doi:10.1093/fampra/cmi076 Family Practice Advance Access published on 29 July 2005

Non-attendance in primary care: the views of patients and practices on its causes, impact and solutions

Chris Martin[a], Tracey Perfect[a] and Greg Mantle[b]

Martin C, Perfect T and Mantle G. Non-attendance in primary care: the views of patients and practices on its causes, impact and solutions. *Family Practice* 2005; **22**: 638–643.

Background. More than 12 million appointments in primary care are not attended each year: this is about 6.5% of the appointments made. Missing appointments is widely perceived as a waste of resources and a potential barrier to the achievement of the 48-hour access target.

Objectives. To explore and compare the views of primary care team members and patients in relation to the causes, impacts and potential solutions to the issue of non-attendance.

Methods. A qualitative study using semi-structured interviews with a purposive sample of 24 patients over the age of 18 years, 7 GPs, a GP Registrar, a Nurse Practitioner and 5 receptionists carried out in one health centre in urban South Essex with additional interviews in a practice in rural Essex and a practice in inner city London.

Results. The major themes were: competing priorities for patients; the efficiency of appointment booking systems; the significance of relationships on non-attendance; differing attitudes towards non-attendance between different groups; and interventions. Poor patient–staff relationships was given as a reason for non-attendance, while missing appointments was seen as making relationships worse. Inefficiencies in the appointment booking systems were perceived as key in this 'relationship' context.

Conclusions. Some non-attendance is inevitable with pre-booked appointments, as GP appointments must compete with patients' other priorities and the complexities of their day. Utilising modern communication technologies, such as SMS text messaging, may make cancellation simpler. A structured approach to matching supply and demand of appointments might reduce problems arising from non-attendance.

Keywords. Appointments and schedules, attitude of health personnel, patient compliance, primary health care, professional–patient relations.

Introduction

Non-attendance has been portrayed as problematic in terms of time wasted and the financial cost involved.[1] More than 12 million GP appointments are not attended each year (about 6.5% of all appointments) and are said to cost about £162 million.[1,2] Some believe that this increases waiting times for appointments and creates an obstacle in meeting the NHS Plan aim to reduce waiting times to 48 hours or less.[3,4]

Received 18 November 2004; Accepted 29 June 2005.
[a]Laindon Health Centre Primary Care Research Team and [b]Institute for Health & Social Care, Anglia Polytechnic University, Chelmsford, UK. Correspondence to Chris Martin, E-mail: chris.martin@laindonhc.org.uk

Research on non-attendance in general practice has tended to focus on characterising groups of non-attendees.[4,5] This study offers a comparative exploration of the views of primary care staff (medical and reception) and patients with regard to non-attendance, its causes, impacts and approaches to the problem.

Methods

Design

We conducted semi-structured interviews using a schedule with set questions and follow-on prompts allowing comparison of participants' responses. The interviews were audio-recorded and transcribed. A 50% random sample of participants were invited to review their transcripts for accuracy.

TABLE 1 *Participants*

Non-attendees	22
Patients who have never failed to attend	2
GPs	7
GP registrar	1
Nurse Practitioner	1
Receptionists	5
Total	38

TABLE 2 *Exclusions*

Total number of non-attendees	1273
Total number of exclusions	421 (232 under 18′s and 189 adults)
Total number of eligible patients	852

TABLE 3 *Categories of non-attending patients sampled*

Group	Number sampled (total = 22)
Gender	
Male	9
Female	13
Age	
18–30	7
31–45	5
46–64	7
65+	3
Attendance pattern	
Missed 0–3 appointments	19
Missed more than 3 appointments	3
Socio-economic classification	
1 Higher managerial and professional occupations	1
2 Lower managerial and professional occupations	4
3 Intermediate occupations	0
4 Small employers and own account workers	1
5 Lower supervisory and technical occupations	5
6 Semi-routine occupations	5
7 Routine occupations	0
8 Never worked and long-term unemployed	6

Setting

The study took place over 10 months, mainly in three separate practices in one urban primary health care centre in Essex, but additional interviews took place in two other health centres, one in rural Essex and one in inner city London.

Participants

The participants were a purposive sample of 38 participants (Table 1). Sampling continued to saturation of themes. All the participants were White, and British, with English as their first language. Potential participants were selected to represent sexes, a wide age range (18 to 84 years) and, for the patients, a varied socio-economic background.

