workshop held at the Nuffield Trust, and supported by NHS England, in March 2014. The workshop brought together experts on this topic with policy-makers and practitioners.

The briefing examines the following issues:

- The definition of supply-induced demand, including the ways in which we experience the concept in everyday life.
- The extent to which demand for services is stimulated by suppliers of new forms of primary care (induced demand), and how far this stimulates additional use of other services (induced utilisation).
- The role that service providers can play in modifying supply-induced demand and whether it is possible to alter patient behaviours and expectations of different forms of primary care services.
- Finally, it identifies some important considerations for those evaluating the impact of the Prime Minister's Challenge Fund.

Defining and understanding supply-induced demand

Economic definitions of supply-induced demand

Traditional definitions of supply-induced demand are rooted in economics, and reflect the role of doctors as agents for patients, with the ability to shape patients' views about the services they want and need. Economists draw a distinction between *supplier*-induced demand – in which the relationship between doctor and patient is used to increase patient use of services (Bickerdyke and others, 2002), and *supply*-induced demand – related to the availability of services in a region rather than specific interactions between patient and doctor (Dartmouth Atlas Topic Project Briefing, 2007).

16%

of people attending walk-in clinics reported that they would have done nothing if that service had not been available

Supply-induced demand in health care might not, in itself, be a bad thing. For example, the 'demand' for health checks and early detection of common conditions has in part been stimulated by the supply of conveniently located facilities in supermarkets, libraries and other civic spaces. Checking a long-neglected symptom because an easy opportunity arises could lead to early detection of an underlying illness. In addition to creating extra capacity for unmet need, services such as walk-in centres and minor injury units have other benefits, including access for unregistered patients, convenience for local workers unable to take time off work to attend their own GP, and increased choice for patients. But the ease of access they offer also has the potential to induce demand. And where the outcome of a consultation is advice to attend another service, for instance to return to their own GP, such consultations result in additional utilisation. This increase in demand and utilisation has the potential to draw funds away from other services, which may offer greater health benefit. Furthermore, checking – or re-checking – a common, minor, self-limiting ailment can reassure, but can also erode self-confidence about the ability to self-care. If limited general practice resources and workforce are spread over extended hours, providing rapid access for acute conditions that are often self-limiting, this may restrict availability for multidisciplinary team working and disrupt continuity for patients with complex needs.

In the context of improving access to primary care in the NHS, an additional issue comes into play. Surveys by the Picker Institute and others (see, for example, Picker Institute, 2013) describe how some patients attend direct access and unscheduled primary care services because they cannot obtain a timely appointment with their usual GP. Others are confused about which service to use for different types of illness. Data from the national GP patient survey (Wallis, 2013) reveal that, of people who could not get a convenient appointment at their GP practice, 22.6 per cent either used another service or did not see anyone at all, including 9.2 per cent who went to accident and emergency (A&E) or a walk-in centre. However, national GP patient survey data do not currently enable estimation of the number of A&E appointments resulting from patients not being able to get a GP appointment.

During the Nuffield Trust workshop, Professor Jon Nicholl from the School of Health and Related Research in Sheffield, usefully added to the idea of supply-driven increases in service use, distinguishing between induced *demand* and induced *utilisation* (see Box 1).

Box 1: Terminology for induced demand and utilisation

Supplier-induced demand

The impact that doctors (or other professionals), as providers of services, may have on creating more patient demand than there would have been if they acted as perfect agents for their patients.

Supply-sensitive demand

Increased use of health services stimulated by increased regional supply of services (Dartmouth Atlas Project Topic Brief, 2007).

Induced demand

Attendances at walk-in centres, 111 or urgent care centres where the patient would not have chosen to use the service if it had not been available.

Induced utilisation

Use of services following an initial contact with a direct access service, which would have occurred even if the direct access service was not available and are therefore *additional* attendances.

With the Prime Minister's Challenge Fund set to stimulate innovation in access to primary care, the issue of (supply) induced demand and induced utilisation requires some attention. The following sections consider in turn:

- Can we measure and monitor the extent of induced demand and utilisation?
- Can we design services to minimise the impact of induced demand and utilisation?
- Can we influence patient behaviours and expectations about access to services?

Measuring and monitoring supply-induced demand

46%

of patients using walk-in centres could be seen to have had additional encounters that they would not have had if the direct access, unscheduled service was not available

Research on quantifying induced demand and induced utilisation was presented during the workshop by Professor Jon Nicholl. Drawing on patient surveys from evaluations of six walk-in centres and two urgent care centres, he identified the proportion of patients who would not have used an alternative service (induced demand) and the proportion of patients who were referred onto an alternative service after their unscheduled contact (induced utilisation).

