ADULTS AND HEALTH SELECT COMMITTEE

3 March 2022

SURREY HEARTLANDS INTEGRATED CARE SYSTEM COVID-19 RECOVERY – CITIZEN INSIGHTS INTO GP ACCESS

Purpose of report: To update the Select Committee on the activity being undertaken by Surrey Heartlands ICS to develop models of access for primary care that reflect the needs of our citizens, supported by co-design with stakeholders.

Introduction

1. Following the report to the Select Committee in October, which included an update on the Surrey Heartlands COVID-19 Recovery Programme, this paper expands on the current co-design process, which is supporting the development the new model of access to primary care.

2. Primary Care GP services have traditionally been accessed by citizens in a consistent way for many years. If we became ill or needed help from our GP practice, we phoned the surgery to make an appointment (or more recently book one online), in order for a doctor to call us back or to go in for a face-to-face appointment.

3. Changes to this traditional access model had been in development for some time, firstly as part of the 2016 GP Forward View[1], which helped us consider options for 'online consultations' as a way for citizens to request help from a GP practice. This was developed further as part of Surrey Heartlands response to the NHS Long Term Plan[2] (published in 2019), which pledged to improve digital access to services for our citizens.

4. To support this work, the CCG carried out both qualitative and quantitative research in 2018 to understand the needs and preferences of citizens and GP practices (findings of which can be seen in Annex 1). Several GP practices also took part in pilots during this period to test the functionality offered by the new online consulting tools and help understand which type of system(s) would be most beneficial for our citizens. The results of this were shared via engagement with GP practices, patient groups and other stakeholders, including the Digital Citizen Ambassador from Surrey Healthwatch, to help finalise a set of requirements for the local online consulting service.

[1] https://www.england.nhs.uk/gp/gpfv/
[2] https://www.longtermplan.nhs.uk/areas-of-work/primary-care/

5. As a result of this work, a digital platform (called 'Footfall') that provides both a GP practice website and online access for patients, was procured as a digital front door for GP practices at the end of 2019, with the roll out scheduled to take place over the following 12 months. This meant that when the pandemic hit, Surrey Heartlands was able to accelerate this roll out as part of its response, establishing the digital front door for primary care more rapidly than expected.

6. The result of this rapid change has been that many practices offer citizens greater ability to manage their health and wellbeing digitally. This includes;

   a) practice websites becoming a first point of contact to access help and support,
   b) submitting written requests and receiving an online reply from the practice,
   c) completing consultations using video,
   d) accessing online information on local wellbeing services and much more.

Summary of changes to GP access as part of the pandemic response

7. As we've mentioned, rapid changes were made to both the way citizens accessed GP services and the way in which practices provided care and support to citizens at the start of the pandemic. The driver of these changes was the request by NHS England for primary care to implement a *'total triage'* model, supported by a Standard Operating Procedure (SOP). This helped ensure both citizens and staff stayed safe during the COVID-19 pandemic, while providing a high level of service and support for citizens in Surrey Heartlands.

8. This total triage model saw practices triaging all requests from patients before booking them into an appointment. The appointment would be then either a phone consultation, face to face appointment or online message (e.g. via email or SMS). Requests were received either digitally or over the phone to help minimise the risks related to people attending practices in person without triage.

9. While a number of practices operated a total triage model prior to the pandemic, it became the normal method of access for Primary healthcare across the country. Digital modes of contact have not been developed to replace existing ways of contacting the practice (e.g. via the telephone or in person), but instead give another option for those who want to use it. This can bring the added benefit of reducing inbound call volumes, making it easier for people who cannot use the online option to get through on the phone.

10. The introduction of online consulting and switch to total triage were implemented rapidly and without the level of consultation with citizens that would have taken place in 'normal times' if and when practices make significant changes to their operation.

11. In addition, many practices chose the introduction of online consulting and requirement to triage all requests as an opportunity to move towards a 'total digital

triage' operating model. This sees all requests, including those made by phone, also entered onto the online consulting system and treated within the same workflow. An illustration of how this works can be seen in Figure 1 below.