Procedure

For patient participants, GPs identified non-attendees in their surgeries and informed the researchers. Patients were excluded if they were under 18 years old or their GP felt they were unsuitable for inclusion, for example those who were terminally ill, or potentially violent (Table 2). A covering letter, information sheet and consent form were then sent to each of the suitable patients inviting them to take part in the study. Patients willing to participate were telephoned to arrange a mutually convenient time for the interview to take place and were given a choice of interview venue: the patient's own home or a private room in the health centre.

Patients were sampled to include the categories shown in Table 3. We also ensured that we interviewed patients from surgeries of GPs of each sex, a GP registrar, and a Nurse Practitioner at various surgery times.

Medical staff were selected purposively to include different surgery times and varying attendance rates at the urban health centre. Two GPs from other practices were included, one from a rural practice in North Essex with a very low non-attendance rate, and the other from a busy practice in East London with a higher non-attendance rate. Reception staff were selected in order to represent different levels of responsibility and various working hours.

Analysis

Transcripts were coded by one researcher using NVivo software. An external researcher was recruited to review a subset of coded transcripts for reliability. Themes were developed from the coding by discussion among the team. In-progress presentations were made to two peer groups of researchers and responses contributed to purposive sampling, development of themes and assessment of validity. In addition to the original transcripts, a provisional report was shared with all participants.

Results

Analysis of the data identified five major themes: competing priorities for patients; the efficiency of appointment booking systems; relationships; differing attitudes towards non-attendance between the different groups interviewed; and interventions.

Competing priorities

Both staff and patients initially cited 'forgetfulness' as a key cause of non-attendance. However, many patients went on to identify various matters or events that had distracted them: employment and family matters

were the main demands competing for the patient's attention.

> ''... if I get a client who calls me, say, if I make an appointment on the Friday, and at the weekend I've had two or three calls and one's urgent for Monday morning, or whatever, then I suppose I prioritise my business against this ... the practice [...]'' (Patient 6)

Medical staff felt that non-attendance was mainly due to such 'patient' factors.

> ''It's more about what's going on in their lives, it's not about us. Well, I mean, obviously there'll be odd occasions where it might be, but the norm is nothing to do with us, really.'' (GP 1)

Efficiency of appointment systems

Patients spoke about their frustration with long waits to see their preferred GP. Walk-in appointment systems were discussed but the idea was not popular among patients, who preferred to have a defined slot, and had worries about conflict that might arise over uncertainties about who was next in the queue to be seen.

Communication

Organisational factors acted as barriers for patients, preventing them from attending an appointment or cancelling one.

Communication issues at all levels were seen as a problem by all groups of participants. Patients frequently had difficulty getting through to the surgery by telephone, as lines were often busy.

> ''... ... it's so hard to get an appointment with him. It did feel to me as though it was a waste of an appointment, because if I, if I could have got through, somebody might have rang for a cancellation and they could have got one.'' (Patient 7)

Time management

Professionals felt that patients turning up late for their appointments was, in fact, even more disruptive than non-attendance.

> ''... people that, perhaps, come 15 minutes late, or 20 minutes late, and they come in and then, often, they still want ... several things, or discuss several issues, and I find that more, more annoying, more disruptive than if people just don't come.'' (GP 9)

From their accounts, it was apparent that patients did not realise that being late for an appointment would affect a surgery to the extent that doctors felt it did. Patients felt that because they often had to wait in surgery past their appointment time, the practice would have a more relaxed attitude to them arriving late. Whilst some patients felt guilty about missing appointments, others felt that non-attendance was occasionally inevitable and therefore acceptable.

Relationships

A perceived lack of empathy and understanding from GPs was seen as a barrier for some patients.

> ''Well the doctor himself. I think, every time I walk into that room, and it's not been very often, he's sitting there, like, 'Yeah, what do you want?' He don't even look at you. And I get the feeling I'm wasting his time.'' (Patient 11)

Many patients felt that the relationship they had with their GP was extremely important. Some of the medical staff did express the view that patients were less likely to attend if a relationship had not been established, although it was apparent that they did not fully appreciate the value patients placed on the doctor–patient relationship.

Some patients resented the receptionist's role as gatekeeper and perceived this as interference.

