

Whatever happened to all those attempts to improve access to General Practice? Ethnographic study exploring if and how appointment systems are abandoned, adapted or sustained. (GP-SUS)

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ABSTRACT

Background: Access to an appointment in general practice is important to patients, but hard to achieve. Research has focused on discrete systems for managing access e.g. telephone prioritisation or same day only appointments which have been variably successful in managing demand. Patient satisfaction with access to general practice has decreased as consultation numbers have risen. We sought to draw on the experiences of practices that had participated in earlier evaluations of different types of access systems to understand the long-term sustainability of access systems.

Aim: To work with general practices that have in the past tried interventions designed to improve access for patients, to learn whether and how these innovations were abandoned, adapted or sustained, and to use this learning to support long term improvements in access to general practice.

Design: Scoping review and stakeholder consultation, focused ethnographic case studies, collaborative workshops.

Setting: Eight English general practices that had previously been part of a variety of access intervention studies that completed at least 18 months before March 2020 and a comparator Danish practice with experience of implementing a specific same day appointments model.

Methods: We conducted a systematic scoping review to consolidate the evidence around different types of general practice access system and held stakeholder consultation meetings to discuss the findings. The review informed case study site selection. We conducted focused ethnography including observations, interviews with a purposive sample of patients (n=89) and with general practice staff of all types (n=79). Analysis used thematic approaches and cross case comparisons. We held three consecutive collaborative workshops to discuss findings and further develop our understanding. Patient and public team members contributed throughout each part of the study.

Results: The review showed that the rationale behind access systems were practice rather than patient focused and systems either changed appointment capacity, modified patient pathways or both. This was observed in the case studies, with the focus on management of demand within the practices leading to use of multiple approaches and a complex access landscape that was confusing for patients. When patients and practice staff had different expectations about access this could cause dissatisfaction. Reception staff saw their roles expand in line with the various approaches to access and this was particularly the case for

digital routes. We found that ongoing adaptation to access systems was a necessary and reasonable response to the challenges of access in general practice.

Discussion: There is a clear need for general practices to use resources, time and space to adapt access arrangements for their populations. Access solutions tried in previous research (and favoured by politicians and high-level policy makers) have not 'stuck' or provided a long-term solution to the access problem. An alternative approach would be for policymakers to support adaptive capacity in general practice, recognising that they may need tools and resources to tweak and improve their access systems. Patients and the public need to understand access systems, supported where necessary to navigate these or work around them.

Limitations:

Our scoping review analysed evidence from research conducted since 2001 about different approaches to GP access systems set in countries with universal health care, but only included studies published in English as a limitation. It is not an exhaustive account of all access systems but highlights key features and complexity. Our ethnographic work necessarily involves a small number of cases, but nonetheless provides rich detailed information. Further changes to appointment systems will have been enacted since we conducted our fieldwork, and there are access systems elsewhere that we have not examined. The case study findings are specific to the English NHS context and we have included one Danish case for comparison, and as with all such qualitative work predictive generalisations of the kind made in statistical analyses are not possible.

Future work:

The ability of practices to adapt their access systems, and perhaps consider patient focussed systems could be supported by future work. This could support adaptive capacity by exploring and developing the kinds of outcomes practices need to assess the merits of access systems so that they can assess improvements they make. More attention to the crucial and changing role of reception staff and/or practice managers in supporting access and change to access systems is needed. Future research could ask patients what they need or want from their general practice and GP in order to develop mutual understanding between general practice staff and their patients to underpin choices about access systems.

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GP-SUS Briefing Paper 3: Secondary analysis of patient experience data.

GP-SUS Briefing Paper 4: Focused ethnographic case studies.

GP-SUS Briefing Paper 5: Cross-country comparisons.

GP-SUS Briefing Paper 6: Collaborative workshops to formulate study outputs.

GP-SUS Access cards Debrief Sheet

GP-SUS Telephones and Ladders Debrief Sheet

GP-SUS Triage Activity Debrief Sheet

Abbreviations

| | |
|------|---|
| ARRS | Additional role reimbursement scheme |
| DNA | Did not attend |
| ESRC | Economic and Social Research Council |
| GP | General practitioner |
| HCPC | Health and Care Professions Council |
| ICB | Integrated Care Board |
| NHS | National Health Service |
| NIHR | National Institute for Health and Care Research |
| OSOP | One sheet of paper |
| PCN | Primary Care Network |
| PPI | Patient and Public Involvement |
| RBD | Remote by default |
| RCGP | Royal College of General Practitioners |
| SMS | Short message service |
| SPCR | School for Primary Care Research |
| SSC | Study Steering Committee |
| UKRI | UK Research and Innovation |
| US | United States |
| UK | United Kingdom |
| WP | Work package |

PLAIN ENGLISH SUMMARY

Getting a General Practitioner appointment was described by our PPI advisors as *the* single most important issue for patients. Access is a concern for policymakers, healthcare staff and the public. General practices have tried different ways of allocating appointments and deciding how urgent different requests are. Some access systems have been tested in research studies, but this has not identified what works best.

We read the published research and talked to doctors, patients, researchers and policymakers to learn what had been tried in the past. Then we worked with eight general practices in England to learn about the appointment systems they used, and how and why these systems were adapted locally. We compared our English practices with a practice in Denmark to see what we might learn. We brought the learning together in a series of workshops to design resources to support improvements in access to appointments.

Access can be managed in two ways, by changing how patients get an appointment (for example seeing if they really need an appointment, or sending them to see someone who is not a GP) or by changing how many, or the kinds of appointments are available. That seems simple but it is not. We made a map of the complicated, different types of ways that practices try to manage how patients get an appointment. When we studied what practices did, we found that patients and practice staff have very different experiences and understandings of how access systems 'work'. Many systems appear to make getting an appointment difficult for the patient, putting barriers in their way or making them 'go round in circles' before they get to see a GP. We found that practices constantly tweak and adapt access approaches using trial and error-based learning about what works for them. We also showed how important reception staff are in shaping and delivering access.

We suggest that rather than looking for one-size-fits-all solutions to the access problem we could encourage learning and knowledge sharing between general practices, to support adaptation and tailoring systems to meet the needs of their patients.

PREFACE

This is a synopsis of our project addressing what happens, long term, to innovations designed to improve access to general practice.

At the heart of our project is a comparative focused ethnography of nine diverse general practices that have previously tried to improve access to General Practitioner (GP) appointments. We examined the use of new access systems, and explored systems that were abandoned or adapted (including the re-introduction of previously abandoned access systems or components of these). This rich case study data was augmented by a scoping review and workshops with key stakeholders.

This synopsis details how we conducted the project, and summarises the key findings. Our main findings have been submitted for publication as five papers (listed below). A summary of each is provided in this synopsis. We also provide summaries of additional outputs from the study and plans for ongoing dissemination of this work.

Core articles

Eccles A, Bryce C, Driessen A, Pope C, MacLellan J, Gronlund T, Nicholson B, Ziebland S and Atherton A. (2024). Access systems in general practice: a systematic scoping review. *British Journal of General Practice* 74 (747): e674-e682
<https://doi.org/10.3399/BJGP.2023.0149>

Atherton H, Eccles A, Bryce C, Driessen A, Gronlund T, Pope, C. (2025) Access to General Practice appointments and sustainable change: Focused ethnographic case study. *British Journal of General Practice* <https://doi.org/10.3399/BJGP.2025.0140>

Pope C, Driessen A, Eccles A, Wheeler B, Bryce C, Heath J, Phillips C, Gronlund T and Atherton H. (2025) Bugbears in the waiting room: revisiting Arber and Sawyer's classic study of GP reception work using ethnography in eight English general practices. *Sociology of Health and Illness*. Nov;47(8):e70104. <https://doi.org/10.1111/1467-9566.70104>

Atherton H, Gronlund T, Eccles A, Bryce C, Martin A and Pope C. (2025). Collaborative workshops to formulate outputs from a mixed methods study of access to general practice NIHR Journals Library <https://doi.org/10.3310/WBWD8844>

Due T, Ziebland S, Drivsholm T, and Dowrick A. Thinking differently about demand: staff perspectives on innovations in general practice access systems. *Journal of Health Services Research and Policy*. Under review

INTRODUCTION

What is the problem with GP access?

The crisis in access to appointments in general practice ¹ pre-dates Covid-19. Before the pandemic various systems for managing access were tried ²⁻¹² but results were often inconclusive or contradictory. Research did not always translate into sustainable improvements. Patients continued to report waiting too long for GP appointments ^{13, 14}, and GPs continued to report 'unmanageable' workloads ¹⁵. During the Covid-19 pandemic NHS services made greater use of online and digital technologies, and primary care in particular pivoted to remote systems ¹⁶. Post-pandemic NHS England updated the standard operating procedure (B0497) to state that general practices must offer more face-to-face appointments, choice of consultation mode, physical access to reception, consistent triage across consultation mode, and adapt access models with patient input ¹⁷.

Reducing waiting and delay in the NHS is a key focus of the Five-year Framework for General Practice ¹⁸. Being able to see your GP in a timely way matters hugely to the public, service providers, politicians, policy and other decision-makers. Accessibility has been a consistent priority for patients over recent decades ^{19, 20} and our patient and public advisors emphasised that getting an appointment was "the pressing issue facing general practice", prompting us to undertake the study presented here.

One of the paradoxes of contemporary general practice is that GPs appear to be working harder than ever yet are less accessible. Over the past decade GPs have increased face-to-face contact with patients, and practices have increased the number of appointments they deliver, providing approximately 28 million appointments in June 2024, a 20% increase on the same period pre-pandemic ²¹. Pre-pandemic, UK press reported that the average wait for a routine GP appointment was over two weeks ²² and stakeholder engagement at a primary care network workshop held in March 2020 confirmed that general practices were still struggling to respond to appointment demand. A British Medical Journal commentary argued that digital access during and after the pandemic had 'opened the floodgates' to demand rendering general practice 'unviable' ²³.

Access is only one of a number of interconnected challenges facing general practice. Recruitment and retention of GPs has been falling and fewer GPs aspire to be partners. Practices have been closing and workloads increasing for those that remain, contributing to GP stress, reduced job satisfaction and wellbeing ²⁴⁻²⁸, prompting concerns about GP burnout and further practice closures ²⁹.

Covid-19 accelerated the use of digital triage and remote consultations, apparently overcoming previous resistance to these modalities. Practices rapidly pivoted to 'remote by default', predominantly using phone, but also online and video for first contacts and triage in an effort to protect patients and staff. During the pandemic routine appointments and consultations for non-Covid symptoms reduced; patients were reluctant to consult and there were concerns that some (e.g. those with cancer symptoms) did not access timely help. Practices continued to provide face-to-face appointments, including treating and managing urgent/non-emergency Covid-19 cases, and then providing Covid-19 vaccinations. The pandemic provided a stress test and (often unwelcome) exposure to new ways of managing patient access for many practices. New systems raised new concerns, notably whether they exacerbated inequalities and failed to protect the most vulnerable, including those for whom safeguarding is a concern. Moving out of the pandemic, general practice is being asked to move to a 'new normal', keeping some or all of the new systems and technologies used in the pandemic and at the same time (re)opening non-digital channels and face-to-face access. For this reason, our study of access to general practice is timely.

What is already known?

Before embarking on our study, we examined research literature from three overlapping fields: a) research about patient 'demand' b) empirical studies of interventions intended to manage demand and c) contemporary observations and emerging research about general practice activity during the pandemic.

Patient 'demand'

There is a long-standing health services research literature on the creation and management of demand for health care^{30, 31}. It is clear why this matters so much to patients and health systems: when access to the GP is or is perceived to be limited the consequences can be serious. Our own previous cross-country comparative research on cancer diagnosis found that some English patients' delays in consultation were attributable to difficulty getting an appointment alongside an initial reluctance to risk 'wasting the doctor's time' and lack of clarity about when to return if symptoms did not abate³². The number of primary care consultations has increased year on year in an attempt to meet patient demand, and it is estimated that 90% of NHS contacts take place in primary care settings. Analysis by the Nuffield Trust suggests that although some of this demand has been met by other staff (e.g. nurses, paramedics and pharmacists), patients now present with more complex needs and require more in-depth consultations (a result of an ageing population, rising inequalities and increasing multi-morbidity) and often require GP input. In addition GPs now undertake more

non-clinical and administrative work, leaving less time for patient consultations³³, exacerbating the access problem.

Interventions to manage demand

Various systems for managing patient access to their GP have been developed and evaluated, in the UK^{34,35} and elsewhere^{35,36}. These include triage (using phone, online or email assessment before offering an appointment), restriction (e.g. limiting appointment availability, length, or number of problems to be dealt with), substitution (e.g. offering consultation with a nurse) or offering alternative contact modalities (asynchronous consultations online e.g. via SMS/email; real time video consultations). None of these interventions has demonstrated meaningful clinical improvements, some have re-distributed rather than reduced workload, or even led to increased demand where they sought to contain it. Others, such as video consultations, have not been widely adopted³⁵. In short, many strategies have been tried but the evidence base is poor and often contradictory.