Sixteen per cent of people attending walk-in clinics and 12 per cent of those attending urgent care centres reported that they would have done nothing if that service had not been available. In the walk-in centres, the percentage having additional encounters, combined with those who would not have used an alternative service, matches those whose care was completed during their visit.

In total, approximately 46 per cent of patients using walk-in centres and 33 per cent of patients attending urgent care centres could be seen to have had additional encounters that they would not have had if the direct access, unscheduled service was not available. The presentation did not cover whether or not the attendances were 'appropriate', necessary or avoidable. The urgent care centre completed over 75 per cent of

consultations without onward referral, whereas the walk-in centre completed only 50 per cent. Tables 1 and 2 summarise the data presented during the workshop, with the figures in red highlighting the volume of induced activity created by the unscheduled, direct access services.

Table 1: Induced demand and induced utilisation as a proportion of all contacts in six private*, doctor-staffed commuter walk-in centres

	Pre-consultation intentions N (%) (What would you have done if the walk-in centre was not available?) Induced demand	Post-consultation plans N (%) Induced utilisation
A&E	139 (11.7)	74 (5.0)
GP	631 (53.2)	368 (25.0)
Other	228 (19.2)	295 (20.0)
Self/nothing	189 (15.9)	737 (50.0)
Total	1,187 (100.0%)	1,474 (100.0%)

* These were private Medicentres situated at train stations.
Source: Adapted from O'Cathain and others, 2009; and Coster and others, 2009.

Table 2: Induced demand and induced utilisation as a proportion of all contacts in two private*, doctor-staffed urgent care centres

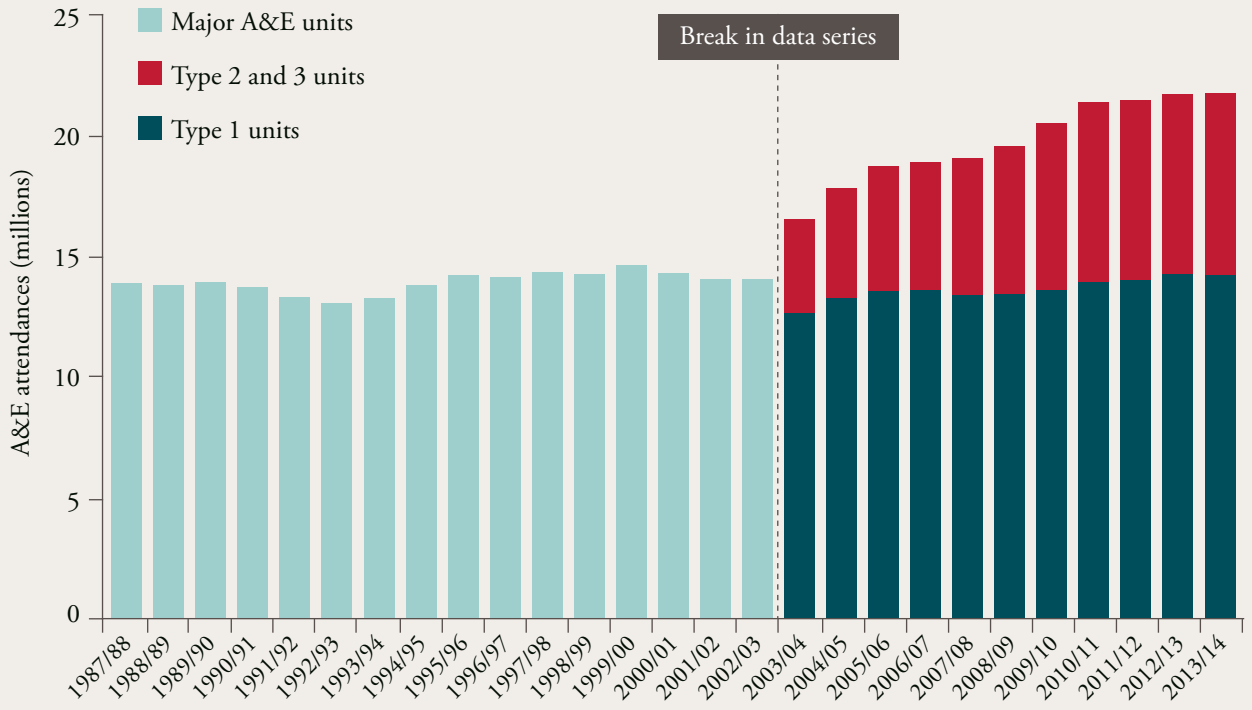
	Pre-consultation intentions N (%) (What would you have done if the urgent care centre was not available?) Induced demand	Post-consultation plans N (%) Induced utilisation
A&E	202 (23.2)	38 (4.4)
GP	340 (39.0)	146 (16.7)
Other	226 (25.9)	30 (3.4)
Self/nothing	103 (11.8)	659 (75.5)
Total	871 (100.0%)	873 (100.0%)

