

Non-attendance in general practice: a questionnaire survey

William Hamilton, Barnfield Hill Surgery, Exeter, UK, Manjo Luthra, Timothy Smith and Philip Evans, St Leonard's Research Practice, Exeter, UK

Non-attendance in general practice is increasing. In contrast to hospital non-attendance little research has been undertaken on the topic. The aim of this study was to identify the characteristics of non-attending patients and to determine the reasons for general practice non-attendance, so that strategies to reduce it could be devised. Four hundred and ninety-three consecutive non-attenders from five practices in Exeter, Devon were studied. A questionnaire was sent enquiring about the reasons behind the patient's non-attendance and possible strategies to reduce future non-attendances. Of 17 264 appointments 493 (3.9%) were not attended. Females accounted for 278 (56.4%) of the non-attenders. The highest number of non-attenders was in the age group 25–44 years. One hundred and seventy-four (35%) responded to the questionnaire, of whom 60 (35% of responders) had forgotten the appointment. Strategies to reduce general practice non-attendance should focus on assisting the patient to remember the appointment.

Key words: non-attendance; primary care; questionnaire survey

Introduction

Non-attendance for general practice appointments is increasing (McCarthy, 1998). An estimated 8.3 million GP appointments are missed each year in Great Britain (McCarthy, 1998). This approximates to 3% of all booked appointments. Non-attendances increase the pressure on appointment systems, so that the impact is borne primarily by reception staff and patients wishing to see their doctor. Patients rate being able to obtain an appointment with their doctor very highly (Which, 1995b), but this is made more difficult by non-attenders (Turner and Cooke, 1991). Perversely, the GP is often unaffected by a non-attendance, using the time to catch up on a surgery already running late, or to perform an administrative task. Little research has been done on general practice non-attendance, in contrast to non-attendance at hospital outpatients, which has shown younger patients (Dickey and Morrow, 1991; Dyer *et al.*, 1998), males (Dickey

and Morrow, 1991) and patients of lower socio-economic status (Hamilton *et al.*, 1987) to non-attend more frequently. Some of the explanations for hospital non-attendance should not pertain to general practice, such as very long waits for the appointment (Dickey and Morrow, 1991; Dockerty, 1992; McGlade *et al.*, 1988), failure to receive the appointment (Pal *et al.*, 1998), or failure to understand the reason for referral (Hamilton *et al.*, 1999; Pal *et al.*, 1998). Because the patient has choice in booking times for general practice appointments – as opposed to hospital appointments where a fixed appointment is usually sent – non-attendances due to work commitments (Frankel *et al.*, 1989; Pal *et al.*, 1998; Verbov, 1992) would be expected to be less frequent.

Some practices have tried to reduce non-attendance by putting up notices in the surgery, or by contacting patients who have failed to attend. Free phone telephone lines for patients to cancel have been suggested. Overbooking of appointments to allow for anticipated non-attendances is unpopular with patients (Ward, 1998). However, these strategies have been implemented before the reasons for general practice non-attendance have been elucidated, and may not address the real

Address for correspondence: Dr William Hamilton, Barnfield Hill Surgery, 12, Barnfield Hill, Exeter EX1 1SR, UK.
E-mail: w.hamilton@bt.openworld.com

reason, or reasons, why patients miss their appointment. Three studies have looked at aspects of general practice non-attendance. One study sent a general health questionnaire to non-attenders in a general practice, finding 55% with high scores (Inglesfield, 1999). Although suggestive of psychological ill health this finding has to be viewed against all general practice attenders, who obtain similar scores (Hamilton, 1999; Kessler *et al.*, 1999). An unpublished survey by the Association of Community Health Councils in England and Wales found that some patients felt they were doing the practices and other patients a favour by failing to keep their appointments. The third study (Cosgrove, 1990) interviewed 27 non-attenders, with illness and forgetting the appointment explaining half of the non-attendances. Other studies have investigated specific services within practices. The main reason for non-attendance at a nurse-run asthma clinic (Woodward, 1998) was forgetting the appointment. However, the wait for appointments was 4–6 weeks, so this finding may not extrapolate to routine general practice. Studies on new patient checks and screening procedures (Baum, 1995; Elkind *et al.*, 1988; Neilson and Jones, 1998; Pill *et al.*, 1988) are similar.

Therefore, we designed a survey to determine the characteristics of non-attenders and their reasons for non-attendance, in order to develop strategies to deal with the issue.

