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Setting standards based on patients' views on access and continuity: secondary analysis of data from the general practice assessment survey

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Abstract

Objectives To examine patients' views on access and continuity in general practice to derive quality standards.

Design Secondary analysis of data from general practice research studies and routine quality assessment activities undertaken by practices and primary care trusts.

Setting General practice.

Participants General practice patients.

Results Satisfactory standards of access were next day appointments with general practitioners and a 6-10 minute wait for consultations to begin. A satisfactory level of continuity was seeing the same general practitioner "a lot of the time." Standards varied with the analytic method used and by sociodemographic group.

Conclusions Standards expected by patients in primary care can be derived from linked report-assessment pairs. Patients may have expectations of access that are in excess of government targets. Patients also have high expectations of continuity of care. It is unclear the degree to which such standards are reliable or valid, how conflicts between access and continuity should be resolved, or how these standards relate to other priorities of patients such as high quality interpersonal care.

Introduction

The UK government has emphasised the measurement of performance in the NHS, including the setting of standards, some of which legitimately include the views of patients.^{1,2} For example, patient surveys and consultation exercises before the NHS plan helped set the standard for a maximum waiting time of 48 hours for appointments to see general practitioners.^{3,4}

Another approach to setting standards is provided by the general practice assessment survey, a self report questionnaire examining patients' views of aspects of general practice.⁵ Some scales in the questionnaire use two types of items: report (the patient's experience of care) and assessment (the patient's evaluation of that experience). These report-assessment pairs relate to waiting times for appointments with a particular general practitioner, with any general practitioner, and

for consultations to begin, and the proportion of consultations with the patient's usual general practitioner (continuity of care).

We aimed to examine relations between reports of access and continuity in general practice and assessments of acceptability to derive patient based standards and to examine differences in standards between patients from different sociodemographic groups.

Methods

The general practice assessment survey comprises multiple subscales, but we restricted our analysis to access and continuity items with report-assessment pairs.⁶ The relevant items are listed on bmj.com (a copy of the questionnaire is available at www.gpas.co.uk). The survey is completed by patients attending surgeries or sent by post to those on the practice list. However, items refer to care in general, not to specific consultations.

The data (21 905 patients) derive from a survey of quality of care, a questionnaire validation study, an evaluation of pilots for personal medical services, and data analysed for primary care groups and trusts by the National Primary Care Research and Development Centre.^{5,7,8} Table 1 details the source of the data.

Statistical methods

We used cross tabulation to examine patterns of missing data and for the main analysis of relations between reports and assessments. For simplicity, we dichotomised assessments of satisfaction into dissatisfied (very poor, poor, or fair) and satisfied (good, very good, excellent).

To set standards, a minimum proportion of patients (for example, three quarters) might be prescribed who must be satisfied with a given aspect of the service. Such criteria are unambiguous but also arbitrary and are sensitive to relatively small differences in the proportion of satisfied patients (for example, between 74% and 76%). Alternatively, standards might be based on large discontinuities in the data. For example, if a large proportion of patients are satisfied at one level of service (with an appointment the next day, for example) and far fewer are satisfied with the next level (waiting two or three days), then this might suggest a degree of agreement among patients as to an acceptable level of service. Such an approach is less