> ''[...]you think 'Oh God! I've got to get through them [receptionists] first', and like, it's always, 'Do you think it's important?' Or, 'What's wrong with you?' I think, 'What's it got to do with them?' You know, they're not doctors, they're not nurses. But I think they should, they could improve that side of it somehow. [...]'' (Patient 11)

From their accounts, receptionists did not see themselves as a barrier but instead as a go-between, citing the efforts they often made to negotiate with patients to find them a suitable appointment slot in order to minimise missed appointments.

> ''I listen to what the patients say. I don't know about the other receptionists, but I listen to what they have to say. You can gauge ... if you've got an elderly person, and you think to yourself, 'Well, they've probably got a bus pass', so you sort of give them a slot after nine o'clock.'' (Receptionist 4)

Differing attitudes

One of the most striking aspects of the interviews was the variation in the way different participants think about non-attendance. While many patients believed that it was annoying for the doctors when patients didn't attend appointments, GPs often did not feel negatively about non-attendance, although this seems to depend on the type of patient missing the appointment and on where the non-attendance fitted into the surgery schedule. Missing appointments was even seen as being useful in certain circumstances:

> ''It just allows you to catch up with work. I mean, you ... you ... it depends on the timing of the DNA [did not attend]. [...] If your first couple

of appointments in the day don't turn up, you've not really started your work, so it's wasted time, but later on in the morning, you can usually spend it writing up notes or doing some other administration.'' (GP 5)

It appears that GPs classify patients who miss appointments into 2 distinct groups: those who might be 'excused' because of their difficult life circumstances; and those who were simply reckless about keeping appointments and therefore blameworthy. They were, however, resigned to the fact that patients with chaotic lifestyles may not attend appointments and had some sympathy for them. It would seem then that it is the patient's attitude towards their non-attendance that is of concern to the medical staff rather than the non-attendance itself.

''Some people's lives are so chaotic they are incapable of remembering things, and you just have to live with them. Other people just view it as they couldn't care less, and those would be annoying.'' (GP 1)

Receptionists recognised the dual aspect of missed appointments that the medical staff had expressed.

''... doctor wise, it's a waste of their time but I'm sure they love it [laughs] because they get time to go and have a cup of tea. You know, they're gonna finish their surgery a bit quicker or do a referral maybe quicker ...'' (Receptionist 3)

Reception staff themselves, however, found missed appointments more frustrating and irritating. They talked about how hard they had worked to find patients an appointment slot. If this appointment was then wasted there were less appointments available to other patients. Despite this, some receptionists felt that patients were making valiant efforts to cope in difficult circumstances and were wary of judging them for not attending.

Interventions

Various ways of reducing missed appointments were explored; some initiated by the interviewer, and others by the participants. Paying a financial penalty was suggested by some of the patients interviewed, who felt they would be able to relieve their guilt about not attending an appointment and that the NHS would be partially reimbursed for any losses:

''... But had I needed to pay a fine, I would have probably paid the fine, which would have helped the NHS, and I would probably feel less guilty! But it wouldn't have made a difference to me not coming in, I still wouldn't have come in. But at least the NHS would have got something for their time, which is fair enough.'' (Patient 6)

Medical staff generally felt reluctant to impose such a penalty. Some were opposed to it, but others, although not against the idea in principle, felt it would be virtually impossible to put into practice.

Almost all of the participants felt that telephone reminders and postal reminders were too costly and time-consuming to be of benefit.

Some patients felt that the capacity to leave a message on an answering machine would reduce the number of missed appointments because of difficulties with congested telephone systems. Medical staff and reception staff, however, felt that it would be difficult for existing staff to manage such a system as it would have to be checked regularly in order to be effective. Some patients suggested SMS text messaging as an easy means of alerting the practice about their desire to cancel an appointment.

Straightforward educational measures such as posters encouraging patients to attend their appointments were often suggested. Both patients and receptionists also felt that appointment cards, with the time and date of the appointment, were a useful reminder.

Discussion

Relationships, appointment systems and attitudes to non-attendance were clearly important as individual issues and there may also be a 'feedback effect' acting between them. Some patients fail to attend because of negative experiences in booking appointments or a poor relationship with the GP or practice in general and this in turn may result in a hardening of attitudes and a further deterioration in relationships. Unused appointment slots reduce the availability of appointments and the choice of times. This generates frustration for patients and may increase the likelihood of non-attendance.

