Barnham&Raynor

Primary Care Access Research: report

January 2022

SURREY COUNTY COUNCIL

Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

Executive summary

Main research aim

To understand perceptions of access to and delivery of Primary Healthcare in Surrey Heartlands, via the Triage First process, amongst a representative sample of residents.

Key findings

- **Wide variation** in experiences depending on practice, IT literacy, individual circumstances /abilities/ disabilities & the medical issue.
- **Many struggle with access**: in reality, most claim to be directed on-line or to the phone and given appointments into the future (on-line) or the same day (phone).
- This fails to serve the needs or wants of most residents, most of the time.
- Only a **very small number have wholly positive experiences**. These individuals are IT literate and at surgeries that have 'fully functioning' Triage First systems in place.
- Those with **learning & sensory disabilities require special attention** to enable them to operate independently.

Conclusions

- The **Triage First process for Primary Care access should work but in practice often fails to**.
- To address this issue, **BOTH phone & on-line access should be available AND** the system needs to **accommodate urgent appointments as well as routine**/non-urgent appointments.
- The system needs to **flag those with disabilities** and provision be made to meet their needs.
- **Educating residents** in how to access Primary Care is another essential development.

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Detailed research objectives

To understand:

1. Current perceptions around NHS Primary Care.
2. User experiences of digital and non-digital methods of access and their impact on satisfaction - including positives and negatives.
3. Citizen perceptions around the use of triage to support efficient use of resources.
4. The impact of Covid-19 on Primary Care and the likelihood of residents not to use Primary Care because of this.
5. Perceptions of future Primary Care access and whether more people can be supported to access digital services.
6. The appetite for a number of potential digital tools/innovations online.

Research approach

27 x remote and face-to-face paired depths with Surrey residents:

7 x Low Income	3 x Voluntary Excluded 4 x Involuntary Excluded
4 x Long Term Conditions	2 x Voluntary Excluded 2 x Involuntary Excluded
4 x Learning Disabilities	2 x Voluntary Excluded 2 x Involuntary Excluded
4 x Older Respondents	2 x Voluntary Excluded 2 x Involuntary Excluded

5 x 'Advocates'
3 x 'Reluctant Acceptors'

- Age breaks: 25-40, 41-65, 66-80
- Geography: spread of urban, small town and rural residents
- Maximum of two respondents per GP practice
- 4 x Respondents from ethnic minorities

All sessions conducted between 25th Nov. & 16th Dec. 2021

Primary Care: pre-Covid expectations and practices

Primary Care access pre-Covid

- **Access recalled as being easier prior to first lockdown – most called the surgery:**
  - To make an appt for that day if urgent
  - To make a future appt if it was non-urgent
  - Occasionally to speak to the doctor if there was no need to see him/her
- **Even before Covid, some could make appts with their GPs online** – access to a calendar to book themselves for a future date
  - Those with digital access liked it; book at a time convenient to them
- A small number of elderly patients went to the surgery & waited
- Some empathy with GP surgeries evident – overworked/under-resourced
- Also, a belief that it was/is important not to waste NHS/GP surgery time:
  - A+E & walk-in centres only used in emergencies or out of hours
  - 111 used as above
- LIVI known by some pre-Covid, but none recall using it then.

Accessing GP surgeries pre-Covid

Whilst not completely ideal pre-Covid, Primary Care access was understood, it felt personal and patient-centric and most here had confidence that they would get attention & treatment if, and when, they needed it.