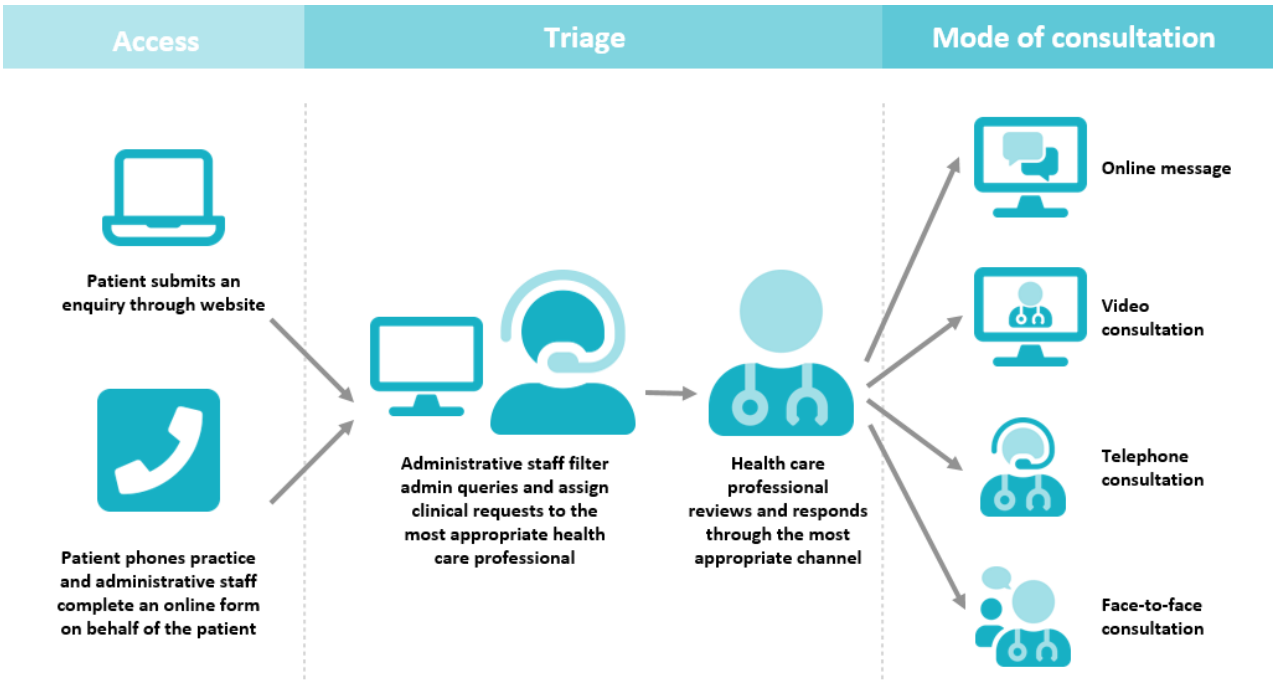

Figure 1: Example of a Total Digital Triage model – providing a consistent patient experience regardless of how they choose to request help

12. Total digital triage uses an online consultation system to gather information and support the triage of patient contacts, enabling care to be provided by the right person, at the right time, using a type of consultation that meets the patient's needs. Patients who don't wish to use the website can continue to call or visit the practice, with a member of the GP practice staff taking them through the form over the telephone or in person. Practices are then able to manage all their requests through a single workflow, prioritising care based on need, rather than having variation depending on how a patient accesses the practice. This approach helps to ensure equity of access between both digital and non-digital users, because regardless of the way a patient chooses to contact their practice, whether in person, over the phone or digitally, their request is dealt with in the same way.

13. As a result of being brought in during the pandemic, the changes to access (such as total digital triage mentioned above), were introduced without the opportunity for further research and engagement, which would have been the case had the change not been rolled out rapidly as part of the pandemic response.

14. This change of approach, combined with the impact of the pandemic, has increased demand in two ways. Firstly, from the number of online requests being submitted, but secondly, many practices are also reporting that the level of complexity has gone up

significantly. Figure 2 below highlights the growth in online requests since March 2020. This has levelled off somewhat following the introduction of controls for the practices allowing them to control access to online forms in periods of high demand, i.e. switching them off when necessary and preventing further requests being submitted when they are already dealing with as many requests as they can safely manage.