Access to general practice in the pandemic

Research during the pandemic included studies of: remote consultations (Greenhalgh ESRC Remote By Default (RBD)³⁷; Horwood NIHR SCPR unintended consequences of digital health tools (DECODE)³⁸; Murphy NIHR SCPR Collecting rapid COVID-19 intelligence to improve primary care response (RAPCI)³⁹; Hammond NIHR PRP optimising people centred care)⁴⁰; calls to NHS111 (Barnes SCPR NHS111)⁴¹; and patients' experiences of Covid-19 symptoms, diagnosis and care seeking (Ziebland UKRI)⁴². These studies found that there was greater use of eConsultation, online or phone 'total triage' systems⁴³ and a significant increase in use of NHS111 services, offering pre-assessment and triage ahead of GP consultations⁴⁴. The RAPCI study showed that while the number of face-to-face appointments reduced dramatically, and there was a reduction in GP consultations, in the early months of the pandemic, the rate of consultations increased thereafter³⁹. Research showed that the telephone was a more familiar and dependable technology for remote consultations than video, and was used more than other remote technologies during the pandemic^{39,45}. OPTEL (Atherton, NIHR)⁴⁶ examined the use of telephone first triage during the pandemic for patients aged over 65 years and found that they accepted these changes in the pandemic, but lacked confidence in using telephone consultation and expressed a conflict between being a loyal and responsible patient and advocating for their own healthcare needs. Studies in the United States⁴⁷ and the United Kingdom RBD³⁷ research highlighted the additional access hurdles encountered by the most vulnerable and disadvantaged patients with regard to remote consultations.

Demand for, and access to, GP services is a problem. Many solutions have been tried yet the problem persists. We saw potential to learn from revisiting previous attempts to improve access in general practice – we wanted to see what happened when an access system is no longer ‘new’ and after the original research teams or innovators had left. This is what our study set out to examine.

AIM

There have been numerous funded and unfunded studies evaluating the initial implementation of new access systems in general practice. Our aim was to work with general practices that had tried interventions designed to improve access for patients, to learn whether and how these innovations were abandoned, adapted or sustained, and to use this learning to support long term improvements in access to general practice.

OBJECTIVES

1. To create a typology of different organisational approaches and digital technologies used to enable patient access to general practice appointments (with a GP or other primary care clinician, via face-to-face, phone or online consultations).
2. To describe and compare the longer-term impacts of different approaches to patient access to general practice (including the rapid changes introduced during the 2020-21 Covid-19 pandemic) to understand whether the various approaches worked as anticipated, were adapted or abandoned, and whether practices were able to sustain any improvements over time.
3. To distil and develop deep, transferable learning about sustainable approaches that support and improve access to general practice.

RESEARCH DESIGN

The project comprised three linked work packages (WP) (see Figure 1) to review what has been tried (WP1), examine whether and how innovation became day to day (WP2) and to consolidate and share our learning (WP3). Findings from our scoping review in WP1 informed our purposive sampling of practices for the focused ethnography in WP2 and findings from both these work packages provided content for collaborative learning in stakeholder workshops in WP3.

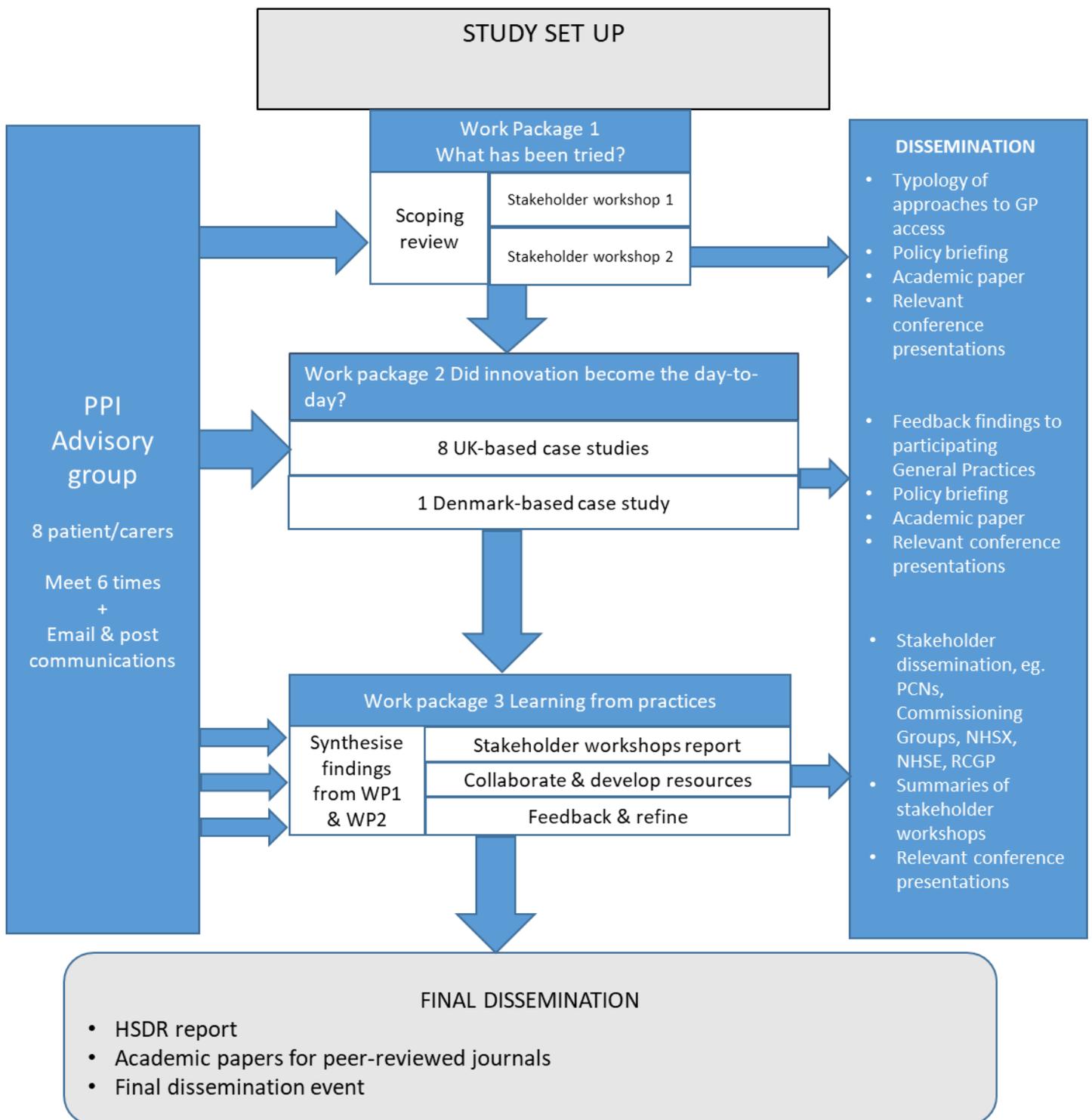
Rationale for focused comparative ethnographic case studies

We conducted comparative focused ethnographic case studies of eight English and one Danish general practice that had tried to improve access. This design supported a deep, detailed comparison of different access systems, and allowed us to analyse how different systems worked, and what prompted decisions to abandon, adapt and/or maintain particular systems. Qualitative research methods are especially well suited to this type of exploration. Focused ethnography ⁴⁸ is a versatile approach to the conduct of case study research that has proven especially useful for team-based research addressing concentrated research questions in a limited timeframe. While strictly speaking a 'control case' is not required in ethnography, we included a comparative case study of a Danish general practice that had pioneered a successful appointment access system which had not been tried in the UK. This enriched our analysis of our eight English cases, by providing an example of a practice embedded in a different geography, culture and history, thereby pushing us to interrogate and clarify the sometimes-hidden understandings embedded in the NHS primary care and access systems used in English general practice.

Theoretical framing

We conceptualise general practice as a complex adaptive system ⁴⁹ and, recognising this we are aware that change and innovation seldom follows simple linear pathways, and is rarely enacted as anticipated. Our thinking is influenced by scholarship on the tension between work as imagined and work as done; 'work as imagined' offers an idealised view of the tasks associated with managing and delivering GP appointments, that rests on a formal, standardised version of 'an access system' that can be implemented. By contrast, 'work as done' describes the messier reality of access, looking at what actually happens day-to-day ⁵⁰. Given this tension between imagined and enacted, and the complex environment of general practice, our study drew on a number of social science theories to inform our data collection and analysis.

Figure 1: Flow diagram of the research pathway



We drew on the Normalisation Process Model⁵¹ to comprehend the work of embedding change, and the NASSS⁵² (which encompasses the core elements of the broader Normalisation Process Theory) to provide a sensitising and framing device for our data collection and analysis. These theoretical framings helped us to focus on how access systems become routine/embedded (normalised) and the processes that underpin adoption or abandonment of practice change. The study was more broadly informed by theories of cultural and health service organisational change^{53, 54}, diffusion and implementation of innovations⁵⁵⁻⁵⁷, theories of sustainability^{58 59} and foundational ideas about healthcare demand and help-seeking behaviours⁶⁰. These ideas were augmented by our awareness of social, temporal and spatial differences in the implementation of change, and the growing body of theoretical and methodological work surrounding cross-country comparisons⁶¹. In addition to these theoretical offerings there are various models of access that have been used previously showing that socio-structural factors are important in understanding access to general practice^{62, 63}. While we did not seek to test the veracity or utility of these models per se, we used them to inform our understanding of previous attempts to improve access to GP appointments.

Our study sought to understand access systems from the perspective of the practices and patients involved in previous attempts to improve access. While we drew on theory to inform our work, we also maintained space for induction and the opportunity to develop explanations from/with the data we collected.

Defining access

We were primarily interested in patient access to a GP appointment (i.e. access to a clinical encounter with a doctor). Traditionally such access was enabled via face-to-face interactions with practice staff, or by telephone. Both these access routes continue to be used, but they have been joined by new ways of getting an appointment including online triage/booking, and email or SMS (text messaging).

Our working definition of access for this study encompassed: *registered or temporary registered patient access to an appointment for a consultation with a GP or an allied health care professional (e.g. practice nurse, paramedic, physician associate) employed by or contracted to work from General Practice. The appointment or consultation with a HCPC registered health care professional based in General Practice may be offered as face to face or by telephone/video.*

From a patient perspective access to general practice can be more colloquially understood as “getting an appointment when you need it”.

Analytical approach

In keeping with the ethnographic case study design adopted, our analytical approach was interpretive and our analytical methods largely inductive. For the case studies data analysis commenced alongside data collection. Researchers produced practice summary documents, detailing contextual information and key findings from the fieldwork^{64, 65} to aid team analyses during the fieldwork period. Analysis of ethnographic data included initial independent open coding, refinement and team discussions that informed the development of a thematic coding structure. Qualitative data analysis software (NVivo) was employed to help manage data and generate 'reports' containing all the relevant data across cases/themes. We used the 'One sheet of paper' (OSOP) method⁶⁶ to identify lines of argument, and employed matrices and charting^{67, 68} to support comparison and consideration of outliers and negative cases. The team worked together to refine themes and build interpretations that moved beyond description to offer explanatory accounts.

The work packages

WP1: What has been tried?

Scoping Review

Some text in this chapter has been reproduced from Eccles et al.⁸³. This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: <https://creativecommons.org/licenses/by/4.0/>. The text below includes minor additions and formatting changes to the original text.

A systematic scoping review was conducted, alongside two expert stakeholder consultations, to describe the different kinds of access systems previously tried in general practice settings. Literature searches were run across relevant databases in May 2022. The search strategy was limited to studies published after January 2001 to ensure contemporary relevance. Studies that examined the use, application, or evaluation of an access system within a general practice setting were included. Access systems were defined as those providing access to an appointment for a consultation. Our focus was on routine general practice care excluding studies investigating access to 'out-of-hours' urgent care services, even if in primary care settings. Participants of interest were patients, staff, or both. Studies focusing on access limited to a specific condition or follow-up appointments were excluded.

We included quantitative, qualitative, or mixed methods study designs, published in English. Editorials, debate pieces, conference abstracts, and reviews were excluded. Title, abstract, and full-text dual screenings were carried out independently. Data from included studies were then extracted and synthesised, using a narrative synthesis approach ⁶⁹.

Stakeholder workshops

The scoping review was supplemented with two stakeholder workshops allowing input from academics, public representatives, front-line healthcare professionals, policymakers and commissioners. Co-production techniques ⁷⁰ and visual minutes facilitated discussion of the emerging schematic representation outlining access systems derived from the scoping review. These stakeholder contributions, along with the review findings, informed our case site selection for WP2, and provided foundational content for WP3.

WP2: Did innovation become the day to day?

Focused Ethnography

We conducted a focused ethnography ⁶⁵ in general practices that had previously tried different innovative approaches to improve access. We sought practices that had participated in studies before September 2018 and at least 18 months before easing of the Covid-19 pandemic restrictions. We were also interested to learn about new access systems used in the pandemic and this informed our case study selection. We purposively sampled six English practices that had taken part in earlier research studies about access, the earliest in 2003 and the most recent in 2018. To add further diversity to our sample we selected two additional English practices from geographical areas not well represented in our sample and in locations characterised by significant deprivation (see Table 1). Alongside the English case studies, we selected a Danish practice that had pioneered a seemingly successful appointment access system which has not yet been emulated in the UK to provide additional comparative understanding of social and contextual differences. We used qualitative interviews and observation, and collected relevant documents to gather rich, detailed data about the different access systems used in each practice. During periods of non-participant observation, we also had informal conversations with staff and patients. Observations were recorded as handwritten fieldnotes, which were later digitalised, elaborated upon, and deidentified, and we prepared summaries for each case study to aid analysis. Interviews were recorded, transcribed and deidentified for analysis.