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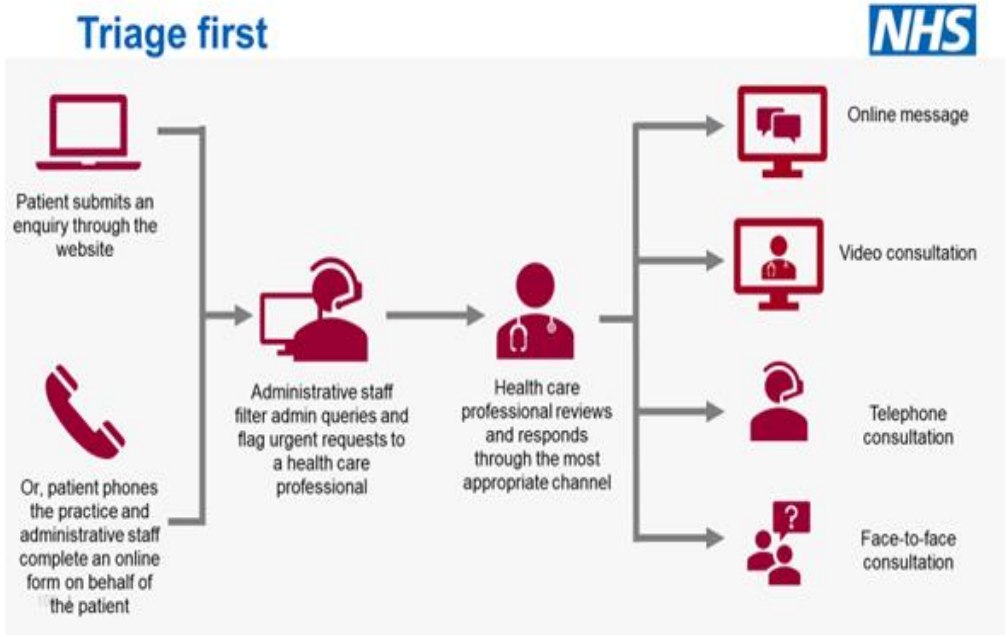
Triage First: in theory and in practice

Triage First: in theory



In principle, this process should work BUT key parameters omitted:

- **Information & education for patients** so that they know what to expect and feel sense of control over health outcomes
- **Opportunity for patient to differentiate between routine/non-urgent and emergency appointments** & make informed decision in terms of what they need/want
- **Timeline** from point of contact to consultation
- **Recognition of/flexibility to accommodate special needs** of some individuals

Triage First: in practice - overview

Immediately clear that there is wide variation in what patients experience – the 'Triage First' model is not being delivered consistently across all practices. Also, timeframes from contact to consultation vary widely.

For e.g.

- Some practices no longer allow website access whilst others steer all patients to the website & barely allow calls.
- Several practices only make appointments on a day by day basis, thus forcing all to be treated as emergencies even though a future appointment would suffice.
- Digital access often only allowed in surgery hours not 24/7.
- Information about how to access Primary Care is available on practice websites, but for IT illiterate, this is not helpful.

Subsequently, many feel confused and out of control re accessing their GP.

Triage First: in practice - overview

But there is also evidence of very successful access to Primary Care:

- Often younger IT literate that report the best experiences, but some older individuals too.
- Their GP practices seem to have implemented the Triage First system to perform optimally for both the practice and its patients.
- It accommodates both urgent and non-urgent cases via both the phone and digital platforms.
- The practices have often adopted other technologies for efficient running of all facilities e.g., check in on screen on arrival to avoid queueing with those waiting for other reasons; menu on phone for repeat prescriptions, test results, emergency appointments and non-urgent appointments.
- Also ‘practice partnerships’ expand the pool of healthcare professionals and specialisms offered.

Patients in these practices feel confident and in control of the attention and care they receive. Systems and processes in place to facilitate the right treatment at the right time.

Triage first: in practice - overview

Different resident typologies have different needs and experiences, but there is a lot of common ground:

Low Income

- Life experiences, work and income tend to mitigate against confident IT usage
- On-line form filling is challenging or impossible
- Phone option preferred, but either not available or all call at 8am for appointments that day only
- Real struggle to get seen/heard

Long term conditions

- Sensory disability requires special attention regarding communication & case should be flagged at all times/points of contact
- Medical conditions mean that patient faces regular appointments to manage condition and reassure – some practices accommodate well; others don't

Learning disability

- Those living independently want to take control, but system often fails them
- No 'easy read' form, so need help to complete it
- Also, receptionists to be trained in communicating with LD patients and understanding their needs to avoid anxiety & behavioural issues

Triage first: in practice - overview

Different resident typologies have different needs and experiences, but there is a lot of common ground (continued):