Table 1 Details of data in general practice assessment survey

Source	Sample size* (% response rate)	Type of administration	No of practices	Mean age (years) of patients†	% women	% white	% with chronic illness	% employed‡	% owner occupier
Research study ⁵	7254 (66)	Consecutive attenders	55	39.8	63.6	64.5	47.8	No data	33.8
Research study ⁷	4488 (38)	Postal survey	60	51.3	61.4	92.8	28.5	53.3	77.7
Research study ⁸	2940 (65)	Postal	23	47.9	57.9	93.5	29.2	51.2	67.0
Routine assessment	2204 (54 in postal survey only)	Consecutive attenders and postal survey	13	No data	64.0	98.6	45.6	No data	74.9
Routine assessment	1672 (unknown)	Consecutive attenders	30	51.9	66.5	97.8	51.4	No data	81.4
Routine assessment	1492 (unknown)	Consecutive attenders	10	48.7	66.5	98.5	35.7	47.3	74.7
Routine assessment	1069 (unknown)	Consecutive attenders	13	46.5	64.6	97.5	34.2	52.1	74.5
Routine assessment	452 (unknown)	Postal survey	4	49.9	58.0	97.8	25.6	52.9	69.1
Routine assessment	176 (70)	Postal survey	1	53.8	60.2	100	66.3	50.3	86.5
Routine assessment	158 (79)	Consecutive attenders	1	60.6	56.9	98.7	34.4	34.9	94.1

*Number of respondents returning questionnaire in each study (including cases with missing item data).

†Personal data (means and percentages) based on cases with complete data in each study.

‡Full or part time employment.

arbitrary and more sensitive to the actual distribution of data.

We used both methods in our analyses. The first criterion was that three quarters of patients should report being satisfied, which we then relaxed to two thirds of patients. In addition, a large discontinuity was defined as an absolute percentage change of greater than 25% in the proportion of satisfied patients between different levels of service. Where there was more than one such discontinuity, we took the largest.

To examine effects of demographic characteristics, we stratified raw cross tabulations by age (16-30, 31-45, 46-59, ≥ 60), sex, ethnicity (white or other), chronic illness (yes or no), employment (employed full or part time or other), and accommodation (owner occupied or other).

Results

Table 2 shows the raw cross tabulations of report and assessment items. We found at least one identifiable discontinuity in all analyses and more than one discontinuity in some. Table 3 shows the standards identified by the different methods.

Associations with sociodemographic variables produced relatively minor variations in the identified standards. Acceptable waiting time for consultations to begin was the issue most sensitive to socio-demographic factors. Age and ethnicity were the most consistent moderating factors, with patients from ethnic minorities generally having higher standards and patients in the older two age groups (46-59, ≥ 60 years) having lower standards. Details of these minor variations are shown on bmj.com.

Discussion

Standards for primary care services can be derived from linked report-assessment pairs in the general practice assessment survey. Our methods suggest that patients may have expectations of access that are in excess of government targets and also have high expectations of continuity of care. Two key issues are raised. The first is the methodological adequacy of this approach to standard setting. The second, dependent on the first, concerns policy implications of the analysis.

Our analysis was suggested by the nature of the items in the general practice assessment survey, but the

questionnaire was not designed explicitly as an instrument for setting standards. The processes by which patients make judgments in situations designed to elicit standards may differ from those used in completion of routine questionnaires.

The results depend on the validity and reliability of the questionnaire. The questionnaire is reliable and has an interpretable factor structure.⁵⁻⁹ However, patient reports of waiting times have not been validated against objective measures, and validation of subjective assessments of acceptability is problematic.

The standards identified obviously depend on the particular definition of satisfaction and the thresholds applied (66%, 75%, or discontinuities). The binary definition of satisfaction is similar to published recommendations, but ratings of fair might be considered indicative of some degree of satisfaction.¹⁰⁻¹¹ If the data are reanalysed in such a way, different results occur (for

Table 2 Proportion of patients satisfied with access and continuity in general practice (n=14 291)