WP3: Learning from practices

Collaborative learning workshops

Three sequential interactive workshops were held with key stakeholders to discuss findings from WP1 and WP2 and to help us develop resources and outputs that could support sustainable change. Participants included clinical and administrative staff from the case study practices and individuals representing primary care networks, partnership boards of integrated care systems, commissioners, national professional and NHS bodies, independent think tanks, and academics with expertise in primary care research. Workshop one considered early findings from the study, workshop two explored what evidence-based resources participants currently used, and workshop three asked what resources they would like to see produced from the study. The first two workshops were held online, the final was in person. The workshops were co-designed and co-facilitated by the study lay co-investigator, Toto Gronlund. Notes made by research team members were augmented by feedback left in the chat function in Microsoft Teams for the online workshops. Alongside the collaborative workshops we held partner meetings with our patient and public involvement group to capture their views and comments and these were integrated with the learning from the workshops.

FINDINGS

WP1: What has been tried?

Our systematic scoping review identified 49 studies reported in 64 publications (see Figure 2). The majority of these studies were UK-based (n=33) and Advanced Access, telephone triage and online consultations were the main innovations studied. Twenty-three were quantitative, 14 were qualitative and 12 used mixed methods.

We identified two types of approach to access - systems designed to modify patients' pathways, and those designed to alter appointment capacity. These provide an apparently simple typology. However, as we developed our scoping review it became clear that these two 'types' of approach have produced many different ways of managing access. We developed a schematic to illustrate or map these approaches (see Figure 3). This shows, in the top centre, four modes of access (phone, walk in, online and SMS) and that patients' requests for appointments are sifted (by different kinds of health care staff), and routed to different kinds of care provision, shaped by the patients presenting characteristics and needs. The left hand side of the diagram outlines the ways that practices manage demand

offering different kinds of appointments, and juggling capacity to meet demand. The schematic is not intended as a comprehensive representation of access management but conveys the complexity and interlinked features that appear in patient pathways to getting an appointment. In the review it was striking that access systems were predominantly practice-focused attempts to manage demand and improve efficiency. Very few studies described patient-focused aims, or examined access for particular patient groups (a gap also highlighted by our study's patient and public involvement panel).

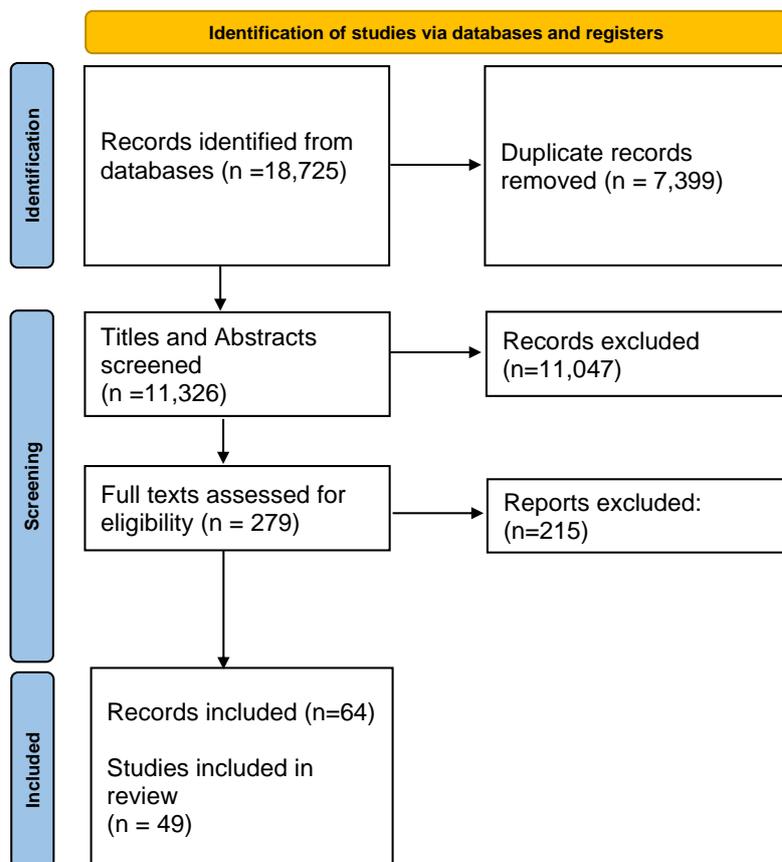


Figure 2: Flow diagram showing results from the scoping review screening process

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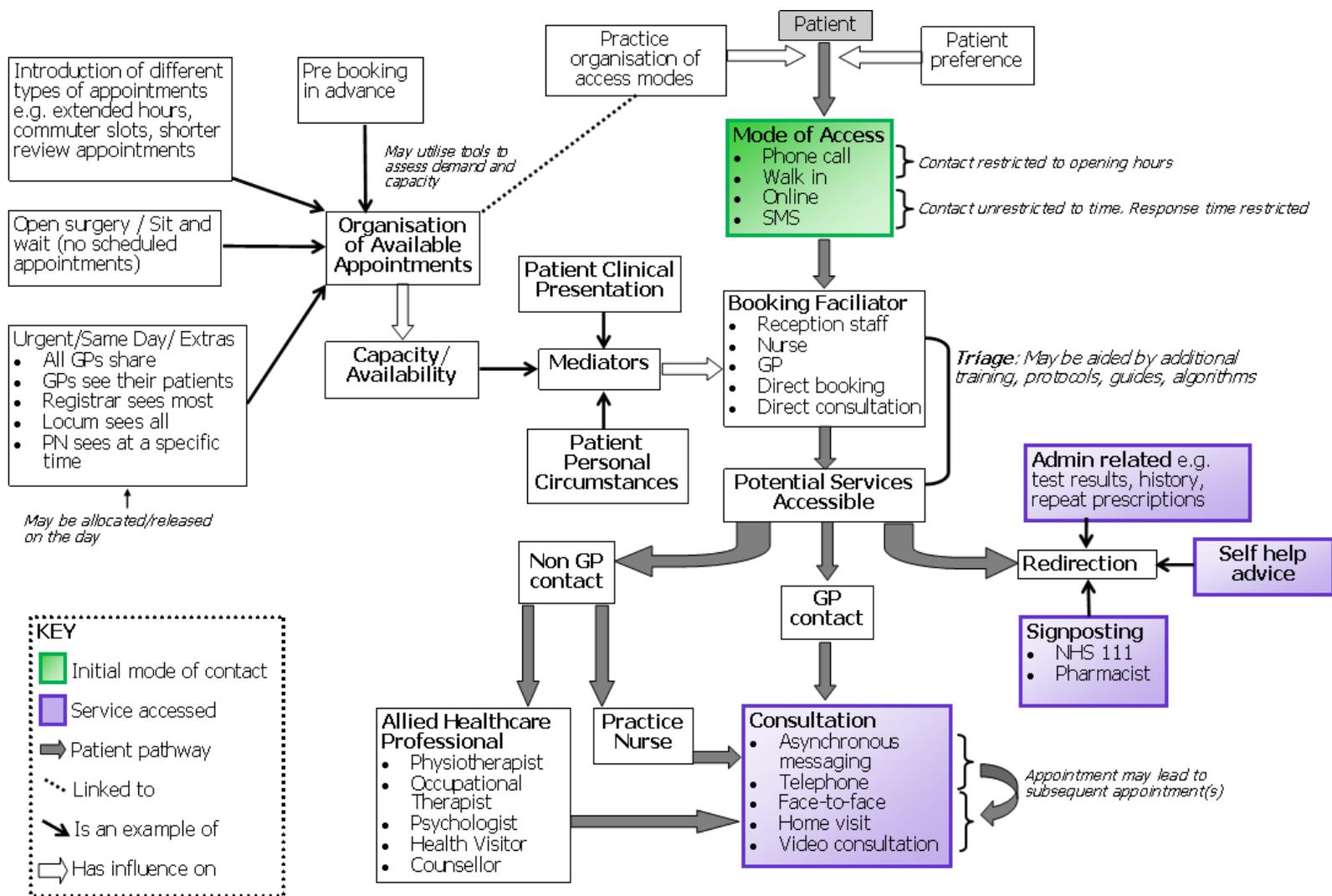


Figure 3: Schematic representation of the components of access systems identified in the WP1 scoping review

Two stakeholder workshops were held to develop and refine the typology of different access approaches.

Workshop 1

This workshop was held as we were beginning to examine and extract data from the included studies. It was attended by 12 stakeholders including academics, research leaders, NHS policy makers and patient representatives. The workshop aimed to inform the development of a typology. After short presentations the attendees were allocated to groups, enabling discussion of their own experiences and views of the models of access described. The workshop was recorded and there was a visual minute taker (see Figure 4). The contributions were used to refine the typology.

Workshop 2

This workshop was attended by nine stakeholders including research leaders, policy makers and patient representatives. Two attendees had attended the first workshop and returned. After initial discussion on the development and refinement of the typology, the group were asked to consider our findings and relate these to their own experiences. There was discussion of gaps in the research literature, how to make the typology useful to both practitioners and end users, and discussion of terminology. Following the event, the team further refined the typology to be inclusive for different settings and audiences.

Conclusion

Work package 1 allowed us to understand and map previous research about GP access systems. It was helpful in identifying patient pathways or routes through these systems and showing us the complicated connections between different elements of access systems. It also revealed that the majority of access systems focused on managing demand (a theme which we will return to later) rather than patient-focused outcomes or experience. The stakeholder consultation provided much needed additional information about more recent access systems and adaptations not yet present in the published literature, including more recent digital approaches. Access systems have tried to channel demand for appointments by altering the mode of contact (particularly digitalising this) and who the patient sees (notably by introducing various non-GP alternatives to the GP consultations). Many of these systems have created additional steps or hurdles to be navigated by patients seeking appointments.



Figure 4: Visual minutes of the first 'Models of access in General Practice' workshop

WP2: Did innovation become the day to day?

Ethnographic fieldwork was conducted in eight English and one Danish practice between November 2022 – February 2024. In addition to informal conversations, 70 staff and 74 patients were interviewed in the English sites (see Table 1 and Appendix 1, Tables 3 and 4). In the Danish practice nine staff and 15 patients were interviewed (see Table 2 and Appendix 1, Tables 5 and 6), and these data were contextualised by interviews with 9 key GPs and a nurse from 10 other Danish practices who had also tried their own versions of the *Time-Same-Day* access system.

Table 1: Characteristics of the 8 English case studies

(*IMD= Index of multiple deprivation score). Table reproduced from Paper 2.

| Site ID | List size | Location | IMD* score | Previously used access system |
|---------|-----------|---------------------------|------------|--|
| A | 33,000 | South Central, Urban | 8 | Advanced Access |
| B | 13,000 | West Midlands, Rural | 9 | Telephone first |
| C | 8,000 | North-West, Urban | 5 | Telephone first |
| D | 5,000 | West Midlands, Urban | 6 | Telephone triage by GP or Nurse |
| E | 20,000 | South Central, Semi-rural | 10 | Alternative consultation (email, video, phone) |
| F | 9,000 | North-East, Urban | 1 | Telephone first |
| G | 12,000 | Yorkshire, Urban | 3 | N/A (sampled for geography/deprivation) |
| H | 12,000 | Yorkshire, Urban | 3 | N/A (sampled for geography/deprivation) |

Note: Referring back to the scoping review and WP1, telephone first, and telephone triage modify patients' pathways by assessing urgency and need before offering an appointment; alternative consultation can be seen as altering appointment capacity by changing the kinds of appointments available, and advanced access modifies the pathway and offers same day appointments (not linked to urgency or need).

Table 2: Characteristics of the Danish case study

| Site ID | List size | Location | IMD* score | Previously used access system |
|-----------------|-----------|-------------------|------------|---|
| Danish Practice | 7000 | Urban, large city | unknown | Pre-booked appointments are only chronic disease check-ups and pregnancy and child examinations) All other appointments regardless of urgency are scheduled on the same day. Patients can email GPs directly to get results from blood tests and ask specific, short questions. |

English case studies

All eight English practices had, at some time, tried to introduce new access systems, but none of these persisted in their original form, and some had been replaced more than once. Some changes were introduced as part of national or local policy directives, and in six sites these had been evaluated in a formal research study. The pandemic too had introduced changes to access systems, some of which persisted. These access systems typically offered a mix of appointment booking by phone or in person, and various different online and web-based systems that triaged, sorted and handled patient requests of different kinds. Rising demand for appointments (linked to demographic changes, growing multimorbidity) was a constant challenge, exacerbated by workforce shortages (especially of GPs), and external change including policy and contractual modification. Digitalisation was a dominant feature of all systems and was a driver of almost continual adaptation and change to access systems, as well as sometimes being a cause of dissatisfaction. In some cases, local policy makers (commissioners and now ICBs) supplied or required the use of particular digital systems or platforms and some simply became obsolete and were replaced with different systems.

Patients and (different members of) staff had different views and understandings about how their particular access system worked. Patients experienced multiple, complicated 'layers' of access, described as 'loops and hurdles'. In some practices they were required to navigate phone menus, online and web-based forms, SMS (Text) messaging, and negotiate in person and by phone to get an appointment. They often felt thwarted in this endeavour. Practice staff were very focused on managing demand for appointments and the role of reception and front desk staff has changed considerably over time to accommodate significant triage responsibilities and different layers of access (e.g. online triage systems need to be monitored and followed up by telephone call-backs). Staff used everyday workarounds to overcome limitations of systems in use, and these fed into longer term adaptations, which did not always meet patients' needs, e.g. if online consultation tools were turned off outside

office hours. Where there was evidence of sustained use of access innovations this was often partial (i.e. specific components of a system that had been tried, such as a telephone menu system) and the adoption of access innovations was often linked to clear leadership and adequate staffing.