Older people

- Often IT illiterate or less confident
- Striving for independence and not to be a burden
- BUT when forced to complete on-line forms, often need help from family/helpers
- Some also need help/support from receptionist to complete form via phone

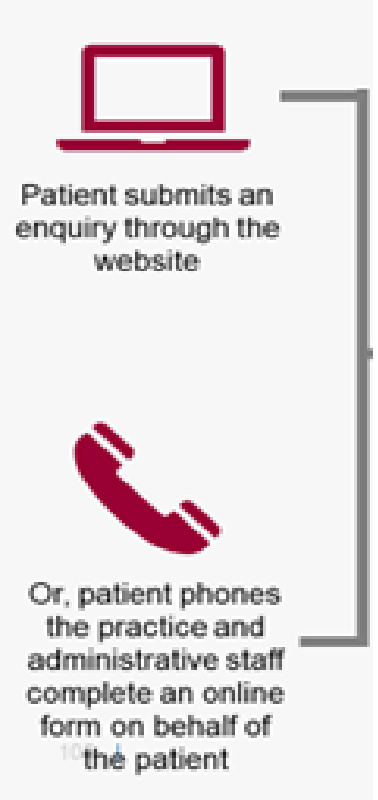
Advocates

- All have positive experiences – successful contact and treatment, often entirely remotely from surgery
- BUT criticisms too...
- Successful experience dependent on forward thinking and sensitive surgery, partnership arrangement and IT competence

Reluctant acceptors

- Also report some positive experiences – IT skills mean on-line not an issue
- BUT at surgeries with poor websites and/or rigid, counter-intuitive systems e.g., appointments only via phone, all calls at 8am, appointments only for that day, Doctor calls on un-recognised number, etc

Triage first - contact in practice: *What works well*

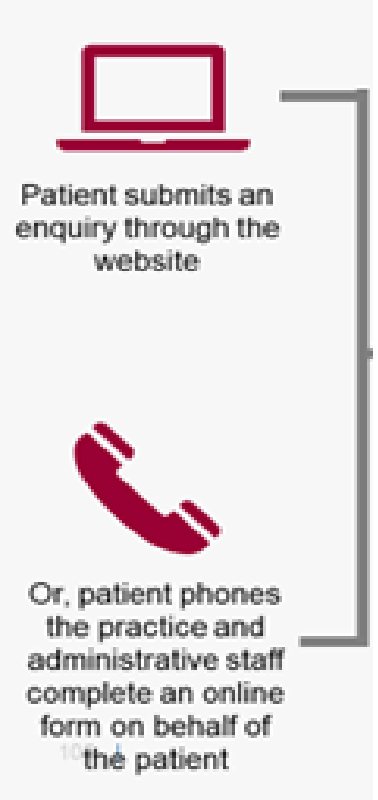


"It's got much better recently. They called in a day with an appointment for a week later on the phone. Then I got a text from the Doctor to say what he thought the issue was & a link to some information and a link to upload a photo. A week later I got another text from my Doctor confirming that the dermatologist agreed with his diagnosis & telling me how to treat it. Problem solved!"
(Advocates; F 41-65)

"We had LIVI at our surgery for 6 months of lock down and that worked really well. And even now the system works well for routine and repeat things and if you don't need to speak to someone."
(Advocates; M 25-40)

"It worked well during lock down. They told me when the Doctor would phone and he called when he promised. Also, texting to upload a picture of my cyst worked well. A nurse followed it up and the problem was dealt with. You don't always need to go into the surgery."
(Advocates; M 41-65)