Patients generally perceived missed appointments to be more problematic than health professionals and a failure to attend an appointment can result in some angst and feelings of guilt for them. The GPs had a more relaxed attitude to non-attendance than reception staff. This arises from the very different impact that the non-attendance has in practical terms on these two groups. It was clear that the receptionists recognised the reasons for the GPs' lack of concern, but there was little indication that the GPs realised the extent of disruptiveness that non-attendance had on the reception staff. Hussain-Gambles *et al*. also found that receptionists felt that they were most affected by non-attendance and wanted GPs to address this in consultations with patients. GPs were more guarded about this, being more fearful of damaging doctor–patient relationships.[6] The receptionists wanted a message delivered to patients about non-attendance and this might not be constructive. Communication around

non-attendance needs to be a dialogue, not just between patients and GPs, but also between primary care team members. This might serve to reduce conflict, improve internal and external relationships and reduce non-attendance rates.

Whilst some patients perceived receptionists as obstructive, they themselves felt they tried hard to find suitable appointment times when the choices available may have been limited. They also felt that the loss of an appointment slot further reduced their ability to accommodate patients' needs and increased their risk of attracting opprobrium. Again these feelings reflect back into the practice-patient relationship and create further tensions as well as the potential for a more generalized hardening of attitudes in reception staff.

Interventions

Interventions could be focused on the patient or the practice. There was a general recognition among all groups that some non-attendance is inevitable and that punitive measures directed at the patient would have little impact on attendance rates. Reminders and educational measures were widely acceptable though all participants felt that any measures to reduce non-attendance need to be simple and cheap to implement. Appointment cards and posters are widely used, although their effectiveness remains uncertain and they would need systematic evaluation in order to determine their impact.[4]

Some patients held the view that missed appointments wasted resources and some suggested that implementing a financial penalty would be justified. At the same time, some patients indicated that this would not have prevented the non-attendance in their particular case. This would suggest that its purpose would simply be compensation for the NHS or a penance for 'guilty' patients rather than an intervention to reduce non-attendance. In the USA, where most appointments involve a financial cost to the patient, non-attendance rates are similar, though there was an association with lack of insurance cover and Medicaid where individuals often have to make some contribution to costs and are by definition poor.[4,7,8] This would suggest that financial penalties would have some effect in reducing non-attendance, but that it would not be substantial. In general, medical staff were not in favour of a system of financial penalties and emphasised the difficulties that would be involved in implementing it. This appears to be at odds with the Developing Patient Partnerships Survey and Hussain-Gamble *et al*.'s qualitative study of primary care team members, although the considerable administrative pitfalls were recognized and, in the latter study, approval of fining was not universal.[1,6] A careful piloting and evaluation of the impact of such a policy on organisational efficiency, costs, and relationships between patients and service providers would be an important preliminary to the development of financial penalties.

Interventions focused on the practice were both directly suggested and implied. Reminders to cancel unwanted appointments seem to reduce non-attendance.[9,10] Some patients recommended that improvements could be made to make cancelling appointments easier. Patients and reception staff also commented on difficulties with the booking of appointments and the effect on relationships. This would imply that improvements in the appointments system would reduce non-attendance rates and their negative impacts.

Data from this study suggests that the quality of relationships between patient, their GP and receptionists is probably a more important cause of non-attendance than the professionals involved realise. Ensuring that patients are given the opportunity to express their choice of doctor at booking would avoid the situation where they are arbitrarily allocated an appointment with a doctor they might feel uncomfortable seeing.

It is clear from the responses of patients that 'ease of access' and 'choice' were important factors in determining: their ability to attend, the chances of them not turning up, and the degree of 'friction' with reception staff. This would seem to provide a powerful argument for adopting systems that improve the accessibility of appointments in primary care such as 'Advanced Access' as advocated by the National Primary Care Development Team.[11] Given the complex interaction between relationships, appointments systems and attendance, significant increases in patient satisfaction and clinical outcomes could result.[12]

Whilst un-booked surgeries would resolve the issue of non-attendance, patients expressed a preference for the appointment system rather than the uncertainties of open surgeries. This does not preclude the use of flexible, heterogeneous booking systems as promoted by the Boston Institute for Healthcare Improvement's 'Idealized Design of Clinical Office Practices' (IDCOP), which is behind the UK concept of 'Advanced Access'.[11,13]

Ease of communication in the event of a patient not being able to attend was an important theme. Making it easier to cancel an appointment might help to reduce non-attendance rates. Answering machines were felt to be impractical. A dedicated cancellation line as suggested by George and Rubin was identified as a potential solution by patients in this study, but was rejected by staff as impractical to implement.[4] However, other methods of asynchronous communication might be utilisable and deserve evaluation such as the use of SMS text messaging or email.