Focus on refugee experience of access from one English case study

As part of our commitment to diversity of participant representation we sought the views of a small number of refugees who were registered with one of our case study practices that had taken on responsibility for the residents of a refugee hotel. The numbers involved are necessarily small (we interviewed six refugees and a practice staff member involved in care coordination) and will not bear the weight of a dedicated publication but we summarise our findings about this work here. Given the small numbers and the need to prevent identification we have not linked the data excerpts presented here to identification numbers in Tables 3 and 4 and instead refer simply to Staff and Refugees.

GP appointments for this refugee population were typically requested through a dedicated care coordinator, rather via the reception or online. This reduced delays. Refugees were usually offered face-to-face appointments and GPs visited the hotel to avoid negative reactions from the general population found in the practice premises. They explained that:

It's not always friendly, the community react very different to asylum seekers and it can be a bit hostile. Staff

Refugees' experiences of GP access was mainly positive, with many expressing their gratitude.

Probably like every time we use the GP, every time we're thankful for that, because everyone helps us, and yeah, we are so thankful about that. Refugee

They really serve us well. The doctors and everyone works hard. Refugee

One refugee was frustrated at having to go through the GP to access secondary care:

If you need a hospital appointment you cannot just get it, you have to go through your GP or seen by the GP here and then be referred to the hospital...and it's time consuming. Refugee

A staff member reflected that refugees were frequently moved around, and this had knock on effects for such appointments:

If they've got a neurology appointment that they've been waiting for nine months for and then they suddenly get moved, it's quite scary. Staff

The practice approach to managing access for this refugee population provides a mini-case study of how trialling modifications to systems for specific patient groups can improve access. The tailored access system, aligned with, but separate from, the system used for the wider practice population improved refugee access to the GP and reduced delays. Having a separate coordinating system and arranging what were in effect 'home' visits had the additional benefit of protecting the refugees from possible hostility and racism, and minimised additional workload for reception staff. At the time of our fieldwork this system was working well but staff at the practice noted that the frequent moves experienced by refugees could easily disrupt this arrangement. While this kind of bespoke model could be deployed to mitigate access barriers for other vulnerable populations who have difficulty accessing care, this approach was a unique example of targeted access arrangements for a single group with shared characteristics. These kinds of tailored access approaches for specific groups or types of patients have implications for staff and other patients and may not be possible in other practices. The resourcing of this in terms of administrative and clinical staff was an additional cost that not all practices could meet, and necessarily took some staff away from delivery of care for the non-refugee population. In addition, while in this case, the system deployed protected the refugee population from possible racism or hostility by other patients, greater awareness of the tailored system could lead to accusations of preferential or inequitable treatment.

Danish case study

The Danish practice offered pre-booked appointments only for follow ups regarding long-term health conditions, routine check-ups, and pregnancy and child examinations. These are arranged online, by phone, or during a prior visit and account for approximately 50% of the appointments offered. All other appointments regardless of urgency are scheduled on the same day and arranged by phone in the morning. Patients are also able to email their GP directly to get test results and ask short, focused questions. This system (*Time-Same-Day*) had been introduced in response to GPs' concerns about workloads and patient waits of several weeks for appointments and had dramatically decreased waiting times, reduced failures to attend (DNAs) and increased GPs' job satisfaction.

Despite apparently reducing the barriers to access the Danish case study practice reported that patients did not book appointments 'unnecessarily' and they felt that the system had engendered trust and mutual understanding between staff and patients. An online booking system had been tried but was discontinued for technical reasons and had not been

reintroduced after the pandemic. Direct booking by patients was not seen as an option, since staff felt the need to maintain some control over appointment bookings. As in the English practices we observed some flexibility and workarounds instituted by reception staff to support vulnerable patients (such as elderly people living with dementia, or those in jobs that made same day access difficult).

Lessons from the cross-country comparison

Our cross-country comparison focused in detail on two of the English practices and one in Denmark. These three practices had developed different approaches to address the issue of on the day needs and were therefore good examples for comparison. The first English practice had begun offering only same day appointments to combat a high 'did not attend' (DNA) rate (estimated as 1 in 5 appointments) and a shortage of GP staff. Their care navigators and advertising in the waiting rooms promoted the appropriate use of other health care professionals (physiotherapist, GP assistant, nurse) or the community pharmacy. The second English practice had introduced an acute care clinical team including a GP, practice nurse and pharmacist to assess and prioritise urgent requests for appointments. The Danish practice, as described above, had adopted *Time-Same-Day*.

All three practices adapted their access systems to make best use of capacity. Primary care staff in these practices appeared highly motivated by a sense of fairness and access according to need, recognising that systems could enable 'unfair' access for those with better service navigation skills. Staff also expected patients who requested an appointment, or a call from the clinical team, to be willing to prioritise the appointment, or (in England) to accept help from another professional such as a practice nurse or pharmacist. Despite online appointment booking being popular among patients, staff in all three of these settings cautioned against it, arguing that giving patients this agency interrupted their systems of triage and prioritisation.

There were differences - in the Danish practice patients were given more responsibility to decide for themselves whether they needed an appointment on the day, meaning this was more easily achieved than in the English practices. Counter-intuitively the Danish practice staff argued that this approach has reduced, rather than increased, overall demand.

Conclusion

We found that general practices constantly adapt access approaches, enfolded new digital technologies and different work practices to manage requests for GP appointments. The result is locally tailored and evolving access systems rather than recognisable standardised solutions. The ways that practices manage access are influenced by the challenges of local patient demand, but also by external pressures such as the lasting effects of the pandemic

and continual policy change. The context is made more challenging by significant staff shortages, especially of GPs, and the effects of an ageing population, multi-morbidity and socio-economic factors. Our research showed that access systems in the English practices have, in different ways focused on managing demand by introducing barriers and diversion (our so-called 'layers' of access). Our comparison with the Danish case study suggests that easing barriers to patient access may help to reduce demand.

WP3: Learning from practices

We invited a total of 21 people to take part in the stakeholder workshops. One person declined and six did not respond. The workshops had between 7-12 participants selected from those who expressed an interest in taking part, and six of these attended more than one workshop. The workshop attendees included practice managers and GPs from practices involved in WP2, academics, policy makers and a representative from a think tank. Some were connected to national bodies (such as the Royal College of General Practitioners) or NHS organisations (e.g. NHS England). Through these workshops we were able to explore different perspectives on GP access and obtain responses to our early findings. Participants considered the kinds of evidence that could inform access system improvements, and the barriers to change, noting the particular power of experiential and relational learning. We obtained a clear recommendation that 'another toolkit' would not be welcome at practice level, and endorsement of our findings about the presence of and need for 'persistent tinkering' or adaptation to general practice access systems. While the main aim of the workshops was to identify ways to effectively disseminate our findings, inevitably the discussion also touched on wider debates about the nature of the access problem and the wider challenges facing contemporary general practice. This included consideration of the nature of the 'crisis' in general practice, and the ways that public perceptions and media portrayals fed into how the access problem was understood and addressed.

Conclusion

The process of holding workshops and engaging stakeholders provided helpful guidance about how best to disseminate our research findings.

Summaries of core Publications

Paper 1: Access systems in general practice: a systematic scoping review

This publication (<https://doi.org/10.3399/BJGP.2023.0149>) presents the findings of a systematic scoping review consolidating the current international evidence base related to different types of GP access systems. The publication outlined the types of approaches studied, their rationales, temporal changes, gaps in the literature and included a schematic representation of approaches previously studied. This review provides a useful tool in understanding access systems' aims, designs, and rationales, and highlights areas warranting further investigation.

Paper 2: Focused ethnographic comparative case study examining whether previous attempts to improve access to general practitioner appointments have been adopted, adapted or abandoned.

This paper (<https://doi.org/10.3399/BJGP.2025.0140>) uses the qualitative data from our case studies of eight English general practices to examine the sustainability of previous attempts to improve access to general practitioner appointments. We argue that GP access systems are heavily focused on demand and there is no one single access system that has been sustainably adopted. All the case study practices engaged in ongoing changes or 'persistent tinkering' of their access systems, which proved confusing for many patients and created unintended consequences (including significant work and dissatisfaction) for all involved. Adaptation is a necessary and reasonable response to the challenges of access in general practice, in part because the access problem is framed as one of managing demand. Alternative approaches could investigate what patients want or need and consider how this could be delivered. Future work could be directed towards increasing adaptive capacity in general practice and helping patients to better navigate the layers of access they encounter.

Paper 3: Bugbears in the waiting room: revisiting Arber and Sawyer's classic study of GP reception work using ethnography in eight English general practices.

This paper (<https://doi.org/10.1111/1467-9566.70104>) explores important shifts in the role and work of the receptionist surrounding the management of GP appointments. It draws on the focused ethnography conducted in eight English general practices and revisits a now classic metaphor of 'the dragon behind the desk' as a description of the receptionist role. We note that changes in morbidity and the digitalisation of reception tasks have altered reception

work considerably since Arber and Sawyer's paper was published. We show that although reception staff still occupy a gatekeeper position, between the patient and the GP, and as a result continue to be a target for hostility, they are sometimes able to mitigate this by performing other roles, such as 'patient ally', or 'powerless slaves' of digital systems. We delineate how bureaucratic distancing and redirection are used to manage demand and argue that although these new roles help the receptionist to redirect anger or antagonism toward 'the system' the problem of GP access remains

Paper 4: Thinking differently about demand: staff perspectives on innovations in general practice access systems

This paper (under review) focuses on two practices in England and one in Denmark. Each practice was grappling with the problem of high demand for appointments but deployed different approaches to managing this demand. Systems were maintained by tinkering with capacity, understanding where exceptions were permissible, and (in the English case studies) diverting to allied health care professions. Consideration was given to the trade-off between urgency and continuity. Changing their access systems led staff to think differently about demand, with a tendency towards opening rather than limiting access, though staff in all three practices cautioned against systems that were completely open to patient bookings. A challenge remains to identify which routine data, tracked for how long, might be used by practices to find out whether their innovations 'work' for patients and staff.

Paper 5: Collaborative workshops to formulate outputs from a mixed methods study of access to general practice

This publication (<https://doi.org/10.3310/WBWD8844>) describes the three sequential interactive workshops with stakeholders and summarises insights gained that informed our decisions about how best to disseminate our research evidence.

Summaries of additional publications

Paper 6: "Loops and hurdles": secondary analysis of patient interview data to explore the experience of patient access to UK general practice.

This paper (under review) developed from discussions with our patient and public involvement advisors and built on work from the systematic scoping review. It examines patients' experiences of accessing general practice using a secondary thematic analysis of archived qualitative interview data. The data comprised a total of 331 interviews collected

between 2020-2023 from five original datasets. A combination of deductive and inductive coding was used to identify how patients access GP care. We show how patients get “lost” or “stuck” when trying to access general practice and navigate “loops” and “hurdles” in their pathways to care.

Paper under review.

Paper 7: UK media depictions of access to General Practice in the run up to the 2024 General Election

This paper (<https://doi.org/10.3399/BJGPO.2025.0141>) reports a thematic content analysis of newspaper coverage of access to general practice in the six weeks prior to the general election on the 4th July 2024. The 194 selected articles highlight important differences in the characterisation of the access problem although the idea of “crisis” dominated much of the coverage. Workforce shortages were a prominent theme, as was the increase in use of alternative healthcare providers such as health care assistants and pharmacists through the Additional Role Reimbursement Scheme (ARRS). A dominant narrative focused on long waits for appointments and negative impacts of these waits on patients’ health. Political promises on access were closely tied to the crisis narrative, offering potential solutions however, the media often framed these promises as insufficient or implausible.

Both papers 6 and 7 derive from summer internships attached to the GP-SUS project in 2023 and 2024, funded by the University of Oxford UNIQ+ programme.

<https://www.uniq.ox.ac.uk/>

DISCUSSION

Our study set out to answer the question “Whatever happened to all those attempts to improve access to General Practice?” to learn whether and how these innovations were abandoned, adapted or sustained. The access systems examined adopt two key approaches, they attempt to modify patients’ pathways to obtaining appointments and/or alter appointment capacity. Some innovations have attempted to introduce whole systems (e.g. Advanced Access, or telephone triage), others have entailed ‘add-ons’, often linked to the introduction of digital technologies and/or new staff roles that have become available in recent years. The Covid-19 pandemic led to a rapid increase in the levels of use of digitalised access systems (especially phone menus and online triage), as well as remote consulting. Some of these new modalities have persisted as routes of access, although we could already see them being adapted and adjusted in our case studies. Our work with

stakeholders identified further adaptations not (yet) present in the literature or being used in all our case study sites, particularly new online platforms, and apps. Horizon scanning, our reading of the literature and conversations with practice staff and stakeholders suggests that the pace of digital innovation in this space will continue, and we note in particular the growing speculation about the use of Artificial Intelligence, for example in triage and electronic record keeping in healthcare settings.

Our scoping review identified that the rationales behind different access systems were predominantly practice-focused, seeking to manage demand and improve efficiency. While some previous studies described patient-focused aims, such as convenience, reduced waiting time, and access to healthcare advice, these aims were often coupled with, and secondary to, efficiency or demand management. The typology of different organisational approaches to enable patient access to general practice appointments (with a GP or other primary care clinician) that we have created from our review, maps the many, and sometimes confusing, ways of managing patient demand for GP appointments.