Triage first - contact in practice
Need for improvement



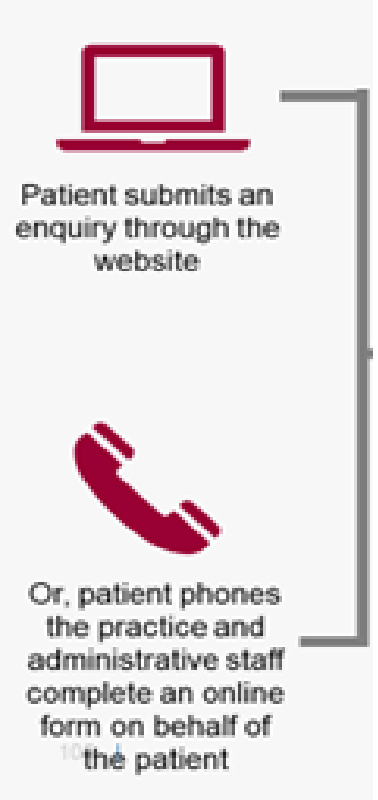
"They've shut on-line triaging so you have to phone our surgery. But when on-line was working, it was very hard to find 'appointment booking' in the menu. The website is very clunky."
(Advocates; M 41-65)

"If you call, you hang on for ages & then you're told to go to the website. There you fill in an e-form – 5 pages – but you can't complete it at the weekend. Why not?"
(Reluctant Acceptors; M 66-80)

"You call and you're told to go on-line or onto the app to make an appointment. But I can't use the website or an app. I want to talk to someone. We're not being properly looked after."
(Low income; Invol. Excl M/F 41-65)

"You have to go on-line & fill in a form, but I need someone to do it for me. I don't understand 'Doctor Speak'. And then you might wait a week before they come back to you to tell you when the appointment is."
(LD; Vol Excl F 25-40)

Triage first - contact:
Ideals for the future



Online AND phone options available in every practice for appointments that day AND future appts

Website access:

- **Tab for 'book appt' clear and easy to find**
- **Usable 24/7**
- Enquiries acknowledged to confirm receipt at least
- Commitment to time frame for confirming appt date/time
- **Opportunity to book on-line for BOTH urgent and non-urgent appts**

Phone access:

- **Calls answered during practice hours – NO requirement for all calls at 8/8.30am for appts that day and that day only-treats** all appts as emergencies
- **Facility to book future appts** always an option
- Admin staff to complete form in private space when patients call – not on broadcast to waiting room/surgery

Triage first - filtering in practice: *What works well*

"I did have an emergency and I was seen that same day in this new system. So it did work for me."
(Low income; Vol Excl F 66-80)

"If it's an emergency, you phone and get put on a list and as soon as Doctors become free, they work their way through the list that day."
(Advocates; F 41-65)

"That does feel about right – but they are only doing it during surgery opening hours."
(Advocates; F 41-65)

Triage first - filtering in practice: *Need for improvement*

"You wait on the phone for ages for someone to answer and then you can't get past the receptionist. Also, they have to rely on me correctly reporting my symptoms (at 80 yrs old)."
(Low income; Invol Excl F 66-88)

"You have to ring at 8.30, but I am often at work then and by the time they pick up, all the appointments for that day are gone. So you have to try again the next day. I'm not sure that they are flagging urgent requests."
(Older respondent; Invol Excl F 66-80)

"It does feel as though they are discouraging you from seeing a GP. There's a massive gatekeeper system."
(Advocates; M 25-40)

"How qualified are the admin staff to make these decisions? Also there's a big delay between filling in the e-form and speaking to a healthcare professional - and it does rely on the patient to accurately convey how they feel."
(Reluctant Acceptors; M 66-80)

Triage first - filtering:
Ideals for the future

Is receptionist right person to flag emergencies?

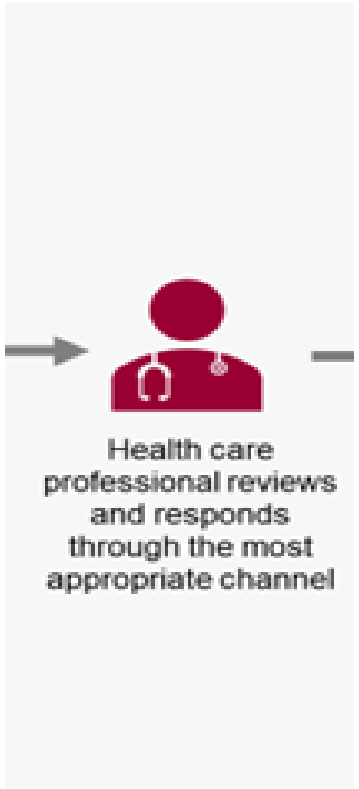
- Medical training seems essential

Treat all equally – review all on-line and phone requests together and prioritise on case-by-case basis for genuinely urgent appts – don't hand out appts on first come, first served basis based on calls only

AND why can't some self-triaging by patients take place?