* These were private Medicentres situated at train stations.
Source: Adapted from Arain and others, 2013; Arain and others, 2014; and Arain 2014.

Other workshop contributors described patients who had attended multiple different direct access services over a short space of time for the same condition. One participant presented evidence of increased use of NHS services after the launch of initiatives designed to reduce service use. The underlying message was that additional NHS services are often not substitutive and tend to increase overall service use. This may be desirable where there is currently unmet need, but may increase utilisation in an inefficient way if it is not directly related to need.

Data from The King's Fund (Appleby, 2013) illustrate this point well, in an analysis of the impact of type 3 services (that is, walk-in centres, minor injury units and urgent care centres) on A&E attendances. The data show that, despite their aim of substituting for A&E attendances, the services are largely additive, with little change in overall A&E attendance since the time the new services were introduced.

Figure 1: Accident and emergency attendances by unit type, 1987/88 to 2013/14



Appleby, 2013. © The King's Fund; reproduced with permission.

Workshop participants considered whether it is possible to classify demand for GP appointments as 'more' or 'less' appropriate or, using more emotive language, into 'good' or 'bad' demand, with two schools of thought emerging. Some argued that if people feel they need professional advice, they should be able to access this, with the onus on professionals designing care services to make it easy for them to choose the right service for each individual's problem. Indeed, some national campaigns promote exactly this kind of consultation (see, for example, the National Awareness and Early Diagnosis Initiative for cancers; Cancer Research UK, 2008). Other participants thought that single or repeat attendances about minor illnesses represented an inefficient use of scarce NHS resources, where the investment could be better deployed elsewhere. They saw value in triaging minor self-limiting illness towards self-management support and in working to build the capacity of families and communities to manage minor illness, and to change health-seeking behaviours and public expectations about what the NHS can provide.

Further discussion focused on two main themes: designing provider responses to minimise induced demand and utilisation, and changing individual and community behaviours and expectations.

Designing provider responses to reduce induced demand

This discussion covered whether induced utilisation can be reduced by ensuring that service providers make intelligent decisions about the management and onward referral of patients who use each service.

Data on the impact of the 111 telephone advice line on use of other NHS services showed that it has not reduced use of A&E and urgent care centres. The pilot sites resulted in approximately 0.5 million additional contacts with the NHS across all study

sites that would not have occurred if the service had not been available (Turner and others, 2013). A number of points emerged from the discussion about how to design provider responses that do not induce additional demand:

Triage by a skilled and experienced person

Induced utilisation, with people moving through multiple health system contacts (when a single service with a focus on 'one-stop' management might suffice), was partly attributed to risk-averse algorithm driven services. The 111 research mentioned above illustrates how this model of service, using non-clinical call handlers, has been unable to divert callers away from other services. An alternative service design is seen in Denmark where GPs triage out-of-hours calls. Approximately half the calls are managed over the phone and one third are asked to attend for a face-to-face consultation, with 19 per cent receiving a home visit (Christiensen, 1998). These figures were very similar in the Netherlands, where out-of-hours telephone triage is undertaken by nurses working under the supervision of doctors in cooperatives covering 50,000 to 500,000 people. A higher proportion of callers were diverted away from hospital care following home visits if the cooperative worked in an integrated way with the hospital emergency department (Grol and others, 2006). The design principle of initial assessment by a highly skilled individual was proposed in the recent Nuffield Trust report, *Securing the Future of General Practice: new models of primary care* (Smith and others, 2013).

The key challenge is to identify different patient groups through triage systems and steer them to a service that can resolve their problem with the smallest number of contacts. A potential outcome measure for Prime Minister's Challenge Fund sites could be addressing all needs to the satisfaction of the patient during a single contact. The potential for people to self-assess using online resources and self-management guides was also discussed, and is considered further in the next section.