All eight of the English practices we studied had tried to address their access challenges by introducing new systems. These changes were driven, for the most part, by a desire to manage demand. Often demand for appointments was seen as “high”, “increasing/rising” and many respondents concurred with the RCGP Chair’s view that this demand was “outstripping our resources”⁷¹. Our study looked in detail at six practices that had been part of a research study that evaluated changes to their access systems. The two additional sites, while not part of previous formal research evaluations had been part of the enforced ‘natural experiment’ with remote and digitalised modes of access made necessary by the Covid-19 lockdowns. We found they too had a history to trying to improve access before and after this pandemic. (We also learned that one had abandoned an eConsultation platform when external funding subsidy for this ceased). It was striking that so many of the systems introduced previously no longer existed in their original form, some had been abandoned completely, some had been replaced several times over.

Our study has helped us to understand why different access systems did (or did not) work as anticipated, and had shown how and why these systems are adapted or abandoned, and how difficult it is for practices to sustain access improvements over time. We are clear that local contexts and wider system challenges often combine to make access innovations and new systems unworkable. Rising demand for appointments, workforce shortages (especially of GPs), and external factors (such as changes to GP contracts or new national and local policy directives) created turbulence and drove the need to abandon or adapt access systems. These responses appear reasonable given the local contexts and challenges we have described, and we would therefore encourage framing adaptations and adjustments to

access systems not as failure to embed improvement but as the necessary ‘persistent tinkering’ that Mol and colleagues see as required “in a world full of complex ambivalence and shifting tension”^{72, 73}. Mol and others have used ‘persistent tinkering’ to explicate the situationally-determined, often moment by moment adjustments that carers (formal and informal) and patients themselves make to treatments and therapeutic processes⁷⁴⁻⁷⁶. We argue that this term also aptly captures the everyday adaptations made to organisational systems, such as the access systems we studied here.

Practices tinker with access systems, often using trial and error-based experiential learning rather than shared learning from other practices or research evidence. Changes to access systems were often coupled with clear leadership (typically a reception manager or individual GP driving change forward) and relied on adequate staffing. In the wider context of primary care, fundamental workforce challenges need to be addressed and many of the solutions to better access lie outside General Practice (in financing primary care, GP education and addressing the causes of disease and health inequalities). We suggest that further, top-down, singular solutions to access challenges are unlikely to confer significant improvement. Instead, more could be made of opportunities for cross-practice learning to help identify adaptations that ‘work’ in local practice contexts.

Patients and the public currently have limited input to the design of access systems. We have shown that patients and staff have very different views about how access systems work and very different experiences. Patients present (in person, on the phone or via online systems) with an apparently simple goal, to get an appointment with their GP. Yet the systems that they encounter manage their requests in ways that – they feel – are designed to thwart their access to these appointments. Statistical evidence shows that GP teams are delivering more appointments than ever before⁷⁷, and just under half of these appointments are delivered by a GP (approximately 162.5 million appointments were delivered by GPs in 2024)⁷⁸. Yet we know there are fewer GPs and working patterns are changing with increasing shifts to part-time working by this medical workforce. Notwithstanding these capacity limitations, the national data show that many patients get appointments – approximately 40% of them on the same day and the majority within two weeks⁷⁸. However, the experience and perceptions of many of the patients we spoke to and observed did not correspond with these statistics. Indeed, patients included in our study often appeared resigned to delay and frustration when seeking appointments and appeared surprised or concluded they had been ‘lucky’ when they did obtain an appointment without delay. Patients said they found accessing appointments with their GP time-consuming and difficult to navigate. The practices’ focus on managing demand for appointments resulted in complicated layers of access that were experienced by patients as barriers to access.

Components of access systems, especially digital technologies, could create tortuous 'loops', (such as a phone menu that directed patients to an online triage that redirected them back to the GP appointment system, accessed by the same phone number; or advice to see a community pharmacist who was unable to provide the necessary treatment and redirected them to the GP).

Everyday workarounds and adaptations helped the practices manage demand for appointments, but did not always meet patient's needs or expectations. Examples that appeared problematic include the frequent turning off of online or eConsultation tools (some of which had originally been designed for 24-hour use) and the ever-expanding telephone menu systems which 'buried' the mechanisms for requesting a GP appointment in a long list of mutable, alternative options. More positive examples include the attempts to flex access 'rules' or tailor them for disadvantaged groups, for example those with physical impairments or mental health conditions. We note here the additional efforts made in the practice serving the local refugee hotel to provide appointments for this group. These examples could inform access systems to better meet the needs of diverse patient groups.

We have highlighted the central role that reception staff play in the persistent tinkering of access systems to make them work. Our research has also provided detailed analysis of the role of reception and front desk staff in general practice, augmenting the larger corpus of research about administrative staff in healthcare settings, notably recent work by Litchfield et al ⁷⁹⁻⁸¹. We have shown how the role of the receptionist has changed over time and that they are now required to take on significant responsibilities to triage, prioritise and manage how patients use and move between the different 'layers' of access. We have used the term receptionist throughout to simplify the account presented here, but these staff are also called patient liaison, patient support, or care navigators, and many undergo additional training for these extended roles and this triage and prioritisation work that they do. The discretionary decision-making powers of reception staff should not be underestimated. Their workarounds directly shape how patients experience access systems. We saw how some reception staff worked hard to overcome digital and e-health literacy barriers by supporting some patients to navigate these systems. We have also shown that reception staff are often aligned or allied with the patients in the "quest to get an appointment" from what appear to be increasingly un- or inhuman systems. We have shown how this allyship may reduce hostility towards these staff, but note too that we also gathered accounts and examples of incivility and aggression from patients. We would therefore echo the conclusion of the recent systematic review by Willer et al ⁸² that poor access systems can be considered a cause of violence and aggression directed towards receptionists, and one that might be avoided. We have uncovered some of the forms of talk that receptionists use to successfully manage access

encounters, but a conversation analytical approach could take this further. The importance of the various 'reception' roles in shaping and delivering access should not be underestimated.

As well as developing a typology of patient access to general practice appointments (objective 1) and comparing different approaches to understand whether practices were able to sustain improvements over time (objective 2) we set out to offer deep, transferable learning about sustainable approaches that support and improve access to general practice (objective 3). The papers we have written and presented and the other outputs we have prepared distil our learning so far. This synopsis is one part of our attempt to share that learning. We have undertaken a range of different activities to disseminate our findings, including our various stakeholder workshops, our PPI work and the innovative escape-room inspired event (see Section Impact and Learning). Further outputs are planned.

PATIENT AND PUBLIC INVOLVEMENT

Given that access to appointments was described by our PPI advisors prior to submission of our research grant application as *the* single most important issue for patients, we fully engaged with patients and carers in designing our study. We involved our lay co-investigator throughout the study and she led the appointment of a PPI panel comprising a further 8 representatives (1 subsequently withdrew). We took great care to understand their motivations for taking part, to ask what support they might need to do so effectively and to ask what they would like to get out of their participation. Informal one-to-one orientation meetings with individual panel members unexpectedly revealed valuable insights into lived experience of GP access from a wide variety of perspectives, which we were able to share (anonymously) with the study team to inform and enrich our understanding of access.

PPI contributions to WP1: What has been tried?

Three PPI partners participated in the first stakeholder workshop where their experiences of, and views on access systems formed part of the discussion with other stakeholders. Three different PPI partners contributed at the second workshop, which resulted in further refinement of the typology⁸³. At a subsequent PPI advisory meeting further discussion about the typology provoked reflections about the 'real world' access issues that they and their family and friends experienced. The research team mentioned the University of Oxford archive of patient interviews which contained similar 'real world' accounts and this led to a sub-study of previously collected interviews conducted by Uniq+ intern Alazawi (see Section

Equality, Diversity and Inclusion). This allowed us to augment the typology and illustrate the different routes patients used when accessing GP care (Paper 6 above).

PPI contributions to WP2: Did innovation become the day-to-day?

Three partners participated in a pilot interview with members of the research team, to test and refine the interview topic guide for the focused ethnographies. Their suggestions included modifying some terminology (e.g. access systems) and re-phrasing some questions. We also received useful feedback that patients would value being asked how access to appointments systems could be improved – a change which was embedded in the topic guide.

The practical challenges of conducting multiple case studies and data governance protocols that prohibit access to study data meant that the PPI panel had limited input during the main data collection phase. However, having the PPI lead as a co-applicant holding a fixed term honorary post at one of the study Universities provided a contractual framework by which secure access could be granted and this allowed her to participate in team discussions. As co-investigator, Gronlund reviewed practice summaries and provided sense-checking of our ideas and interpretations as the analysis progressed. We delivered an educational session on ethnography for the PPI panel which answered some of their questions about the methods we used and stimulated a useful discussion. In addition, the Danish team delivered a session about the *Time-Same-Day* access system which the panel found thought-provoking and interesting. Once the data collection was complete and the team began writing the core papers from the study, we invited PPI representatives to experiment with “shadowing” the writing of Paper 3. Over a series of online meetings and email exchanges the two PPI panel members saw how the ideas for Paper 3 were developed from initial (and uncertain) codes and themes to the final academic submission. The PPI members provided challenge and insights that helped us to push our thinking forward as we shared ‘messy’ drafts and practiced conference presentations of this material, confirming along the way the veracity of the evidence and the arguments we were making. While this was time-consuming and asked for additional input from our PPI panel members it improved the final paper and proved to be a valuable sharing of perspectives between academics and people with lived experience.

PPI contributions to WP3: Learning from practices

The collaborative stakeholder workshops were co-designed by PPI lead Gronlund, who also acted as facilitator for workshops 2 and 3. Alongside these workshops we ran a series of

partner meetings with our PPI panel and continued to work with them on public facing outputs from the study.

PPI representation on the Study Steering Committee

In addition to the professional membership, the Study Steering Committee comprised three PPI representatives; PPI lead Gronlund, Martin Tod (Men's Health Forum) and Jenny Lee. All commented critically on the study findings and their implications for access to primary care.

PPI and our wider dissemination activities

Our PPI partners have contributed to outputs and to the dissemination plans. The PPI panel were instrumental to our main study Dissemination event based on an innovative 'escape room' format. They enthusiastically embraced the idea of this innovative format; they tested and helped to refine the 'Telephones and ladders: Get an appointment' game, and shaped the patient 'personas' used in the 'Escape room: triage' activity. Their contributions provided rich insights from diverse lived experiences, which helped shape key messages from the study in a meaningful, memorable and interactive way. Beyond the study end date, we will continue to engage our PPI panel to co-produce accessible public-facing materials. We will also engage with public and patient reference groups at the practices we visited for the focused ethnography.

EQUALITY, DIVERSITY AND INCLUSION

The study was designed to facilitate the inclusion of a wide range of patients/carers. We were aware that those with disabilities and those in vulnerable groups are often unable to participate in research yet they are disproportionately impacted by difficulties in accessing healthcare. We made it clear to all potential participants that we would make necessary adaptations to support participation and engaged our PPI partners to identify possible adaptations that may be necessary.

In WP1, as part of the stakeholder workshops we used co-production techniques and visual minutes to facilitate discussion of the emerging schematic representation of access systems. The visual minutes were welcomed by the PPI panel and were made available on the study website. For the focused ethnography in WP2 our purposive sampling strategy sought to ensure diversity across the cases (see below). Finally, to ensure we were fully able to distil and develop transferable learning in WP3 we ensured workshops were fully accessible (offering reimbursements to practices to facilitate attendance, a transcription facility for those

held online, and conducting the final in-person workshop in an accessible ground floor meeting room). The workshops and engagement with stakeholders has provided clear insight into the unique needs of different groups and how best to disseminate this research.

Language and Terminology

At the study outset, we generated a 'Jargon buster' document to assist our PPI panel and others understand frequently used terms associated with GP access. We took care in ensuring our Participant Information Sheets were reviewed by a PPI representative and developed an Easy Read version to support those with learning difficulties and English as a second language to participate. We have not needed to translate any research materials (a refugee coordinator acted as an interpreter for sampling of a refugee population in the catchment area of one practice).

Diversity in site and participant representation

We purposively sampled the English general practices to ensure variability in relation to size, deprivation score, number of GPs and location (rural/urban). We endeavoured to include practices that were not necessarily research active, and that were located in areas of higher deprivation. Two practices were deliberately sampled to increase the representation of practices in locations with high levels of deprivation. One practice had not been research-active for many years but saw this study as a gateway to future research participation.

We observed practices on different days and times, and visited in different months to capture differences in activity and diversity of patients (prioritising summer months in locations with holiday trade, and attending before and after bank holidays when staff suggested practices would be busier). Staff interviews reflect variation in roles, time at practice and age.

Participants were largely female, in line with the demographics of the workforce (which includes a majority of administrative and part time female workers). We adjusted our sampling as the fieldwork progressed to ensure we included a wide range of participants, purposively seeking variation and diversity. To support this this, we offered to conduct interviews either remotely (telephone, video) or face-to-face. For the patient interviews we sampled a mix of genders, people with long-term conditions/disabilities and sought to include different age groups. We worked hard to include ethnic diversity and managed to obtain views of a small number of refugees thanks to the inclusion of a practice responsible for a home office designated asylum seeker hotel.

Purposive sampling to capture refugee experience

Refugees and asylum seekers are entitled to use NHS GP services free of charge (exempt from the Immigration Health Surcharge). A qualitative study by Kang et al ⁸⁴ had alerted us to the challenges that refugees face when trying to access care, including language barriers, lack of knowledge of the healthcare system, and discrimination, so we were keen to include this population in our sample. We interviewed six refugees and a staff member involved in their care to understand experiences of access (see section 'Focus on refugee experience of access from one English case study').