- Patients flag emergencies via menu option on phone or unique tab on-line
- OR make own appt on-line, via app and/or by phone for future date for routine/non-urgent issues
- **…to reduce pressure on admin staff first thing in the morning**

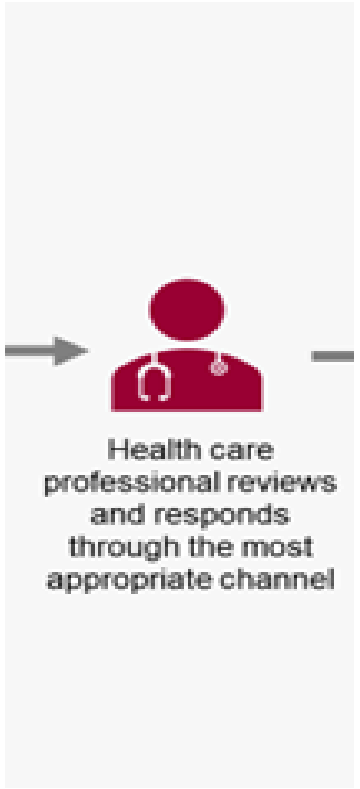
Triage first - review in practice: *What works well*



"They did call back within 2 days and then followed it up with a urologist appointment. It worked well for my daughter. All sorted without leaving the house."
(Advocates; M 25-40)

"It seems always to be phone consultations that they give you, or the very occasional video appointment."
(Advocates; M 41-65)

Triage first - review in practice: *Need for improvement*



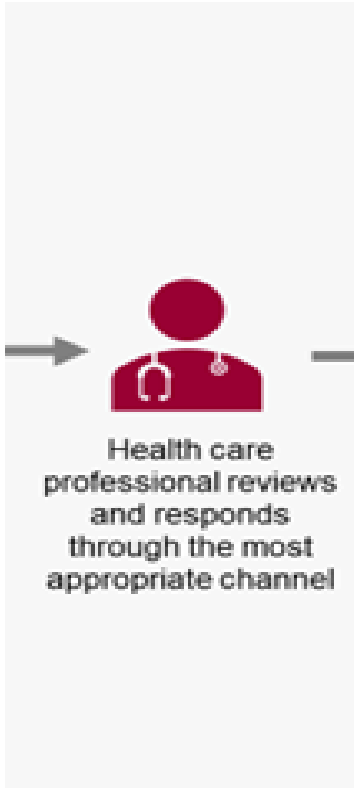
"I had an awful ear infection. I rang on Thursday and didn't get a phone appointment until Sunday. Shouldn't they have come back sooner and asked to see me to look in my ears?"
(Low income; Vol Excl F 41-65)

"It's hard to get a face to face appointment. It's nearly always phone. Once a nurse called, but they'd told me it would be a doctor. Also, they call from unrecognised numbers so I didn't pick up and then I'd lost my chance."
(Reluctant Acceptors; M 66-80)

"They do call back to tell you when your phone appointment is – but you often wait for 2 weeks for the appointment. I don't see why we wait so long. Surely phone appointments are more efficient than face to face appointments?"
(Low income; Vol Excl M 66-80)

"They often send me 'no reply' SMS messages from the surgery asking me to phone to confirm that I can make the appointment."
(Life long profound deafness; Invol Excl M 66-80)

Triage first - review:
Ideals for the future



Some feeling that this and previous stage should be rolled into one task and all issues filtered by healthcare professional – is this possible?

Vast majority of cases are dealt with via phone consultation – is this always the first line of response?

Contact to confirm day/time of phone appt should be within 24, or at most 48 hours, of query – some are waiting up to a week

Inform patients of the number that will be used for contact so that it is recognised and accepted – and agree with patient what number to call them on.