However, the ability to address all needs during a single contact reflects more than just staff skill and experience. Other factors include regulatory restrictions; the underlying 'philosophy' of the service; and the time available per patient seen. For example, the range of services provided by pharmacists is limited by the fact that not all can act as independent prescribers, since this depends on gaining an additional qualification.

Providers of high volume, unscheduled services were noted to operate in a combination of 'problem-solving' and 'safety-netting' modes. Many common, self-limiting conditions such as urine infections or minor injuries can be fully managed during a single brief contact (see Tables 1 and 2 for completed episodes). But conditions with many possible underlying causes need investigations and follow up. A brief assessment to identify and manage urgent symptoms ('safety-netting') before handing back to the usual doctor for further investigation is common practice. Even if rapid access diagnostics are available, complete work up and formulation of a clinical management plan may not be possible in a single contact. The links between unscheduled care provider and usual doctor are critical here, and a key design challenge for emerging services is around defining what the initial assessment should include, along with timely handover of clinical data to support efficient onward care.

During the workshop, Dr David Lloyd, a GP from Harrow, described an inter-related group of scheduled and unscheduled primary care services in a single London borough. He argued that the best way to obtain efficient management of clinical problems that

minimised hand-offs to other providers was to commission a single unscheduled care system combining walk-in services, urgent care and telephone assessment. Such a service would need to be closely integrated with routine general practice.

Balancing timely access and continuity of care

Services which focus only on extending hours of access will spread a limited workforce across longer working hours. It remains to be seen what proportion of this care will be additional to existing provision and how much will substitute for existing in-hours care. If some substituted extended hour appointments go to people who were not previously able to access services and around 30 per cent of contacts reflect induced demand and utilisation (see above), the capacity to deliver continuity for other patients who might want it is likely to reduce unless additional capacity is created. With growing workforce pressures, it may be hard to increase capacity, even if additional funding is available.

A key design challenge for innovative services will be to find ways to combine the management of short-term and long-term problems, and to triage patients towards the clinicians, services or resources that are best able to meet a range of needs in a single or small number of encounters. This reflects a wider challenge to general practice in terms of finding ways to increase its overall efficiency and ability to manage multiple problems in fewer encounters.

Tailor responses to patient sub-groups

A further theme related to tailoring provider responses to different population sub-groups in order to reduce demand on other parts of the health service. For example, some community pharmacies now offer medicine reviews to patients with long-term conditions, which can be delivered at the time they attend to collect medicines; reducing the need for medication reviews in the GP surgery. A wider set of pharmacist roles is emerging among those who are certified as independent prescribers. The London Ambulance Service has developed a range of responses that can be offered, rather than simply transferring everybody to hospital. For example, patients can be assessed as suitable for GP home visit, with the ambulance crew calling the GP surgery to book the visit. And the East Midlands Ambulance Service has developed a 'falls' response which involves referring a person without obvious injuries after a fall to social services for assessment for home adaptations.

Redesigning working practices to support efficient use of services

There were several examples provided during the workshop of service design that results in avoidable use of services. These included transport services that end at 8pm, resulting in hospital admissions only because it was not possible to drive a patient home. Also, GP home visits during the mid to late afternoon when it is often too late to set up services to support a person in their own home, resulting in a trip to A&E or an admission. Examples from beyond the NHS include joint services between health care, social care and housing, designed to combine health promotion and wellbeing with on-site access to immediate support for minor problems. Such initiatives can increase capacity to manage self-limiting illness in the community and support people to stay at home after earlier discharge from hospital.

Changing patients' behaviours and expectations

The third theme of the workshop was how much supply-induced demand can be influenced by changing the expectations and behaviours of service users. It is almost a decade since the last Labour Government proposed a new social contract for health care in which a balance of patient rights and responsibilities would shape the use of services. While the revised NHS Constitution (2010) removed the 48-hour access target, the language of patient choice and rights is still evident, with implications for designing and delivering improved access to primary care, and the nature and purpose of emerging services. Furthermore, the concept of 'reasonable expectations' is hard to define. The NHS has a legitimate role in reducing anxiety about illness and providing reassurance; however, this must be balanced with its role in diagnosis, treatment and continuity of care. How should these issues play out in the access debate?