Diversity in our PPI Panel

We recruited to the PPI Panel through an advertisement targeted towards people from the following categories: people who live with a long-term illness or with a disability; people over the age of 60; men; parents of young children; carers; people from a variety of social and ethnic backgrounds; people without a fixed home address. We appointed eight representatives (one withdrew from the study part-way through) who between them represented a diversity of lived experience and ethnic heritage to join lay co-investigator Gronlund. They included people of different ethnicities, genders and sexual orientation, and with neurodiversity, people with a disability (including deafness), informal carers, mothers with young children, people with long-term conditions and people whose first language was not English.

Reflections on diversity in our research team and wider involvement

Diversity amongst the team included members of both genders, one with a disability, and through our Danish collaborators and one of the UK-based researchers, some diversity in nationality. During the study we hosted two UNIQ+ interns as part of the University of Oxford access programme for promising undergraduate students from disadvantaged backgrounds. Both interns had the opportunity to learn about research design, data analysis and preparing findings for publication.

Reflections on the study and our team

In the closing stages of our study the team reflected on our own work, thinking about what had gone well and proved enjoyable, and also considering what we might do better in future research studies of this kind. The positives included collaboration and sharing of expertise,

learning within the team, for all involved, not only earlier career researchers. The creativity in our dissemination activities and PPI work was highlighted as especially positive, and we felt this produced valuable learning (we would do these activities again). We encountered familiar challenges to empirical research especially bureaucratic and ethical delays, and we will continue to work with the funders, research governance bodies and our institutions to address. We had some staffing challenges (one associated with a very welcome new baby) and this reiterated the need to have continuity and experienced ethnographers to undertake data collection and lead coding and analysis. We were able to make good use of budgeted time for writing retreats and would recommend these as a way to support delivery of key outputs, and we feel that these would also have been useful earlier in the study to support interim analyses. We also cannot emphasise enough the need to have an experienced project manager to support and coordinate these types of studies.

IMPACT AND LEARNING

Dissemination event

We shared our findings (partnering with the NIHR-funded Optimising Access Through Human fit study NIHR202311) at an event held in London in November 2024. The audience included staff from case study practices, other GPs, representatives from NHS England and Department of Health and Social Care, national and local policy-makers, academics interested in the problem of GP access, NIHR, members of the PPI group, Study Steering Committee (SSC) representatives, and think tanks such as the Nuffield Trust and the King's Fund. Various 'challenges' were posed for the delegates as they considered our research findings. This was complemented with an expert panel discussion on the future of primary care access and a presentation on the cross-country comparative work. Attendees enjoyed the interactive games, which were complimented as providing opportunities for constructive non-threatening discussions and effective learning. Attendees saw opportunities to disseminate further to primary care professionals (including early career GPs or trainees) as well as policy makers and politicians for meaningful change.

Attendees came away from the event with an appreciation of the vast amount of research that is being conducted in relation to the issues of GP access and were impressed that the issue of equitable access was being taken seriously. Some felt that the event reinforced their concerns about access and felt their views were broadened allowing them to consider the complexity of the issues, the broad range of approaches and diverse perspectives on GP access. There was an appreciation that GP access was a concern for many people (patients and clinicians) and not just those managing the systems. Some went away with the

impression that more could be done to resolve access issues and some suggested improved access ought to be incentivised.

Efficiency vs patient centred approaches

The dissemination event led some to problematise efficiency as the primary rationale behind GP access systems, as they recognised this could deprioritise other important aspects such as continuity, inclusion and equality. There was consideration around tensions of providing patients access to 'any type of response' and provision of continuity of care for those patients it would benefit. Attendance at the event highlighted how patients' experiences and their perspectives have been previously overlooked and there were strong views that this ought to be prioritised moving forward.

Hope

Many attendees referred to how GP access is often seen as 'broken', however the event allowed them to see a way forward, giving hope that there are ways to overcome these problems. Many felt with national support, leadership and investment, access to general practice can be improved. They also recognised the importance of having patients and clinicians involved in changes.

Cross-country comparison

Most attendees enjoyed learning about a different model. Many thought this was of value, although some felt they would appreciate more evidence about the *Time-Same-Day* system and the role of fee for service in this setting. Presentation of the Danish approach allowed attendees to consider how increasing patients' access to appointments may (counter-intuitively) lead to reduced demand and made attendees aware of important cultural differences worthy of further study.

Expert panel

The panel discussion explored the complexities of GP access and attendees came away with recognition that there are no easy solutions to 'fix' the system. They gained understanding of the range of approaches that are being adopted and an appreciation of the diversity of perspectives on these issues. Attendees recognised the frustrations of general practice working hard to provide good access, but that patients are not experiencing this. There was wide acknowledgment that better resourcing is an essential requirement to improve access and tackle inequalities. There was recognition that many existing systems prioritise efficiency over quality. Attendees noted the potential value of prioritising patient choice and continuity in the design of access systems, and considered that this may ease

demand and lead to better satisfaction and health outcomes, as well as being more efficient in the long term.

Feedback to practice and policy audiences at local and national level

We have fed back our findings to case study practices who asked for this, and to their public and patient reference groups. With encouragement from the SSC, we are attempting to take the interactive challenges from the dissemination event on a wider roadshow as the messages will be useful for a wider audience.

Resource packs

Resource packs prepared for the dissemination event are available for further dissemination. These contain six, two-page policy briefings together with explanatory debrief sheets explaining the findings underpinning the interactive challenges (https://www.phc.ox.ac.uk/research/groups-and-centres/health_experiences/gp-sus). Visual summaries (from Nifty Fox Creative) augment these briefings and are useful for engaging with both public and professional audiences.

Presentations

Thus far we have presented the findings of the study to the following conferences, targeting a mix of academic, practitioner and policy audiences:

- **South West Society for Academic Primary Care Conference, 2023, Birmingham.** GP access Systems – a scoping review
- **Cancer in Primary Care Research International Conference 2023 Oxford.** *Evidence* for access: systematic scoping review of access systems in general practice.
- **Society for Academic Primary Care ASM, 2023, Brighton.** GP access Systems – a scoping review.
- **Health Service Research UK conference, 2023, Birmingham.** GP access Systems – a scoping review.

- **Health Service Research UK conference, 2024, Oxford.** Getting an appointment to see a GP - case study learning about sustainable access systems
- **Society for Academic Primary Care ASM 2024, Bristol.** Getting an appointment to see a GP - case study learning about sustainable access systems
- **BSA Medical Sociology Group conference 2024, Warwick.** Goblins and bugbears in the waiting room: updating Arber and Sawyer's classic study of GP reception work using ethnography in eight English general practices
- **THIS Space, THIS Institute annual conference 2024, online.** Getting an appointment to see a GP - case study learning about sustainable access systems
- **South West Society for Academic Primary Care Conference, Oxford 2025.** Phones and Ladders – a workshop exploring the challenges of GP appointment systems and inequalities in access to primary care.
- **RCGP Annual Conference 2025, Newport Wales.** 'Can you navigate your way to a GP appointment': an escape room challenge embedded in research into GP access systems?
- **University of Oxford annual GP Tutor Conference 2025, St Hilda's College.** Plenary 'Why top-down solutions are the wrong answer to the problem of GP access.'

We are actively seeking opportunities to take this work to Primary Care Networks (PCNs) and Integrated Care Boards (ICBs) and interested general practices. Our SSC have agreed to assist with brokering connections for this. We have presented the study findings to over 60 members of the South East Oxford Health Alliance primary care network. We have forged strong links with colleagues responsible for the OATH study (NIHR202311) which also examines GP access.

The transition to a new government during our study has made it difficult to get traction with politicians during the study – those we invited to the London event could not attend due to parliamentary duties. We reached out to the Chair of the Health Select Committee with no success. Our SSC advised that it would perhaps be more fruitful to work with the General Practice improvement programme and we are taking this forward.

IMPLICATIONS FOR DECISION MAKERS

There were several addressable factors that could influence the sustainability of access systems in general practice.

Managing demand

The current focus on 'managing demand' dominates the access narrative in UK general practice. Patients are regarded as the 'demand', an amorphous mass that continues to grow, not always seen as worthy of access but demanding it regardless. Initiatives to support access are often supply focused⁸³, channelling demand in different ways and to different people. This is in part because of resourcing issues in general practice, which make appointments scarce. These challenges include a workforce crisis⁸⁵ and a large increase in the numbers of consultations requested by patients⁸⁶.

The challenges facing general practice are very difficult for decision makers to address; a recommendation to increase capacity, in particular of GPs, within general practice cannot be delivered quickly. However, a change in focus from the concept of managing demand could counter the negativity associated with the term, and the tendency to label those who present as worthy or unworthy demand.

Top-down initiatives

The findings of this study show that top-down, national level, standardised changes to how general practices organise access are seldom sustained. Regardless of the initiative, once it reaches an individual practice it is adapted and reshaped into something more locally specific and often replaced and discarded when the next initiative appears. Decision makers should consider appropriate flexibility when introducing new initiatives, allowing a general practice to incorporate elements that work for their population, without being penalised for deviating from the intended plan. Adaptation is inevitable, and as we describe in Paper 2 persistent tinkering is a necessary and reasonable response that should be supported.

Health inequalities

Individual general practices serve very different populations, with different needs. Access systems that are appropriate for one area may be completely inappropriate for another. Practices would benefit from the freedom to provide access that serves their population and allows them to try and tackle health inequalities in access. This is likely to involve taking a considered approach to using digital platforms, with existing evidence demonstrating that not everyone is readily able to access healthcare online and this being evident during our data collection^{87,88}. This is a particular concern for areas of high socioeconomic deprivation.

General practice staff were motivated by a desire to serve those most in need, without being able to necessarily be able to achieve this with what they had to offer in terms of access.

Reception staff

The proliferation of approaches to delivering access in general practice has changed the role of patient-facing administrative staff (receptionists). They are expected to engage in complex negotiations with patients involving several access routes and triage. Their role includes discretionary decision-making and now encompasses a digital element that they have been ill prepared for. A recent study conducted in English general practices, has demonstrated that reception staff are taking significant responsibility for supporting patients to use online services but they may lack adequate training to do this ⁸⁹. Decision makers should consider how this particular staff group could be better supported and think of the impact on this staff group when introducing policies for access, moving away from a focus on the appointment with a healthcare professional, and instead considering the patient journey from the moment they seek care.

Expectations of access

Patients encountered access systems only when they chose to seek an appointment, and with the ongoing changes to how access was delivered, systems were often different each time. The patient focus was on obtaining access to address their problem, at that point in time. General practice staff were seeing the whole of the 'demand,' the full spectrum of patients, from those who were extremely vulnerable, to those who were abusive. Their views on patients were affected by this, and individual encounters were drowned out by the volume of requests. There is room on both sides for understanding. Patients and the public could be informed about access policy and how the decisions made outside of general practice will affect their own experience of trying to get an appointment. General practices may need to consider how they can humanise a process that has become complex and technical. The Danish example raises the seemingly counter-intuitive option that it might be possible to reduce demand by easing barriers to access.

Future access – an alternative approach?

Decision-makers should examine the growing evidence base that accompanies the varied approaches to access in general practice ⁸⁹⁻⁹². Such evidence indicates that the aims of schemes such as 'digital first primary care' or 'ARRS' have complex impact once used in practice, working for some patients, and not working at all for others. Moving away from a focus on demand and placing the focus on what patients need and want from general

practice may be more likely to lead to realistic access systems that serve both general practice staff and patients.

RESEARCH RECOMMENDATIONS

Our scoping review ⁸³ identified that the UK has been world leading when it comes to delivering research on access to a general practice appointment. However, these studies have assessed the merit of different access systems without in-depth consideration for patient related outcomes. The focus has been on management of demand, which, as demonstrated in this study, is the overriding concern for general practice.

We have identified the need to develop adaptive capacity in general practice, i.e. the ability to adjust and adapt access systems to respond to changes in demand and in the wider policy landscape. The role of reception staff and/or practice managers in supporting persistent tinkering could be supported by research to understand what they need to improve access and manage demand. In particular developmental research to understand what outcomes would be most useful in more comprehensively assessing the merits of access systems could change the field and lead to a more holistic evaluation of how access systems impact patients and general practice, and would support adaptive capacity.

In this research, we observed the differing expectations between patients and general practice staff when it came to access. Further research could explore potential avenues for deepening the mutual understanding between general practice and patient. To date, research has focused on patient satisfaction and patient experience, asking patients what they think about the status quo, rather than asking them what they need or want from their general practice and GP ⁹³⁻⁹⁵. To allow general practice to inform patients about the limitations they experience and the pressure they are under, it would be useful to understand how best this can be communicated to patients via appropriate research.

There is also the significant issue of unmet need. The demand experienced in general practice is comprised of those patients who attempt to contact the practice. It is described in the long waits on the telephone line, and varied wait times for responses to online consultations ⁹⁶. It does not include the patients who no longer try to contact the general practice for an appointment, and may choose to contact NHS111, or visit the emergency room, ^{97, 98} or the patients who do not seek healthcare at all. In order to understand what patients need and want from access to general practice, we must ensure that viewpoints extend beyond those managing access to care. Reaching these patients is difficult and

requires researchers to consider participatory methods and communities that are underserved.

Research by Husain et al. demonstrated the value in using personas in research. This approach uses data from people with multiple markers of disadvantage to produce personas that 'illuminate the multiple and intersecting dimensions of disadvantage in patient populations who are marginalised and may prove useful when designing or redesigning digital primary care services'⁹⁹. We propose that this approach is relevant to the broader issue of access to primary care services, and could prove to be a useful tool in illustrating the multiple challenges faced by those who do not consider general practice an option for their healthcare needs.