Triage first - consultation in practice: *What works well*

"In the past, I always tried not to have a phone appointment because if you missed the call, you missed the appointment. But now they try again."
(Advocates; F 41-65)

"Last week I was given a face to face appointment. I felt so reassured and well looked after. But I only got it after a phone appointment when the Doctor decided that he needed to see me."
(Long term condition; Invol Excl F 66-80)

Triage first - consultation in practice: *Need for improvement*

"A lot go to the walk in at A&E because they can't see their own Doctor My Doctor says he hates the system. He wants his patients face to face in the surgery."
(Advocates; M 41-65)

"The patient should be able to decide if they need to see a Doctor and whether it's urgent or non-urgent without the triage system. Then we could book advance appointments on-line and only call in emergencies."
(Reluctant Acceptors; M 66-80)

"I've never been offered a video appointment and that could be helpful if I had something to show them. But I'd need my son to help me."
(Low income; Invol Excl F 66-80)

"I need to see someone for my back, my cataracts and my burst ulcer, but the GP doesn't want to know. I don't get an appointment. I have been to the walk in centre in desperation. It's why A&E is so crowded."
(Low income; Invol Excl F 41-65)

Triage first - consultation:
Ideals for the future

In reality, these are linear, not parallel, options –

- No-one receives an on-line message as an immediate response – though a few have had on-line message as a follow up to a phone consultation
- Tiny minority of video consultations
- Vast majority are phone calls
- Followed up with face-to-face appointment if GP wants to see patient.

As a linear process, there is opportunity to work well

BUT parallel system should also exist:

- Non-urgent future appointments bookable on-line
- Video or phone – Doctor to decide if face to face follow up is necessary

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Triage First:
alternatives and future initiatives

Alternative digital options

NHS App

- Some have NHS app - and are impressed with it to date
- Use for proof of vaccines and repeat prescriptions
- Clear and easy to use; imbues confidence in user
- Feels safe and secure

Other Platforms

- ‘Patient Access’ and ‘E-consult’ mentioned by name by some
- Both criticised as laborious, clunky, but usable

LIVI

- Some have seen ads in GP surgeries
- Small number have used – system in place for them in first lockdown free of charge:
  - Easy to understand and navigate, quick and responsive
  - Happy to accept ‘unknown’ doctor – the situation is urgent....
- If LIVI ongoing digital platform and free of charge, IT literate patients entirely happy to use.

Alternative digital platforms

"I'd stick with the NHS app. Getting an appt that way would be much better."
(Older; Invol. Excl. M 66-80)

"E-consult just says someone will get in touch with you. There's no guarantee."
(Reluctant Acceptors; M 66-80)

"Making appts online should be quicker in theory and you could do it anytime, and anywhere."
(Low Income; Invol. Excl. M 41-65)

"Texts are great – Boots text me when my repeat prescription is ready."
(Advocates; M 25-40)

"There's E- Consult, Ask my GP. The NHS needs to unify its apps and databases."
(Low income; Vol. Excl. M 41-65)

"I saw a bus advert for it (LIVI) and downloaded the app. I'd use it if I couldn't get a GP appointment."
(Advocates; F 25-40)

Potential future initiatives

NHS App

- Very positively received.
- Based on experience of the current NHS App, assumption is that it will work well in future as functionality extended.
- Simple to use.
- 24/7 access to surgery.

Automated notifications

- An essential element of a future system - communication always needs to be **two way.**
- Notifications reassure patients that they are in the system, have successfully made appointments etc.
- Notifications via app or text. Emails can also play a possible role.

Potential future initiatives

Smart machine learning (AI)

- For some, accepted as potentially more reliable than an unqualified receptionist – and an inevitable development in time?
- Others suspicious that the system could be ‘gamed’ – key words etc.
- Yet others horrified at prospect – totally impersonal and very risky.

Chatbot on screen

- Some have successfully used in the past, but most reject this idea.
- Chatbots can be viewed with some degree of cynicism – standard FAQs.
- But if they do help navigation of the surgery home page then they may have a role to play.

Potential future initiatives

Voice recognition

- Some appeal – to those with poor IT skills, or who find typing difficult.
- Feels more private - at home; personal details not ‘broadcast’ in surgery reception.
- But marginal impact – only for a minority of patients.