Education campaigns about choosing the 'right service' provoked mixed views at the workshop about whether they could be effective, and agreement that if they do work, they are slow to take effect. A sustained, local campaign in Tower Hamlets, running over many years, was argued to have successfully changed the behaviour of some patients, who now call a local triage number before attending A&E. But many such campaigns are short-lived – operating only for a few months a year as part of a local 'winter-pressures' campaign – and typically rely on posters and leaflets, rather than wider, multi-channelled campaigns. This may explain why their impact is limited.

An alternative approach to patient education could focus on building long-term capacity for individuals, families and communities to cope with minor illness, and thus reducing the demand for professional care in the early stages of common illnesses. Small pilot services have had some success in this area (Harrop and others, 2009) – but there have been few attempts to scale up this approach.

> patient education could focus on building long-term capacity for individuals, families and communities to cope with minor illness

Some workshop participants argued that the way to increase the impact of education campaigns was to simplify the system. A Picker Institute report (Picker Institute, 2013) identified confusion about which service to use as a key reason why people opt to attend the well recognised 'brand' of an A&E department. Neil Heather, creative lead for the StormCreative Yellow Man campaign (StormCreative, 2013), argued that a clear, simple message repeated over time in multiple media and settings is essential if a campaign is to be impactful. He argued that messages promoting widely recognised and trusted 'brands' – the doctor, the chemist, the hospital – are likely to be the most effective. If people aren't clear what an urgent care centre is, and how it differs from a walk-in centre, they are less likely to choose to go there. This point links directly to the system design challenge described above: the need to create a whole-system approach, linking urgent and unscheduled care to routine general practice and chemists/ pharmacy, which steers people to whichever service is best able to meet their need.

Changing public expectation about access to primary care

The issue of whether it is possible to re-calibrate public expectation about what the health service can offer them in the current financial climate proved controversial. Some participants felt this was an inappropriate question to ask in relation to a service that is so clearly failing to meet current expectations in relation to access. Others argued that the opportunity cost of diverting limited workforce and financial resources towards services that are dominated by attending to minor illness was significant.

There is some evidence that previous policies to increase access have reduced continuity of access for people with complex problems (Freeman and Hughes, 2010; Phan and Brown, 2009). However, Salisbury and others (2007) did not report a reduction in continuity associated with the NHS advanced access policy, although this was a practice-level appointment scheduling initiative rather than a re-distribution of clinicians across longer working hours. Integration and the ability to deliver coordinated care might be reduced if a constrained medical workforce is spread thinly across more hours, leaving them unavailable for multidisciplinary teamwork. Workshop participants argued that the issues of immediate and continuous access should not be seen in direct opposition, but recognised that they are interdependent.

While Neil Heather's presentation sketched an outline of what a sustained national campaign might look like, all agreed there is no easy way to re-calibrate public expectation of what the NHS should offer them. Local education campaigns acting alongside well-designed, high-quality services and initiatives to improve self-care skills were seen as equally important ways to change the way people access services. And, importantly, personal incentives – in terms of time and convenience – were also cited as critical. People will choose the service that delivers the best balance of convenience and effectiveness. Changing these expectations and behaviours will require excellent service design and implementation. Until it becomes just as easy and just as helpful to click on a computer icon or load a phone app for self-care advice as it is to attend a clinic, it is unlikely that people will stop using unscheduled primary care.

Evaluating the Prime Minister's Challenge Fund services

With the pilot schemes that are being funded as part of the Prime Minister's Challenge Fund about to launch at the time of writing, it is important to consider how they should be evaluated and what would be the most appropriate measure of success for the schemes. A simple measure of impact for the access pioneers would be number of patients seen – where high throughput at low cost would appear good. But if every contact resulted in follow up at a different service, induced utilisation would become a problem, with knock-on implications for the capacity of existing services to provide appointments. At least some part of the evaluation would need to focus on completed pathways of care, in which service use for the specific clinical problem that triggered an index consultation is tracked over time and across multiple providers. From this perspective, assessing whether a consultation fully resolved a patient's problems or resulted in appropriate referral would be a valuable outcome measure.

A second methodological challenge relates to evaluating the cost-effectiveness of improved access and the need to understand the cost of specific outcomes. Participants teased out many possible ways of conceptualising improved access, including rapid appointments; access to an appropriate clinician; completed episodes of care; and

access to continuity of care. The apparent 'cost-effectiveness' of the Prime Minister's Challenge Fund services could vary considerably depending on the outcomes chosen, and methodological work is needed to identify the most appropriate measure(s) to use.