Our work has shown the importance of the receptionist in shaping and delivering access. Despite reception staff being the face of general practice, and the subject of derision by the public, they hold a lot of responsibility when it comes to access to general practice. Research exploring their role is limited, though studies have demonstrated their key role in the use of alternative forms of consultation¹⁰⁰, how they rely on common sense and rapport with patients to make decisions⁸⁰, and how they deliver new access approaches without formal training^{80, 101}. There is a need to better understand how reception staff can be supported to deliver their evolving role, including as care navigators, and to understand what the modern general practice receptionist should look like.

We conducted a case study in Denmark. We were able to conduct a cross-cultural comparison which proved illuminating in considering NHS influences on the general practice perspective. Other European countries that have a similar general practice model have encountered similar issues when it comes to access, particularly in relation to the digitisation of healthcare^{102, 103}. Research that compares different countries may lead to further understanding about which aspects of access are typical of general practice, and which are unique to the UK setting.

We have demonstrated the depth of complexity and variation when it comes to access to general practice, and recommend research that furthers the understanding of how best to improve access for the benefit of both patients and general practitioners.

CONCLUSIONS

Access to general practice is not currently satisfactory for either general practice staff or patients. Decades of top-down directives have led to ongoing changes in how access is

delivered, alongside fashions for how patients should access an appointment changing over time, leading to the 2025 combination of telephone and online access. Rather than adopting nationally standardised access systems designed to streamline and channel patient demand, it is possible that a more open system could be fairer and more equitable if practices were encouraged to tinker more, adapting their access systems around local ebbs and flows. We conclude that access is most successfully delivered when general practice is recognised as a complex adaptive system and free to consider and respond to the needs of their population. A challenge remains to find quantitative outcome measures based on routine practice data that might be used by practices to find out whether their innovations and adaptations are 'working' for patients and staff. Our observations suggest that this would be helpful to practice managers and GP partners seeking to improve access to care.

The growing role of reception staff in improving access should be recognised. These staff often have insight into the issues that matter to the practice population and will be able to contribute more if trained and sustained as key members of the team. There is potential in initiatives that help clinical members of staff to understand better the work perspectives, practices and pressures of reception staff.

The focus on management of 'demand' should be called into question, as it risks diverting focus away from patients and positions general practice as needing to respond to the threat of inundation from the public. This can be counter-productive. Renewing the focus towards patient needs and wants would challenge the current direction of policy and access initiatives but could (as our work with our Danish practice suggests) deliver a step change in primary care. We suggest this could be worth exploring further in UK context.

ADDITIONAL INFORMATION

Disclosure of interest statement

Each named author has completed the ICMJE Uniform Disclosure Form for Potential conflicts of Interest (COI).

Helen Atherton declares: grant funding from NIHR for unrelated studies, from the Research Council of Norway and from a University of Warwick Industrial Fellowship (joint funded with eConsult Ltd); honoraria from Imperial College London, University College London and from North West Cancer Research; financial support to attend meetings from the University of Southampton, NIHR, RCGP and the University of Birmingham; participation on Advisory Boards for various NIHR-funded studies not related to this study and the NIHR BRACE rapid evaluation centre; and a role as vice chair of the Scientific Foundation Board, Royal College of General Practitioners.

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Sue Ziebland declares: grant funding from NIHR for studies unrelated to this study; her position as NIHR Senior Investigator Emerita; a role as Trustee and member of the Governing Body of Green Templeton College University of Oxford; a role as Co-chair of the NIHR Senior Investigator appointments Committee 2022 and as Chair for the NIHR Innovation fund to reduce demand for illicit substance 2022-2025.

Catherine Pope declares: grant funding from NIHR for unrelated studies including for her position as a NIHR Senior Investigator; royalties for works published through Wiley, Macmillan and ALCS; membership of NIHR study steering groups not related to this study; roles including unpaid Trustee/Treasurer of the Foundation for the Sociology of Health and Illness (current), member of the Governing Body of Green Templeton College University of Oxford (current), Trustee for the Society for Studies Organising Healthcare (current), and Trustee and Publications Director of the British Sociological Association (until July 2024).

(CRediT) statement

Prof. Helen Atherton: conceptualisation (co-lead), funding acquisition (co-lead), supervision (co-lead), methodology (co-lead), formal analysis (co-lead), writing – original draft (co-lead), writing – review and editing (co-lead).

Dr. Abigail Eccles investigation (equal), formal analysis (equal), writing – original draft (supporting), writing – review and editing (supporting).

Dr. Carol Bryce funding acquisition (equal), investigation (equal), formal analysis (equal), writing – review and editing (supporting).

Dr. Annelieke Driessen investigation (equal), formal analysis (equal), writing – review and editing (supporting). Dr. Tina Drud Due investigation (equal), formal analysis (equal), writing – review and editing (supporting).

Dr. Anna Dowrick formal analysis (equal), writing – review and editing (supporting)., contributed to the WP2 English case study and cross-country analyses, contributed to other academic outputs and gave final approval of the manuscript.

Dr. Bella Wheeler investigation (equal), formal analysis (equal), writing – review and editing (supporting).

Mr. Jacob Heath investigation (supporting), formal analysis (supporting), writing – review and editing (supporting).

Miss. Chloe Phillips formal analysis (supporting), writing – original draft (supporting), writing – review and editing (supporting).

Dr. Lucy Frost investigation (supporting), formal analysis (supporting), writing – review and editing (supporting).

Dr. Brian Nicholson conceptualisation (equal), funding acquisition (equal), writing – review and editing (supporting).

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Ms. Toto Gronlund conceptualisation (equal), funding acquisition (equal), writing – original draft (supporting), writing – review and editing (supporting).

Dr. Angela Martin funding acquisition (supporting), project administration (equal), writing – original draft (supporting), writing – review and editing (supporting).

Prof. Sue Ziebland conceptualisation (equal), funding acquisition (equal), supervision (equal), investigation (equal), methodology (equal), formal analysis (supporting), writing – original draft (equal), writing – review and editing (equal).

Prof. Catherine Pope conceptualisation (co-lead), funding acquisition (co-lead), project administration (co-lead), supervision (co-lead), methodology (co-lead), investigation (co-lead), formal analysis (co-lead), writing – original draft (co-lead), writing – review and editing (co-lead).

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Data sharing

All data requests should be submitted to the corresponding author for consideration. Access to all deidentified data may be granted following review.

Ethics statement

The UK focused ethnography was approved by the South Central Hampshire A Research Ethics Committee on 10th October 2022 (reference 22/SC/0333). For the Danish case study, the work was not classified as a research study needing ethics approval under the Danish Act on Research Ethics - Review of Health Research Projects Section 2. Confirmation that the study could be initiated without approval from The Committees on Health Research Ethics for the Capital Region of Denmark was obtained on 3rd August 2022.

Information governance

All investigators, research staff, PPI and steering group members have complied with the requirements of the Data Protection Act 2018 and UK General Data Protection Regulation (GDPR) 2016/679 with regards to the collection, storage, processing and disclosure of data including any personal information. For all UK data, the Chief Investigator (Pope) is the data custodian, the University of Oxford is the data controller while the University of Warwick and the University of Southampton are data processors. All Danish data is under the custodianship of Thomas Drivsholm and stored according to applicable regulations in Denmark.

Disclaimer

This report presents independent research commissioned by the National Institute for Health and Care Research (NIHR). The views and opinions expressed by authors or interviewees in this publication are those of the authors or interviewees and do not necessarily reflect those of the NHS, the NIHR, or the Department of Health and Social Care.

Research outputs

Publications

Eccles A, Bryce C, Driessen A, Pope C, MacLellan J, Gronlund T, Nicholson B, Ziebland S and Atherton A. (2024). Access systems in general practice: a systematic scoping review. *British Journal of General Practice* 74 (747): e674-e682
<https://doi.org/10.3399/BJGP.2023.0149>

Atherton H, Eccles A, Bryce C, Driessen A, Gronlund T, Pope, C. (2025) Access to General Practice appointments and sustainable change: Focused ethnographic case study. *British Journal of General Practice* <https://doi.org/10.3399/BJGP.2025.0140>

Pope C, Driessen A, Eccles A, Wheeler B, Bryce C, Heath J, Phillips C, Gronlund T and Atherton H. (2025) Bugbears in the waiting room: revisiting Arber and Sawyer's classic study of GP reception work using ethnography in eight English general practices. *Sociology of Health and Illness*. Nov;47(8):e70104. <https://doi.org/10.1111/1467-9566.70104>

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Articles under review

Due T, Ziebland S, Drivsholm T, and Dowrick A. Thinking differently about demand: staff perspectives on innovations in general practice access systems. *Journal of Health Services Research and Policy*.

Alazawi W, Phillips C, Eccles A, Atherton H, Pope C and Frost L. "Loops and hurdles": secondary analysis of patient interview data to explore the experience of patient access to UK general practice. *BMC Primary Care*.

Conference abstracts and presentations

Atherton H. South West Society for Academic Primary Care Annual Scientific Meeting, University of Birmingham, March 2023. 'GP Access Systems - A Scoping Review.'

Eccles A. Cancer in Primary Care Research International Conference, University of Oxford, March 2023. 'Evidence for access: Systematic Scoping Review of Access Systems in General Practice.'

Atherton H. Society for Academic Primary Care Annual Scientific Meeting, Brighton, July 2023. 'GP access Systems – a scoping review.'

Pope, C Health Service Research UK conference, Oxford 2024. 'Getting an appointment to see a GP - case study learning about sustainable access systems.'

Pope C. Society for Academic Primary Care ASM, Bristol, 2024. 'Getting an appointment to see a GP - case study learning about sustainable access systems.'

Pope C, Driessen A, Eccles A, Wheeler B, Bryce C, Heath J, Phillips C, Gronlund T and Atherton H. British Sociological Association Medical Sociology Annual conference, Warwick, September 2024. 'Goblins and bugbears in the waiting room: updating Arber and Sawyer's classic study of GP reception work using ethnography in eight English general practices.'

Pope C. THIS Space, THIS Institute Annual Conference 2024, online. 'Getting an appointment to see a GP - case study learning about sustainable access systems.'

Pope C, Atherton H, Eccles A. Society for Academic Primary Care South West conference 2025. Phones and Ladders – a workshop exploring the challenges of GP appointment systems and inequalities in access to primary care. (Accepted)

Pope C, Atherton H, Eccles A. Society for Academic Primary Care Annual Scientific Meeting 2025. Reconsidering the "dragon behind the desk" - a focused ethnography of GP reception work in eight English general practices.

Pope C, Atherton H, Eccles A. Royal College of General Practitioners Annual Conference 2025. Can you navigate your way to a GP appointment: an escape room challenge embedded in research into GP access systems?

Other academic outputs

Pope C. Research Unit for General Practice, Aarhus, Denmark. Online webinar February 2024. 'Computerised triage – maybe it is trickier than we think'.

Pope C. Plenary, Primary Care Tutors Conference, University of Oxford, December 2025. 'Why top-down solutions are the wrong answer to the problem of GP access'.

Engagement focused outputs (blogs)

<https://www.phc.ox.ac.uk/news/blog/news-from-our-patient-panel-2013-much-ado-about-the-logo>

<https://www.phc.ox.ac.uk/news/blog/jargon-buster>

<https://www.phc.ox.ac.uk/news/blog/stakeholder-meeting-21-july-2022>

<https://www.phc.ox.ac.uk/blog/making-interviews-accessible-pilot-interviews-for-gp-sus>

<https://www.phc.ox.ac.uk/blog/bringing-fresh-perspectives-patient-and-public-involvement-panel-members-shadowing-the-writing-of-an-academic-paper>

Visual summaries

Visual minutes of the first 'Models of access in General Practice' workshop (available from https://www.phc.ox.ac.uk/research/groups-and-centres/health_experiences/gp-sus)

Visual summaries of the dissemination event (available from <https://niftyfoxcreative.pixieset.com/gettingagpappointment/>) (in preparation)

Briefing papers

Available from https://www.phc.ox.ac.uk/research/groups-and-centres/health_experiences/gp-sus

GP-SUS Briefing Paper 1: What was the study about?

GP-SUS Briefing Paper 2: Scoping review and expert stakeholder consultation.

GP-SUS Briefing Paper 3: Secondary analysis of patient experience data.

GP-SUS Briefing Paper 4: Focused ethnographic case studies.

GP-SUS Briefing Paper 5: Cross-country comparisons.

GP-SUS Briefing Paper 6: Collaborative workshops to formulate study outputs.

Games and activities to support dissemination of key messages

Nomenclature matching game and debrief sheet.

Telephone and ladders board game and debrief sheet.

Escape room triage activity and debrief sheet.

Is it Danish? Presentation and activity.