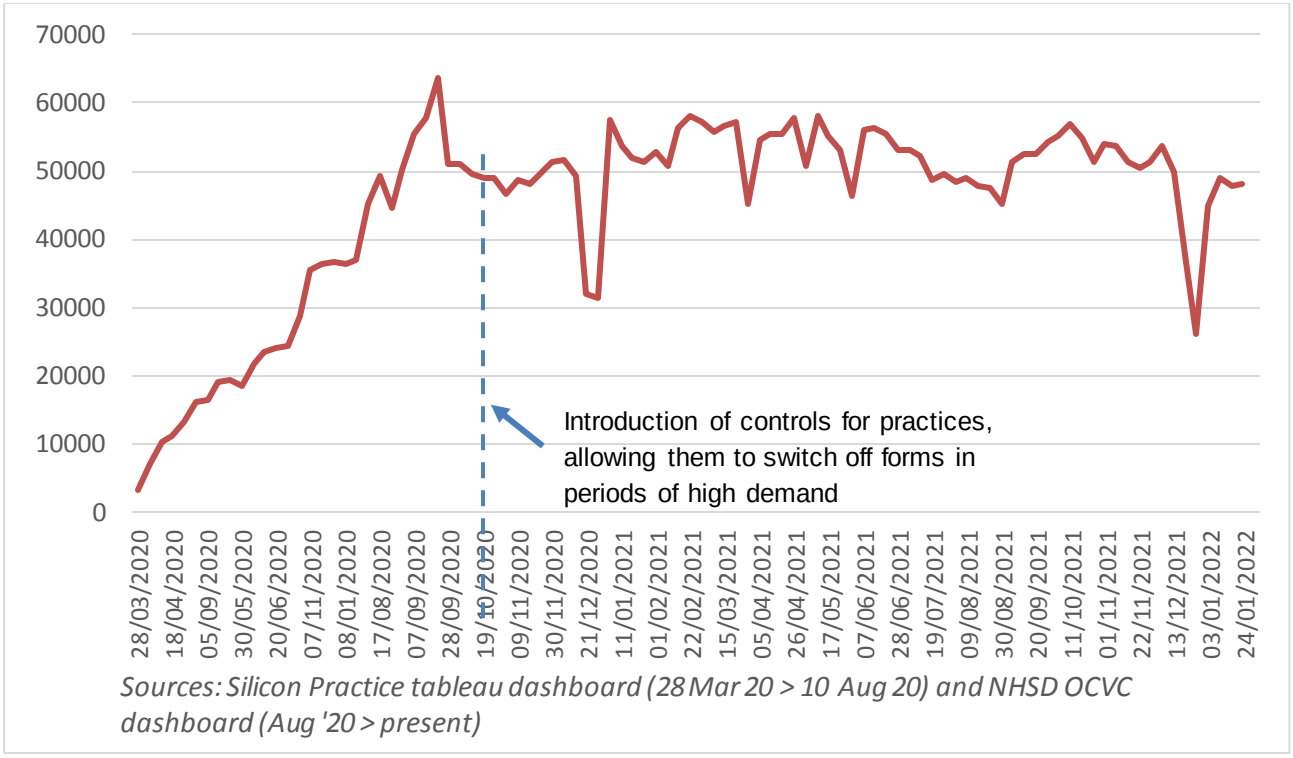

Figure 2 - Total weekly online consulting requests received across Surrey Heartlands