	% (No) not satisfied	% (No) satisfied
Waiting time for appointment with particular doctor:		
Same day	5.4 (123)	94.6 (2143)
Next day	19.4 (617)	80.6 (2570)
2 or 3 days	62.8 (2608)	37.2 (1545)
4 or 5 days	85.5 (1891)	14.5 (320)
>5 days	95.3 (2358)	4.7 (116)
Waiting time for appointment with any doctor:		
Same day	7.3 (368)	92.7 (4687)
Next day	29.6 (1370)	70.4 (3254)
2 or 3 days	71.6 (2335)	28.4 (925)
4 or 5 days	87.0 (758)	13.0 (113)
>5 days	92.7 (446)	7.3 (35)
Waiting time (min) for consultations to begin:		
0	5.5 (33)	94.5 (563)
<5	6.9 (115)	93.1 (1552)
6-10	33.6 (1595)	66.4 (3154)
11-20	71.3 (3100)	28.7 (1249)
21-30	87.8 (1536)	12.2 (214)
31-45	93.7 (710)	6.3 (48)
>45	97.4 (411)	2.6 (11)
Continuity for seeing same doctor:		
Always	2.4 (76)	97.6 (3098)
Almost always	8.1 (412)	91.9 (4651)
A lot of the time	27.1 (576)	72.9 (1552)
Some of the time	65.6 (1927)	34.4 (1010)
Almost never	80.2 (661)	19.8 (163)
Never	75.8 (125)	24.2 (40)

Table 3 Standards identified by different methods

Access issue	75% criterion	66% criterion	Discontinuity
Waiting time for appointment with particular doctor	Next day	Next day	Next day
Waiting time for appointment with any doctor	Same day	Next day	Next day
Waiting times for consultations to begin	<5 minutes	<5 minutes	6-10 minutes
Continuity for seeing same doctor	Almost always	A lot of the time	A lot of the time

example, both 66% and 75% of patients are satisfied with waiting two or three days for an appointment with a specific general practitioner, waiting 11-20 minutes for consultations to begin, and seeing the same general practitioner “some of the time”). In the identification of standards, the 66% and 75% criteria are obviously arbitrary. The presence of discontinuities in the data suggests that thresholds of acceptability do exist, but it should be noted that this method was suggested by preliminary analysis, and a discontinuity was not defined a priori.

The validity of the standards also depends on the representativeness of the sample. The data derive from several sources including practices using the general practice assessment survey for routine service evaluation, although 69% of the present sample derives from three research studies.^{5, 7, 8} One of these studies had a response rate of only 38%, whereas another achieved a rate of 66%.^{5, 7} However, when our analysis was restricted to data from the study with the higher response rate, the results remained unchanged.

The methods of standard setting used by us did not prove highly sensitive to sociodemographic factors (although the dichotomising of sociodemographic variables such as ethnicity may have concealed important variations). Finally, the high standards relating to access and continuity derived from our analysis may reflect that they have not been explicitly compared with other aspects of primary care for their overall priority.¹² Quality of care in primary care is a combination of access to care and effectiveness of the care provided, and surveys of primary care patients in Europe suggest that interpersonal aspects may be more important than access issues such as waiting times for consultations (ranked 34th of 38 aspects of primary care in the United Kingdom).^{13, 14} It should be noted, however, that a quick service for emergencies was ranked first in the same survey (our study did not

include a measure of perceived urgency), and rapid access to appointments has also been ranked highly in previous studies.^{14, 15}

Conclusion

Report-assessment pairs in the general practice assessment survey provide a method for examining patients' views of general practice that may be of use in setting standards and monitoring performance. Patients have high expectations relating to access to care, which may support or exceed current government targets, including the standard for waiting times by 2004 of seeing a general practitioner within 48 hours.⁴ The interpretation of standards must be sensitive to the methods used to derive them, however, and to issues of priority in other aspects of general practice, such as the effectiveness of interpersonal care. Although access to services is an important issue in itself, some definitions of access include notions of effectiveness, and thus evidence concerning the clinical and cost benefits of rapid access is also of importance in the wider debate.¹⁶

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What is already known on this topic

Standards are increasingly being set for the provision of health services

Surveys and consultation exercises before the NHS plan helped set the standard for a maximum waiting time of 48 hours for appointments to see general practitioners

The optimal methods by which patients should be involved in setting standards and the utility of such standards are unclear

What this study adds

Satisfactory standards of access were next day appointments, a 6-10 minute wait for consultations to begin, and seeing the same general practitioner a lot of the time

Patients may have expectations for access to primary care in excess of current government targets