Methods

Participants

Five general practices in Exeter, Devon, UK were invited to participate. Four of them form a subunit of the out-of-hours service, while the fifth (practice E) has a practice area overlapping three of the four. All practices operate appointment systems, with some same day appointments for urgent problems. The maximum wait for routine appointments was 1 week, but it was usually much less. Only the main surgeries participated. All practices are linked electronically to the local health authority. This included a recent address check. The practices keep a record of attendances and non-attendances for GP or practice nurse appointments. Each practice was asked to recruit 100 consecutive non-attenders, from February to April 1999. Each evening, patients who had missed their

appointment were sent a questionnaire for next day arrival.

Questionnaire

The questionnaire asked about the type of appointment (routine/urgent, initial/follow-up, doctor/nurse), transport arrangements, method of making the appointment (telephone/in person), main reason for non-attendance (from a checklist, plus open box), and the patient's opinion about possible ways of reducing non-attendance. Each question had an open section for comments. The questionnaire was developed from our previous work in non-attendance (Hamilton, 1999; Hamilton *et al.*, 1999), and refined after discussion with members of the primary health care teams involved. The covering letter made it clear that the questionnaire was to be returned to a researcher unconnected with their clinical care (ML). Only one mailing was sent. Demographic details of the patient were logged on a research sheet by the practices. Jarman scores were derived from the patient's postcode. The health authority supplied the mean Jarman score for each practice. We used the Jarman score as a proxy for socio-economic status, a higher score indicating deprivation. All data were entered and analysed using SPSS and STATA, with medians, and Mann–Whitney tests used for analysis of non-parametric data.

Results

Characteristics of non-attendance

The details of the five practices are shown in Table 1. Females accounted for 278 (56.4%) of the non-attenders. The number of non-attenders at each age band was 0–4 years 29 (6%), 5–14 35 (7%), 15–24 107 (21%), 25–44 185 (38%), 45–64 89 (8%), 65–74 28 (6%), and over 75 19 (4%). These age bands were chosen to match the age breakdown of attenders taken from a national survey of general practitioner usage. (McCormick *et al.*, 1995).

Replies to the questionnaire

Five questionnaires were returned by the post office. One hundred and seventy-four replies were received, giving a response rate of 35%. The 174 responders were older than the non-attenders as a whole: responders median 37 years (interquartile

Table 1 Details of practices, appointments and Jarman scores

Practice	List size	Situation	Number of appointments kept	Number (%) of non-attenders	Number (%) of replies	Mean practice Jarman score	Median (CI) Jarman score of non-attenders
A	6295	Urban	3225	97 (2.9)	33 (34)	11.63	14.3 (14.3–14.3)
B	6137	Urban	3243	100 (3.0)	35 (35)	13.50	21.3 (17.9–21.9)
C	5919	Urban	2308	98 (4.1)	33 (34)	11.39	21.9 (20.5–21.9)
D	7615	Semi-rural	2240	99 (4.2)	45 (45)	2.44	21.9 (17.6–22.3)
E	4243	Urban	1255	99 (7.3)	25 (25)	25.43	34.1 (34.1–34.1)
Total	30209		12271	493 (3.9)	171 (35)		

range 23.0–56.1); nonresponders 29 (19.8–39.9); $P < 0.0001$. Responders had a lower median Jarman score: responders 17.6 (15.4–29.1); non-responders 21.8 (15.9–29.1); $P = 0.05$. The sex ratio was not significantly different.

Twenty-three patients did not consider themselves to have failed to attend; five of these described what appeared to be practice errors in making appointments, and two gave other reasons for recorded non-attendance. The remaining 16 of these did not fully complete the questionnaire. Thus, each question attracted a different number of responses.

The main reasons given for non-attendance are shown in Table 2. Five out of 154 responders had had the appointment sent to them by the practice; some considered this to reduce the moral pressure to attend. When asked why they did not cancel the appointment 77/138 (56%) answered that they had

either forgotten to, or had not considered it, while 18/138 (13%) stated that they had found the telephone lines busy. Other reasons for failure to cancel the appointment accounted for 41/138 (30%).

Strategies to reduce non-attendance

Table 3 summarizes responses to possible strategies for reducing non-attendance. Many patients commented that none of these would help for patients who simply forgot their appointment. Four suggested reminders, either by telephone or post.