Other relevant points raised included understanding what patients are hoping to achieve by going to an improved access service, and why clinicians and other staff choose to work there. Are patients assuming their problem can be fully managed by the service and, if not, how do they hope to complete the episode of care? How does work in a pilot service compare to routine general practice and is there a difference in the way newly qualified and older GPs see their role in these services?

Workshop participants noted that it takes time for new services to bed in, so drawing early summative conclusions from an evaluation would be inadvisable. Also, prior understanding is needed about how many people are currently using general practice for urgent and routine care during the daytime to set a baseline against which to compare the impact of new forms of access. Drawing together all the points raised during the workshop, key messages for evaluation design were:

- **Clarity of aim:** What balance is each Prime Minister's Challenge Fund pilot seeking to achieve between access for acute and ongoing problems? Between minor illness and complex conditions? Between unscheduled care and bookable appointments with a known doctor? Between treating and referring on, versus completing as many encounters as possible?
- **Evaluation within a local context:** The aims identified (as above) will be shaped by specific local problems with primary care access, and each pilot will be designed to tie in with other local services. This localness of design and purpose must be captured in the evaluation and local leaders should be involved in designing an evaluation from the earliest opportunity.
- **Clarity about expected outcomes:** Including outcomes of the service itself, and (intended and unintended) outcomes for the local health system as a whole. Whole system outcomes are required to quantify induced demand and utilisation, and to evaluate the cost-effectiveness of the pioneer in the local health economy.
- **Patient perspectives:** Should include those who use the pilot service and others with ongoing problems and long-term conditions whose access to continuity of care may be affected by efforts to increase rapid and unscheduled access.
- **Staff perspectives:** The evaluation should include exploration of reasons for working in the service and the underlying care 'philosophy' of participating clinicians. To what extent do they feel a duty to complete an episode of care, or are they safety-netting and handing back to other services?

Conclusion

Improving access to general practice and other primary care services is one of the key issues confronting policy-makers and practitioners, with the Coalition Government and Opposition developing different approaches to resolving a problem that continues to frustrate the public. The Coalition Government has launched its Challenge Fund, which is funding innovative schemes across the country; while the Opposition has outlined a range of new options for improving access to family doctor services.

However, the Nuffield Trust workshop demonstrated the need for clarity about the underlying aim and target population of any service that sets out to improve access to general practice. Services that seek only to extend access to general practice across longer hours, disconnected from usual care providers and without incentives for whole-system efficiency, may end up resolving clinical problems and generating additional demand in approximately equal measure and at high cost. Previous initiatives to promote timely access have revealed how policy initiatives focused on a tiny sub-section of care can result in perverse incentives and unpopular processes. Thus, the Advanced Access policy of the mid-2000s drove the introduction of on-the-day booking systems that were disliked by patients (Anekwe, 2010). And the decision by several clinical commissioning groups (CCGs) to close walk-in centres (Monitor, 2014a), often because of their cost and that they were "additive", is a reminder that we need a good understanding of the cost-effectiveness of the Prime Minister's Challenge Fund services that are established.

Effective triage and whole-system 'logic' that integrates unscheduled care with routine general practice emerged as two important ways of ensuring that patients access a service that can meet their needs

GPs who offer new forms of access across collaborating providers with a shared commitment to balancing access, continuity, efficiency and quality may fare better. Some unscheduled care services (see, for example, Fylde and Wyre CCG, Blackpool CCG, 2012) exemplify whole-system approaches that link core general practice and timely unscheduled access to other services. These examples of services which have combined unscheduled direct access to a range of services and protocol-driven access for high-risk individuals, may offer useful learning for the Challenge Fund sites to minimise 'churn' around the system and avoid induced utilisation.

Effective triage and whole-system 'logic' that integrates unscheduled care with routine general practice emerged as two important ways of ensuring that patients access a service that can meet their needs in the minimum number of contacts possible and with access to a known clinician when appropriate. This raises questions about how to deliver effective triage and what the scope of such arrangements might be. At their most ambitious, triage systems could seek to steer patients through a linear progression from electronic or phone app assessment and provision of self-help advice, through a telephone contact, to face-to-face assessment, if necessary. The Hurley Group are

working on embedding multiple forms of electronic access, using web-based and phone app consultations to divert people to self-care or pharmacy advice where possible, and offering e-consultations for a range of 50 clinical problems if patients choose to select these.