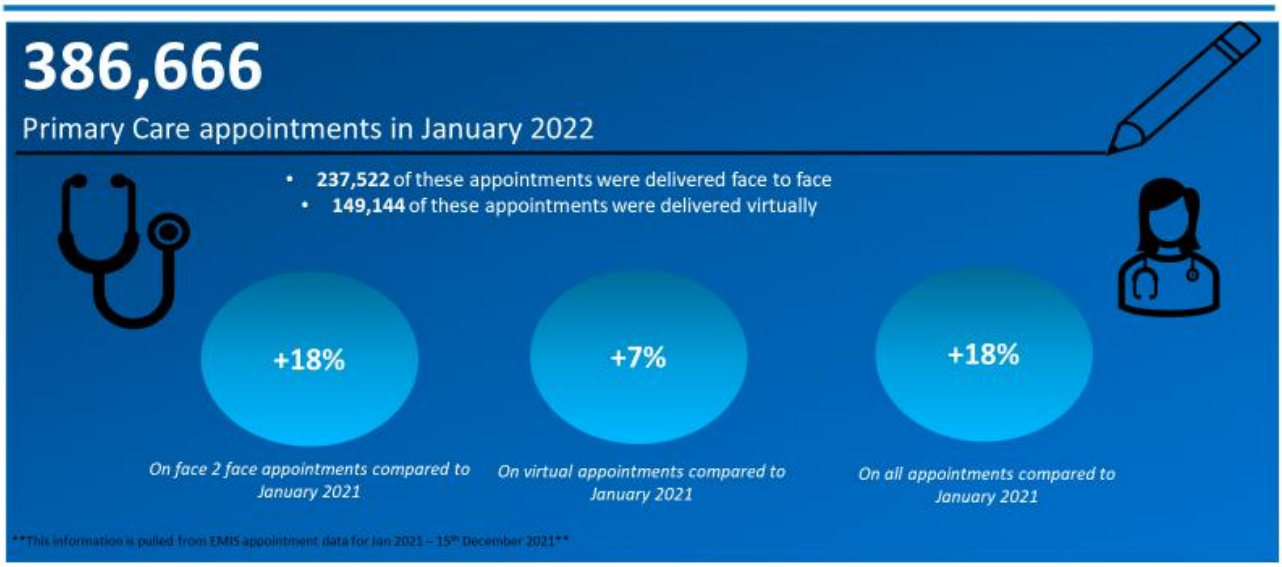

Figure 3: Surrey Heartlands Primary Care appointments in January 2022

15. While the majority of practices still have online consulting access for patients, as mentioned above, some have to restrict access by switching off forms at certain times

of day. An online consulting audit conducted in October 2021 highlighted that 42 practices (40.4%) had forms on between 4-6pm (i.e. covering all opening hours). When checking again when the practice was closed, 27 (26.5%) of practices had forms on, highlighting that just over a quarter of practices have forms on 24/7. These tend to be practices with lower levels of online requests. It is important to highlight that the majority of practices do have forms on at the start of the day, but switch them off when their staff team reach capacity.

16. We know that COVID-19 has had a disproportionate effect on certain sections of the population. This has had the impact of mirroring and even reinforcing existing health inequalities.

17. Feedback about challenges citizens were experiencing when trying to access primary care have been received from a number of sources during the pandemic, these include research and insight gathered via the Surrey Heartlands Research and Insight team in 2021, insights from Surrey Healthwatch around GP access, direct feedback from citizens to the CCG, via local Councillors, MPs and from practices.

18. As the health and care system continues to transition from responding to COVID-19 into Restoration and Recovery, it is vital that while we capitalise on the innovations introduced during the pandemic, we also need to make sure the new, wider multi-disciplinary team (e.g. pharmacists, care navigators, paramedic practitioners) working across Primary Care Networks[3] are used as effectively as possible, while offering access to services in a way that meets the needs of our citizens.

19. Linking to that, the Surrey Heartlands response to the NHS Long Term Plan and work in the Recovery and Restoration workstreams within NHS Southeast Region includes development of a new vision for primary care:

    For all citizens to receive equitable access into primary care through a single point of entry. This single point of entry would allow for a joined-up model of Primary Care that could be built up around Primary Care Networks (PCNs) or Groups of PCNs to direct citizens to the most effective treatment/ service, meaning that citizens can receive the right care, at the right time, by the right person.

20. To help achieve this vision, Surrey Heartlands has started work on the co-design of the model of access to primary care. We are doing this through a design thinking approach, which is 'human-centred', focusing on understanding how citizens would like their GP services to work. This co-design will allow us to develop a model that meets our population's needs both now, and by embedding a process of ongoing review, make sure their needs continue to be met into the future.

[3] Information about Primary Care Networks can be found on the NHS England website - https://www.england.nhs.uk/primary-care/primary-care-networks/ and about the additional roles here - https://www.england.nhs.uk/gp/expanding-our-workforce/

Primary Care Access Research - summarising access challenges

21. To support the co-design process, qualitative research was commissioned through the Research and Insight team of Surrey Heartlands ICS on behalf of Primary Care, using researchers Barnham and Raynor. While the objective included gaining feedback from advocates and reluctant acceptors of the new modes of access, the focus was on some of the groups identified as being the most likely to experience issues around access[4].

22. The findings from this work have been reviewed alongside previous feedback (as described in point 18). This has highlighted a high level of consistency around the challenges that have been experienced when it comes to accessing primary care.

23. It is important to note that the research that has been undertaken is qualitative and as such, we do not know how widespread the key challenges outlined in this section are felt across our populations. However, there were not any surprises or challenges that were expressed during the 27 in depth interviews, as they reflected the feedback already received.

