



Royal College of
General Practitioners

Missingness in health care- a 'new normal' is not a level playing field



‘Missingness’

There was a moment of stillness when all routine care stopped in NHS general practice and fear about the impact of Covid -19 was intense. High demand for care seemed to melt away, practice waiting rooms were silent. GPs across the UK allowed themselves to think- where are our patients?

Missingness in health care is not a new phenomenon. It has been hidden in plain sight for many years; and when it does feature it is more often with a focus on what it means for services¹; *‘xx patients did not attend their GP appointment last month which is xx appointments that could have been allocated to other patients’*.

In the places where marginalisation is common; a person grappling with poverty, the struggle with problem drug use, the experience of homelessness; missingness in health care has been more visible at the patient level. Efforts have been made at practice level² and service level³ to increase attendance and engagement with care.

Our recent research about patterns of missed appointments at the patient level was undertaken when face to face patient contacts were the norm. It brings missingness in health care into mainstream view and has important implications for the *‘new normal’* of health care provision going into the future.

Research

From our linked general practice and secondary care dataset of patients registered with 155 practices across Scotland, 54%, (297,002) patients missed no appointments and 19%, (104,461) patients were *‘high missers’* missing on average 2 or more appointments per year.

We found that patients who miss more than 2 GP appointments per year were likely to be socially vulnerable and have poorer health outcomes. Patients who experience high socio-economic deprivation, those who are aged 19-30 and over 90 years of age were most likely to miss multiple appointments.

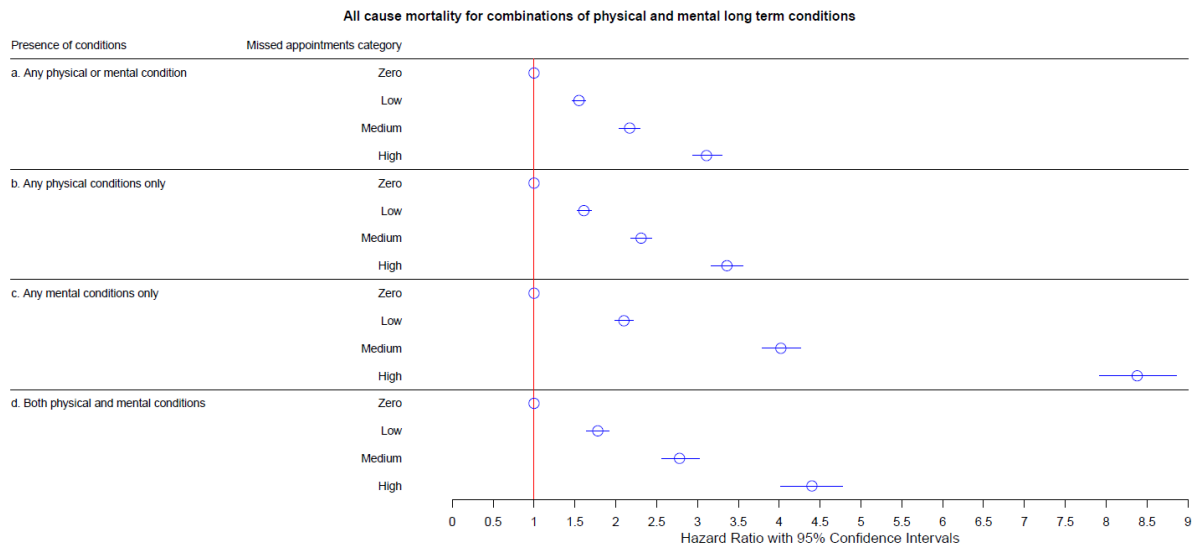
At the GP practice level the strongest predictor of missing multiple appointments was a practice appointment delay of 2-3 days; and patients who experience high socio-economic deprivation who were registered in practices in affluent settings (pocket deprivation) were at highest risk of missing multiple appointments⁴.

We found a *‘dose response’* with morbidity and mortality outcomes- patients with more long- term conditions were at greater risk of missing multiple appointments.

The stark finding though is that missing multiple GP appointments was a strong risk factor for greatly increased mortality. This was the case for patients with more long-term conditions (controlling for number of appointments scheduled) and this risk increased with the number of missed appointments (independent of morbidities).

We were shocked to find that patients with long-term mental-health conditions missing more than 2 appointments per year had more than 8 times the risk of all-cause mortality

compared with those who had long term mental health conditions but missed no GP appointments.



Patients died at a younger age, and commonly from non-natural external factors.⁵ We are due to publish a paper soon from this dataset about how missingness stacks up in hospital care.

The future

Pretty quickly across the NHS fears about what had happened to patients being missing led to action- patients were encouraged to contact services; *'the NHS is open'* when serious health issues arose.


The taps into *'candidacy theory'* which amongst other things, asks whether patients consider themselves to be eligible for care⁶.

There is now a focus on what *'new normal'* should be in general practice care as we learn to adapt. We are all grappling with what remote consulting means for patient care; and the role that digital literacy and poverty might have in that.

If we are to be serious about general practices' contribution to tackling health inequalities, reducing early deaths, and improving care for all patients as we move into this future, then imagining what a *'low threshold-high fidelity model of general practice...defined by the ease of access of those most commonly excluded'*⁷ would look like needs to be part of that.

It is useful to ask ourselves:

How *permeable* are our services for patients? What does appropriately accessible general practice care look like for our whole practice populations?



Who within our practice population would benefit from *sticky care* from the practice team? What does the practice need to do to stay linked in with patients who have need but whose engagement in care is low?

In Scotland it is heartening that the Government has recognised that health care needs to be different going forward in the policy guidance about the NHS's recovery from Covid lockdown; '*Strengthen relationship-based approaches, and provision of support to those who might be missing (eg not using virtual methods, or who DNA from routine appointments).*'⁸

This research on missingness in health care demonstrates that however general practice care develops, missingness is a patient safety issue. What patients need to achieve equity of health care provision; is not a level playing field.

More information about the research can be found here:

<https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/research/serialmissedappts>

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