Creating adequate capacity and local protocols for different person-to-person consultation types will be a further challenge for those seeking to improve access. Efforts to deliver better access to general practice at scale may be confounded by workforce shortages in GPs and community nurses. With application rates for GP training posts down by 15 per cent (Kaffash, 2014) and limited numbers of community nurses in training (The Queen's Nursing Institute, 2013), it is likely to become harder to recruit GPs to fulfil current contractual hours, let alone extended practice. It remains to be seen whether a growth in new extended access GP services will jeopardise the ability of GP practices with registered lists to recruit clinicians, and whether this will impact on the other current policy priority of proactive continuous care for older patients.

From a patient perspective, there is no simple response to the challenge of targeting improved access to those with the greatest needs. In its recent research on walk-in centres, Monitor (2014b) highlighted a difference in professional and patient perspectives about what 'urgent' means. Their review found that whilst most people use walk-in centres for needs that are not classified as clinically urgent, almost half of the patients surveyed viewed their conditions as urgent. Public education has been widely used to encourage patients to make 'good' choices about which service to attend (see, for example, Arden Commissioning Support Unit, 2013) and local evaluations often report large numbers of hits or patient contacts with the campaign. But a literature review on the impact of patient education to support self-management (Coulter and Ellins, 2006) found little impact on patient behaviour – often due to the poor study design; limited description/heterogeneity of the interventions; and limited range of outcomes assessed. The Yellow Man Campaign described in the workshop was notable for its scale, multi-channelled approach to communication and longer duration. It remains to be seen whether this larger-scale, sustained marketing of a message about using health services will have more impact than shorter-lived local counterparts.

Overall, experience suggests that a policy focused on one small and specific aspect of health care may have unintended consequences. A well-designed evaluation, building on the methods described by Jon Nicholls, is needed to quantify the extent to which additional demand and utilisation are generated by the Challenge Fund services.

The twin track national policies for primary care – improving access to general practice and improving continuity of care for people with complex health problems – require a sophisticated response, balancing these two objectives. The national drive to improve access through the Prime Minister's Challenge Fund needs to stimulate effective service design to address divergent policy goals, rather than be a quick fix that diverts limited resources away from the needs of people with complex problems.

References

Anekwe L (2010) 'Advanced access GP appointment systems "no longer acceptable in 2010", BMA warns'. *Pulse*. www.pulsetoday.co.uk/advanced-access-gp-appointment-systems-no-longer-acceptable-in-2010-bma-warns/11038900.article#.U18blPldXTo

Appleby J (2013) 'Pressures on accident and emergency services'. The King's Fund. www.kingsfund.org.uk/audio-video/john-appleby-pressures-accident-and-emergency-services

Arain M (2014) 'Evaluation of GP led walk-in centres in Sheffield and Rotherham'. PhD thesis, University of Sheffield. http://etheses.whiterose.ac.uk/ [further detail can be found in the related Arain and others publications]

Arain M, Campbell MJ and Nicholl JP (2014) 'Impact of a GP led walk-in Centre on NHS Emergency departments', *Emergency Medicine Journal*. doi: 10.1136/emermed-2013-202410.

Arain M, Nicholl J and Campbell M (2013) 'Patients' experience and satisfaction with GP led walk-in centres in the UK; a cross sectional study', *BMC Health Service Research* 13(1), 142. doi: 10.1186/1472-6963-13-142.

Arden Commissioning Support Unit (2013) 'Case study: Fell well choose well campaign'. www.ardencsu.nhs.uk/media-centre/case-studies/case-study-feel-well,-choose-well-campaign.aspx

Bickerdyke I, Dolamore R, Monday I and Preston R (2002) *Supply Induced Demand for Medical Services*. Productivity Commission, Melbourne, Australia.

Cancer Research UK (2008) *National Awareness and Early Diagnosis Initiative (NAEDI)* www.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@hea/documents/image/cr_110747.pdf

Christiensen MB (1998) 'Out of hours service in Denmark: evaluation five years after reform', *BMJ* 316, 1502.

Coster J, O'Cathain A, Nicholl J and Salisbury C (2009) 'User satisfaction with commuter walk-in centres', *British Journal of General Practice* 59, 940–2.

Coulter A and Ellins J (2006) *Patient Focused Interventions: A review of the evidence*. The Health Foundation.

Dartmouth Atlas Project Topic Briefing (2007) *Supply Sensitive Care*. www.dartmouthatlas.org/downloads/reports/supply_sensitive.pdf

Fylde and Wyre CCG, Blackpool CCG (2012) *Fylde Coast Unscheduled Care Strategy*. http://blackpoolccg.nhs.uk/wp-content/uploads/2013/07/Unscheduled-Care-Strategy-Fylde-Coast-FINAL-.pdf

Freeman G and Hughes J (2010) *Continuity of Care and the Patient Experience*. The King's Fund.