Limitations

It would have been interesting to compare responses between groups. However, this study was designed to

ensure that all relevant issues were uncovered, but does not allow meaningful quantitative comparison between subject groups. The majority of participants were sampled from three practices at one health centre and although this limits the generalizability of the study, the issues raised in this work are likely to be echoed in many practices across the country. However, no participants from ethnic minorities were included and so there may be relevant cross-cultural themes that this study has failed to identify.

Conclusions

Non-attendance is an important issue in primary care as a source of and a reflection of damaged relationships between patients and practices. Non-attendance affects the process of managing appointments systems more than GPs' time. Medical staff did not view non-attendance as especially problematic because they felt they were usually able to use the time productively. Turning up late for booked appointments was seen as more disruptive.

Remedial strategies would need to be straightforward and inexpensive. Financial penalties were, on the whole, regarded as acceptable by patients but not by primary care team members. Improving choice and efficiency in appointments systems and the facility to cancel appointments using modern communications systems such as SMS text messaging were seen as having the potential to reduce the rate of non-attendance.

Acknowledgements

We would like to thank all of the patients and primary care staff who agreed to be interviewed, Mrs Marion Haberhauer who transcribed the tapes, Dr Charlie Davidson of Essex University for his guidance, Mrs Mandy Cullen for her administrative support, and Drs Jonathan Graffy and Steven Abbott for reviewing the research protocol.

Declaration

Funding: the Laindon Health Centre Primary Care Research Team receives NHS R&D Support Funding from the Essex Primary Care Research Network (formerly the East London and Essex Network of Researchers).
Ethical approval: given by the South Essex Local Research Ethics Committee.
Conflicts of interest: none.

References

[1] Developing Patient Partnerships. The forgotten millions: missed GP appointments figures released. Developing Patient Partnerships. 24–8–2004.
[2] Waller J, Hodgkin P. Defaulters in general practice: who are they and what can be done about them? *Fam Pract* 2000; **17(3):** 252–253.
[3] Department of Health. *The NHS Plan: A plan for investment; A plan for reform*. London: HMSO; 2000.
[4] George A, Rubin G. Non-attendance in general practice: a systematic review and its implications for access to primary health care. *Fam Pract* 2003; **20(2):** 178–184.
[5] Neal RD, Lawlor DA, Allgar V, Colledge M, Ali S, Hassey A *et al*. Missed appointments in general practice: retrospective data analysis from four practices. *Br J Gen Pract* 2001; **51(471):** 830–832.
[6] Hussain-Gambles M, Neal RD, Dempsey O, Lawlor DA, Hodgson J. Missed appointments in primary care: questionnaire and focus group study of health professionals. *Br J Gen Pract* 2004; **54(499):** 108–113.
[7] Weingarten N, Meyer DL, Schneid JA. Failed appointments in residency practices: who misses them and what providers are most affected? *J Am Board Fam Pract* 1997; **10(6):** 407–411.
[8] Majeroni BA, Cowan T, Osborne J, Graham RP. Missed appointments and Medicaid managed care. *Arch Fam Med* 1996; **5(9):** 507–511.
[9] Wilkinson MJ. Effecting change in frequent non-attenders. *Br J Gen Pract* 1994; **44(382):** 233.
[10] Hagerman GA. Testing the mailed appointment reminder in family practice. *J Fam Pract* 1978; **7(1):** 199–201.
[11] Oldham J. *Advanced Access in Primary Care*. National Primary Care Development Team; 2001.
[12] Murray M. Patient care: access. *Br Med J* 2000; **320(7249):** 1594–1596.
[13] Kilo CM, Endsley S. As good as it could get: remaking the medical practice. *Fam Pract Manag* 2000; **7(5):** 48–52.