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APPENDIX 1

Table 3: Characteristics of 74 patients interviewed in the English case studies (Note: NR denotes item not recorded. ID number 63 was not allocated). LTC denotes long-term condition.)

| ID | Yrs @ GP | Gender | Age group | LTCs | Disabilities | Ethnic group | | Carer |
|------|----------|--------|-----------|------|--------------|--------------|-----------|-------|
| P.01 | 27 | Female | 80+ | Y | Y | White | British | N |
| P.02 | 25 | Male | 50 - 59 | N | N | White | British | N |
| P.03 | 38 | Female | 70 - 79 | Y | N | White | British | Y |
| P.04 | 72 | Female | 70 - 79 | N | N | White | British | Y |
| P.05 | 3 | Male | 70 - 79 | Y | Y | White | Irish | N |
| P.06 | 39 | Female | 30 - 39 | Y | NR | British | Pakistani | N |
| P.07 | 5 | Male | 80+ | Y | Y | White | British | N |
| P.08 | 35 | Male | 80+ | Y | N | White | British | N |
| P.09 | 70 | Female | 80+ | Y | NR | White | British | Y |
| P.10 | 9 | Male | 60 - 69 | Y | N | White | British | Y |
| P.11 | 6 | Female | 50 - 59 | Y | Y | White | British | N |
| P.12 | 6 | Female | 50 - 59 | Y | NR | White | British | N |
| P.13 | 1 | Female | 30 - 39 | N | N | Asian | Other | N |
| P.14 | 5 | Male | 18 - 29 | N | Y | White | British | N |
| P.15 | <1 | Female | 60 - 69 | Y | N | Black | African | N |
| P.16 | 50 | Male | 70 - 79 | Y | NR | White | British | N |
| P.17 | 34 | Female | 30 - 39 | Y | Y | White | British | N |
| P.18 | 62 | Female | 60 - 69 | Y | N | White | British | Y |
| P.19 | 53 | Female | 50 - 59 | Y | Y | White | British | N |
| P.20 | 70 | Female | 80+ | Y | Y | White | British | N |
| P.21 | 2 | Female | 50 - 59 | Y | Y | White | Other | N |
| P.22 | 48 | Female | 70 - 79 | NR | Y | White | British | N |
| P.23 | 13 | Male | 40 - 49 | NR | NR | White | Other | N |
| P.24 | 26 | Female | 18 - 29 | NR | NR | White | British | Y |
| P.25 | 30 | Female | 50 - 59 | N | N | Other | British | NR |
| P.26 | 6 | Male | 30 - 39 | Y | N | White | British | NR |
| P.27 | 1 | Male | NR | Y | N | NR | NR | NR |
| P.28 | <1 | Female | 18 - 29 | NR | NR | NR | NR | NR |
| P.29 | 23 | Male | 60 - 69 | N | N | White | British | N |
| P.30 | <1 | Female | 50 - 59 | N | N | Asian | Other | N |
| P.31 | 9 | Female | 30 - 39 | N | N | White | British | N |
| P.32 | 20 | Male | 70 - 79 | Y | N | White | British | N |
| P.33 | 28 | Male | 60 - 69 | Y | N | Asian | British | N |
| P.34 | 25 | Male | 70 - 79 | N | N | White | British | Y |
| P.35 | 15 | Male | 50 - 59 | Y | N | White | British | N |
| P.36 | 18 | Female | 60 - 69 | Y | N | White | British | N |
| P.37 | 10 | Male | 30 - 39 | N | NR | White | British | Y |
| P.38 | 15 | Female | 60 - 69 | Y | NR | Asian | Indian | Y |
| P.39 | 10 | Female | NR | Y | NR | NR | NR | NR |
| P.40 | NR | Male | NR | NR | NR | NR | NR | NR |
| P.41 | 7 | Female | 60 - 69 | Y | Y | White | British | N |

| | | | | | | | | |
|------|----|--------|---------|----|----|-------|---------|----|
| P.42 | <1 | Female | 30 - 39 | NR | NR | NR | Other | N |
| P.43 | <1 | Female | 18 - 29 | NR | NR | NR | Other | N |
| P.44 | <1 | Female | 40 - 49 | NR | NR | NR | Other | N |
| P.45 | <1 | Female | 18 - 29 | NR | NR | Other | Arab | N |
| P.46 | <1 | Male | 30 - 39 | NR | NR | Other | Arab | N |
| P.47 | <1 | Female | 40 - 49 | NR | NR | Other | Arab | N |
| P.48 | 75 | Male | 70 - 79 | N | N | White | British | N |
| P.49 | 35 | Female | 60 - 69 | Y | Y | White | British | N |
| P.50 | 1 | Male | 50 - 59 | N | N | White | British | N |
| P.51 | NR | Male | 80+ | Y | NR | White | British | N |
| P.52 | 25 | Female | 80+ | Y | Y | White | British | N |
| P.53 | 18 | Male | 60 - 69 | Y | Y | Asian | Indian | N |
| P.54 | 16 | Female | 50 - 59 | Y | NR | White | British | N |
| P.55 | 45 | Female | 60 - 69 | NR | NR | White | British | N |
| P.56 | 30 | Female | 60 - 69 | Y | NR | White | British | N |
| P.57 | 3 | Female | 18 - 29 | Y | NR | White | British | Y |
| P.58 | 17 | Female | 70 - 79 | Y | NR | White | British | N |
| P.59 | 40 | Male | 70 - 79 | Y | Y | White | British | N |
| P.60 | 5 | Female | 70 - 79 | Y | NR | White | British | Y |
| P.61 | 26 | Male | 50 - 59 | Y | NR | White | British | N |
| P.62 | 7 | Female | 60 - 69 | Y | NR | White | British | N |
| P.64 | 72 | Male | 70 - 79 | Y | NR | White | British | N |
| P.65 | 57 | Female | 70 - 79 | Y | NR | White | British | N |
| P.66 | 10 | Male | 60 - 69 | Y | NR | White | British | Y |
| P.67 | <1 | Female | NR | Y | Y | White | British | NR |
| P.68 | NR | Male | 70-79 | NR | NR | White | British | NR |
| P.69 | 14 | Female | NR | NR | NR | White | British | NR |
| P.70 | 31 | Female | 70 - 79 | N | NR | White | British | NR |
| P.71 | 37 | Male | 30-39 | NR | NR | White | British | NR |
| P.72 | 14 | Male | NR | NR | NR | White | British | NR |
| P.73 | 5 | Female | 40 - 49 | Y | Y | White | Irish | N |
| P.74 | 15 | Female | 70 - 79 | NR | NR | White | British | N |
| P.75 | 35 | Female | 40 - 49 | Y | Y | White | British | N |

Table 4: Characteristics of 70 practice staff interviewed in the English case studies (NR denotes item not recorded. Role titles reflect roles with similar content e.g. public facing 'patient services team member' and 'care coordinators' have been classified as receptionists; office, operational and business managers classified as Practice Managers; 'Health care assistant' includes GP and prescribing assistants; Administrators includes secretarial or data/record processing roles that do not include public facing reception work).

| ID | Yrs @ GP | Gender | Age group | Role |
|------|----------|--------|-----------|-------------------------------------|
| S.01 | 6 | Male | 40-49 | GP partner |
| S.02 | 12 | Female | 50-59 | Assistant Practice Manager |
| S.03 | 2 | Female | 30-39 | Receptionist, supervisor |
| S.04 | 7 | Female | 40-49 | Receptionist, supervisor |
| S.05 | 14 | Female | 60-69 | Practice Nurse |
| S.06 | 24 | Male | 50-59 | GP partner |
| S.07 | 4 | Male | 40-49 | Social prescriber |
| S.08 | 4 | Female | 30-39 | Receptionist |
| S.09 | 5 | Female | 50-59 | Administrator |
| S.10 | 20 | Female | 50-59 | Administrator |
| S.11 | 1 | Male | 50-59 | Administrator |
| S.12 | 23 | Female | 40-49 | Practice Manager |
| S.13 | 32 | Female | 60-69 | GP partner |
| S.14 | 6 | Female | 40-49 | GP Partner |
| S.15 | 5 | Female | 18-29 | Healthcare assistant |
| S.16 | 7 | Female | 40-49 | Receptionist |
| S.17 | 27 | Female | 50-59 | Administrator |
| S.18 | 7 | Female | 40-49 | Receptionist |
| S.19 | 2 | Female | 50-59 | Receptionist |
| S.20 | 24 | Female | 40-49 | Practice Manager |
| S.21 | 17 | Male | 50-59 | Practice Manager |
| S.22 | 7 | Female | 30-39 | Practice Nurse |
| S.23 | 4 | Female | 50-59 | Practice Manager |
| S.24 | 17 | Female | 50-59 | Receptionist & Healthcare assistant |
| S.25 | 9 | Female | 30-39 | Healthcare assistant |
| S.26 | 3 | Female | 30-39 | Practice Manager |
| S.27 | 10 | Male | 40-49 | GP partner |
| S.28 | 28 | Female | 50-59 | Assistant Practice Manager |
| S.29 | 6 | Female | 18-29 | Receptionist, supervisor |
| S.30 | 9 | Female | 60-69 | Practice Manager |
| S.31 | 11 | Female | 40-49 | Receptionist, supervisor |
| S.32 | 5 | Female | 40-49 | GP Partner |
| S.33 | 34 | Female | 50-59 | Receptionist & Healthcare assistant |

| | | | | |
|------|-----|--------|-------|----------------------------|
| S.34 | 7 | Male | 40-49 | GP partner |
| S.35 | 33 | Female | 50-59 | Practice Manager |
| S.36 | 19 | Male | 40-49 | GP partner |
| S.37 | 14 | Female | 50-59 | Practice Nurse |
| S.38 | 7 | Female | 40-49 | GP partner |
| S.39 | 2 | Female | 40-49 | Receptionist |
| S.40 | 12 | Female | 40-49 | GP partner |
| S.41 | 3 | Female | NR | Receptionist |
| S.42 | 27 | Male | NR | GP partner |
| S.43 | NR | Female | NR | Receptionist |
| S.44 | <1 | Female | NR | Receptionist |
| S.45 | 15 | Male | NR | GP partner |
| S.46 | 2 | Female | NR | GP partner |
| S.47 | <1 | Female | NR | Receptionist |
| S.48 | 0.5 | Female | 40-49 | Receptionist |
| S.49 | <1 | Female | 18-29 | Receptionist |
| S.50 | 14 | Female | 50-59 | Receptionist |
| S.51 | 11 | Male | NR | GP partner |
| S.52 | 6 | Female | 60-69 | Practice Nurse |
| S.53 | 2 | Female | 30-39 | Practice Nurse |
| S.54 | 10 | Male | 30-39 | GP partner |
| S.55 | 33 | Female | 60-69 | GP partner |
| S.56 | 2 | Male | 18-29 | Assistant Practice Manager |
| S.57 | 17 | Female | 60-69 | Receptionist, supervisor |
| S.58 | 4 | Female | 30-39 | Receptionist |
| S.59 | <1 | NR | 18-29 | Receptionist |
| S.60 | <1 | Female | NR | Receptionist |
| S.61 | 6 | Female | NR | GP partner |
| S.62 | 2 | Female | 30-39 | Receptionist, supervisor |
| S.63 | 9 | Female | 50-59 | Practice Manager |
| S.64 | 3 | Female | 30-39 | Receptionist |
| S.65 | NR | Male | NR | GP partner |
| S.66 | 2 | Female | 30-39 | Receptionist, supervisor |
| S.67 | 32 | Female | 60-69 | Healthcare assistant |
| S.68 | 0 | Female | 40-49 | Healthcare assistant |
| S.69 | 9 | Female | NR | Assistant Practice Manager |
| S.70 | NR | Male | NR | GP partner |

Table 5: Characteristics of 15 patients interviewed in the Danish case study (Note: LTC denotes long-term condition.)

| ID | Yrs @ GP | Gender | Age group | LTCs | Disabilities | Ethnic group | | Carer |
|------|----------|--------|-----------|------|--------------|--------------|--------|-------|
| P.01 | 25 | Male | 80+ | Y | N | White | Danish | N |
| P.02 | NR | Male | 50 - 59 | Y | N | White | Danish | Y |
| P.03 | 35 | Female | 50 - 59 | Y | N | White | Danish | N |
| P.04 | 5 | Female | 40 - 49 | Y | N | White | Danish | N |
| P.05 | NR | Female | 70 - 79 | Y | N | White | Danish | N |
| P.06 | 37 | Female | 70 - 79 | Y | N | White | Danish | N |
| P.07 | 2 months | Female | 50 - 59 | N | N | White | Danish | N |
| P.08 | 34 | Female | 70 - 79 | Y | N | White | Danish | N |
| P.09 | 20 | Female | 40 - 49 | N | N | White | Danish | Y |
| P.10 | 3 | Male | 30 - 39 | N | N | White | Danish | Y |
| P.11 | 20 | Male | 50 - 59 | N | N | White | Danish | N |
| P.12 | 3 months | Male | 18 - 29 | N | N | White | Danish | N |
| P.13 | 17 | Female | 60 - 69 | Y | N | White | Danish | N |
| P.14 | 3 | Female | 18 - 29 | N | N | | | N |
| P.15 | 3 months | Male | 18 - 29 | N | N | White | Danish | N |

Table 6: Characteristics of 9 practice staff interviewed in the Danish case study

| SID | Yrs @ GP | Gender | Age group | Role |
|-----|----------|--------|-----------|--|
| DS1 | 25 | F | 60-69 | GP partner |
| DS2 | 22 | F | 50-59 | GP partner |
| DS3 | 7 | F | 40-49 | GP partner |
| DS4 | 1 | M | 40-49 | GP partner |
| DS5 | 16 | F | NR | Practice Nurse |
| DS6 | 17 | F | NR | Practice Nurse |
| DS7 | 5 | F | NR | Receptionist and minor tests |
| DS8 | 1,5 | F | NR | Receptionist and minor tests |
| DS9 | NR | F | NR | Medical Student (receptionist and minor tests) |

The 10 other Danish practices where additional interviews provided contextual information were characterised as follows. There were nine GP partners and one nurse; seven were male and three were female. They were all located in the Eastern part of Denmark, but varied in geographical location, distance from the capital, whether rural or urban and in municipal social group score. They also varied in when they had initiated the *Time-Same-Day* access system and how they had adapted it.