Grol R, Giesen P and van Uden C (2006) 'After-hours care in the United Kingdom, Denmark and The Netherlands: new models,' *Health Affairs* 25, 6, 1733–1737.

Harrop E, Addis S, Elliott E and Williams G (2009) *Resilience, Coping and Salutogenic Approaches to Maintaining and Generating Health: A review*. Cardiff Institute for Society, Health and Ethics.

Ipsos MORI (2013) *The GP Patient Survey: December 2013*. Publication summary report.

Kaffash J (2014) 'Revealed: 15% drop in GP training applications set to exacerbate recruitment crisis', *Pulse online.* www.pulsetoday.co.uk/your-practice/practice-topics/education/revealed-15-drop-in-gp-training-applications-set-to-exacerbate-recruitment-crisis/20005739.article#.U18fjfldXTp

Monitor (2014a) *Walk-in Centre Review: Final report and recommendations*.

Monitor (2014b) *Advice and Recommendations for Commissioners: Deciding the Future of Walk in Centres*.

NHS England (2013) Prime Minster's Challenge Fund. www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/

O'Cathain A, Coster J, Salisbury C, Pearson T, Maheswaran R and Nicholl J (2009) 'Do walk in centres for commuters work? A mixed method evaluation', *British Journal of General Practice* 59, 934–939.

Phan K and Brown SR (2009) 'Decreased continuity in a residency clinic: A consequence of advanced access scheduling', *Family Medicine* 41(1), 46–50.

Picker Institute (2013) *Review of Unscheduled Care In Greenwich*. Report prepared for Greenwich Clinical Commissioning Group in support of its urgent and unscheduled care review.

The Queen's Nursing Institute (2013) *Report on District Nurse Education in England, Wales and Northern Ireland 2012/13*. www.qni.org.uk/docs/DN_Education_Report_2012-13.pdf

Salisbury C, Montgomery A, Simons L, Sampson F, Edwards S, Baxter H, Goodall S, Smith H, Lattimer V and Pickin D (2007) 'Impact of Advanced Access on access, workload, and continuity: controlled before-and-after and simulated-patient study', *British Journal of General Practice* 57(541), 608–614.

Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R and Walsh N (2013) *Securing the Future of General Practice: New models of primary care*. Nuffield Trust.

StormCreative (2013) NHS Yellow Men. www.stormcreative.co.uk/case_study/title/NHS-Yellow-Men

Turner J, O'Cathain A, Knowells E and Nicholl J (2013) 'Impact of the urgent care telephone service NHS 111 pilot sites: a controlled before and after study', *BMJ Open* 3:e003451 doi:10.1136/bmjopen-2013-003451.

Wallis J (2013) *GP Patient Survey: Review of access to GP services data*. NHS England.

About the author

Rebecca Rosen is a Senior Fellow in Health Policy at the Nuffield Trust and a General Practitioner in Greenwich. She is also an accredited public health specialist. Her current policy interests include integrated care, primary care, new organisational models for general practice and NHS commissioning.

Rebecca is a clinical commissioner in Greenwich Clinical Commissioning Group – where her lead areas are long-term conditions and quality. Within her GP practice, Rebecca leads work to improve continuity and quality of care for people with chronic complex ill health and to apply the principles of the chronic care model in a practice setting.

In the past, Rebecca has worked as Medical Director of Humana Europe; as a Senior Fellow at The King's Fund; and in NHS and academic public health departments. Past research interests include the diffusion of new medical technologies, patient choice and primary care policy.

evidence for
better health care

nuffieldtrust

For more information about the Nuffield Trust, including details of our latest research and analysis, please visit www.nuffieldtrust.org.uk

Download further copies of this briefing from www.nuffieldtrust.org.uk/publications

Subscribe to our newsletter: www.nuffieldtrust.org.uk/newsletter

Follow us on Twitter: Twitter.com/NuffieldTrust

Nuffield Trust is an authoritative and independent source of evidence-based research and policy analysis for improving health care in the UK

59 New Cavendish Street
London W1G 7LP
Telephone: 020 7631 8450
Facsimile: 020 7631 8451
Email: info@nuffieldtrust.org.uk

www.nuffieldtrust.org.uk

Published by the Nuffield Trust.