Discussion

This is the first questionnaire survey of general practice non-attendance, and showed an overall non-attendance rate of 3.9% for medical and nurs-

Table 2 Main reasons stated by respondents for not attending their appointment

Main reason stated by patient ($n = 174$)	Number (%)
Forgot	60 (35)
Practice error	20 (12)
Mix-up over dates/times	20 (12)
Could not get time off work	11 (6)
Another engagement took priority	10 (6)
Traffic problems	7 (4)
Symptoms improved	6 (3)
Appointment was not with own GP	5 (3)
Overslept	5 (3)
Needed an earlier appointment	4 (2)
Was admitted to hospital	2 (1)
Attended accident and emergency	1 (1)
Other	16 (9)
Not answered	7 (4)

Table 3 Patients' views on possible strategies to reduce non-attendance

Possible strategy	Number (%) considering this the most effective strategy (116 replies)	Number (%) considering this the least effective strategy (111 replies)
A dedicated telephone line for cancellation	26 (22)	22 (20)
A free telephone line for cancellation	23 (20)	8 (7)
A warning letter after non-attendance	21 (18)	31 (28)
A fine	16 (14)	22 (20)
An open surgery system	25 (22)	20 (18)
More than one of these	5 (4)	9 (8)

ing appointments. The Doctor Patient Partnership survey estimated a rate of 3% (McCarthy, 1998), so our findings are likely to be representative. Females accounted for 56% of non-attendances. However, females consult more frequently than males, accounting for 55% of appointments nationally (McCormick *et al.*, 1995). Our findings of increased non-attendance with lower socio-economic status need to be interpreted with caution, because we could only obtain mean practice Jarman scores. Each practice's mean Jarman score was below the 95% confidence interval of the non-attenders' median score, suggesting that non-attenders are of lower socio-economic status. Patients of lower socio-economic status consult more frequently (Ben Sholmo *et al.*, 1992), so the probable association with non-attendance will reflect this in part. In contrast, are the age findings; patients aged 20–40 are normally the lowest users of their general practitioner (McCormick *et al.*, 1995). Therefore this age group provides a disproportionately high rate of non-attendances.

The reply rate to the questionnaire of 35% is disappointing, but not surprising. Surveys of hospital non-attendance have achieved reply rates of 38–43% from non-attenders (Lloyd *et al.*, 1993; Pal *et al.*, 1998). Only one cycle of questionnaires was sent. A second cycle would probably have increased the reply rate, but the delay involved in sending a second questionnaire would have reduced the value of the responses as we considered that the inherent time delay would have reduced the quality of the response. Furthermore, we did not wish to upset patients, some of whom may feel guilty about their non-attendance; we judged it reasonable to send a single questionnaire, but regarded two as intrusive. The ethics committee endorsed this view. Wrong addresses can only explain a small part of the low reply rate; the practices have stable populations, a recent address check had been performed, and only five letters were returned by the post office. Nonreply was associated with younger age and lower socio-economic status. It is probable that the factors that make non-attendance more likely also make non-reply to a questionnaire more likely. It is clear from this study, however, that different methodology will be needed to elucidate the reasons for general practice non-attendance.

The rationale for this study was that strategies to reduce non-attendance could be derived

from the results. The main reason for non-attendance – forgetting the appointment – is not easy to counter. Furthermore, it is probable that patients who regarded their reason for non-attendance as 'legitimate' were more likely to reply. Therefore, the true percentage of non-attenders who simply forgot their appointment may be even higher. Practices could examine their procedures for ensuring that patients have an *aide-memoire* of the appointment. A reminder phone call is unlikely to be cost-effective, even if the issue of confidentiality could be overcome. Some patients considered that there was less pressure to attend if the appointment had been organized by the practice, such as immunization or cervical smears. Although pre-arranged appointments increase the uptake of these preventative measures, the timing may be inconvenient for the patient. Furthermore, these appointments may have a longer interval between sending out the appointment and its taking place. The interval is a strong predictor of outpatient non-attendance (Hamilton *et al.*, 2002). Further research could examine the trade-off between the higher uptake of prevention against patient inconvenience. Understandably, strategies with a penal element were less popular. Additionally, they may penalize patients most in need, such as the mentally ill, in whom non-attendance is associated with severity of illness (Killaspy *et al.*, 2000).

Any human system will contain inefficiencies. Perhaps an overall non-attendance rate as low as 3.9% cannot be reduced without the risk of creating a barrier to general practitioner access. However, the rate is rising. Practices should work with their patients to combat this rise, particularly in making appointments less easy to forget.

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