Training and guidance

- Clear need for better education about any new system implemented.
- A lack of communication during Covid is a key factor in the current situation.
- Essential, however, not just to explain the system – guidance also key.

Future initiatives

"They don't tell you what is happening. They don't get back to you at the moment."
(Older; Vol. Excl. M 66-80)

"AI is a terrible idea. People would game the system. It would be all over social media."
(Low Income; Invol. Excl. M 41-65)

"I'd love to use an app (that worked). It would be way more convenient."
(Reluctant Acceptors; F 41-65)

"Chatbots are not helpful. 'Live chat' is just a robot pretending."
(Low income; Invol. Excl. M 41-65)

"Leaflets would be good, but it's the receptionists that need to be trained – not us."
(Low income; Invol. Excl. F 41-55)

"Being able to talk to the computer would be better. It would save typing."
(Older; Vol. Excl. M 66-80)

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Conclusions and recommendations

Conclusions

- **Access to Primary Care is not working well** for many Surrey residents a lot of the time.
- This is not because the Triage First model is broken, but because **it is not being delivered optimally, or consistently**, across the county.
- Also, there is **no timeline** attached to it.
- Therefore, **experience is highly variable**.
- A **small number are extremely satisfied** with Triage First. Their surgeries have implemented the system to deliver optimum performance, creating a contact process that is both flexible and accommodating. They have used technology to complement and enhance the phone option. This results in an approach that seems to work for both the GP surgery and for patients.

Conclusions

- **Many have had poor experiences**.
- They **struggle to make contact** with the surgery and then either **fail to get an appointment**, or have to **wait ages**. In many practices either the **phone or the on-line system is the only channel** available for contact. And then to compound the problem, **only appointments for that day are available**; there is **no opportunity for advance booking.**
- Also, practice websites, where available, are often clunky and difficult to navigate.
- Few, if any, practices seem to have clearly informed patients of their options for contacting the surgery.
- Critically, **many do not create clear distinctions between urgent and routine/non-urgent access/appointments**. Some surgeries make the mistake of treating all patient contacts as if they are potential emergencies – when many patients know they are not.
- In effect, **practices have a single access channel.**

Conclusions

- Those with **learning difficulties and/or sensory disabilities emerge as the most critical of the Triage First system**.

- Those with **learning difficulties** are mainly unable to cope with on-line form filling (there is **no 'easy read'** option), or subject to a lack of understanding in surgery - and hence liable to anxiety, with behavioural consequences.

- The **sensory impaired** are left **bewildered by persistent text messages asking them to 'call the surgery'** when they have profound deafness or blindness.

Recommendations

- What is needed is a **more flexible and agile system** that allows **phone and digital access** for both **urgent/that day appointments AND future, non-urgent appointments**.

- To work optimally, it might well be that **parallel digital systems** are required as well as **different options via the phone** – for urgent **OR** non-urgent enquiries – so click on tab A or B or press 1 or 2 on the phone menu.

- The **NHS app** could be the platform or a platform employed for digital contact /communications/appointments, though a few favour a surgery specific website/app to gain a sense of a more personal relationship. Confidentiality on the NHS app is not seen as a problem.

Recommendations

- Many assume that **more/advanced technology will be adopted over time** to reduce reliance on staff in practices. As long as the developments deliver an enhanced service for the patient and feel patient-centric rather than solely practice-centric, then most can accept this. With the proviso that any additional/enhanced digital platforms and channels are easy to understand and navigate, and that provision is always made for the IT illiterate.

- Those with **learning difficulties and/or other sensory disabilit**ies will always need a **more bespoke** or more specific route to accommodate their needs. These people need to be carefully noted, and flagged, when contact is made, to ensure appropriate communication and the right channels are adopted.

- Taking a **pro-active stance to patient education** and guidance on how to access the surgery and approaches to adopt for urgent and non-urgent attention is also recommended. If patients are equipped with this knowledge, it is likely to deliver some peace of mind and confidence, which seems to be lacking in many residents currently.

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