24. A copy of the full report and its findings can be found in Annex 2.

25. The key finding from Barnham and Raynor was that access to Primary Care is not working well for many Surrey residents a lot of the time. This is not because the total triage model is broken, but because it does not appear to be being delivered optimally, or consistently, across Surrey Heartlands. Also, there is no timeline attached to the request, often leaving patients uncertain about when they will receive a reply. Therefore, experience is highly variable.

26. Added to this, as the pandemic has progressed, demand for primary care services has increased significantly. This meant that while the on online service initially made it easier for patients, the improved accessibility of GP practices has made it easier for patients to request help, which in turn has contributed to Primary Care being overwhelmed. This has required them to once again control the flow of incoming requests (i.e. by temporarily switching forms off when they reach capacity) in order to manage them safely.

27. The research showed that some patients are extremely satisfied with Full Digital Triage. Their surgeries have implemented the system to deliver optimum performance, creating a contact process that is both flexible and accommodating (as shown in Figure 1 above). 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.

[4] These groups were identified via insights from Surrey Healthwatch and a Surrey Heartlands stakeholder engagement event

28. People who participated in the research typically reported having poor experiences. They struggle to make contact with the surgery and then either fail to get an appointment or have to wait too long. In many practices either the phone or the on-line system is the only channel available for contact. To compound the problem, only appointments for that day are available; there is no opportunity for advance booking.

29. Taking on board feedback received during the qualitative research, and insights from previous research and engagement, we have collated these themes of feedback to help make sure we can address each of them during the co-design. Using a structure created by Surrey Healthwatch when they were evaluating feedback received around GP access, we have grouped the feedback themes into three main areas; Access, Triage & Consultation Mode. As we have started analysing the research feedback, we have seen areas where they overlap and impact each other. These have been visually mapped in Annexes 3 and 4, which look at the benefits to patients of total triage and then challenges currently being experienced.

30. Looking at this from the practice perspective, we can also see the 'flip side' of these themes. For example, where the patient wants an online 24/7 request service, managing that demand can be difficult because when that access is 24/7, it becomes easier to submit a form to a GP practice than to visit a local pharmacy to ask about a minor illness. Added to this, there are also challenges around managing the expectations of the patient, when an immediate response is expected in many other areas of their life (e.g. 30 minutes delivery windows).

31. Previously patients were able to book appointments for non-urgent requests and they didn't mind waiting for these. However, with the increased demand from online requests, patients aren't as prepared to wait and want responses within a much shorter timeframe. This is partially down to the evolving perception around online services in other sectors such as retail and food delivery, and partially due to lack of understanding of the restricted resources available and processes within practices.

32. Although providing a patient with multiple channels of access is important to give citizens the option that best suits their circumstances, we need to be aware that this can create multiple channels of activity for the practice. Managing and prioritising those multiple workflows can be difficult and there needs to be a simple and easy consolidated way to manage this to reduce the pressure on the service and maintain the capacity and resources to effectively work through them. This is where 'best practice' needs to be more clearly communicated to practices.

33. Understanding the status of a request is a key feedback theme from patients, as well as on the practice side when it comes to monitoring progress of referrals. The practice is often the go-to for an update, but without integrated systems, they don't know any more than the patient which can cause further frustration and delays.

34. Multiple touchpoints for the patient increase repetition of conversations and duplicates potentially unnecessary contact.

35. There is a lack of efficiency surrounding video consultation, which does contribute to the very low usage (which is a national picture). The technology should be seamless and allow a natural switch over from telephone to video consultation to encourage it's use. It shouldn't be seen as an alternative to F2F but a complementary part of phone triage.

Work underway to address challenges

36. There are a number of projects and programmes already underway within Surrey Heartlands ICS which are looking to address the access challenges identified. These key areas of work can be broken down into six sections:

1) **Remote Consulting Procurement** – The current co-design process will help us understand how citizens would like the new remote consulting tools (things like online and video consulting, text messaging and the websites) support their access to primary care. These requirements will be used to evaluate bids from suppliers when we go into procurement later this year.

2) **Second Phase Insight** - Additional research will be commissioned to get a more in depth understanding of the needs of people with learning disabilities, sensory disabilities, people with English as a second language and carers (both adult and young carers).

3) **Primary Care Co-Design / Training & Support** – This sees us including people working in GP practices in the co-design process. We will also identify and share examples of best practice, where both patients and practice teams are using the tools effectively.

4) **Citizen Co-Design** – Working with citizens to get feedback on the challenges identified and co-design the model of access to primary care to help address the challenges while maximising the benefits of recent changes.

5) **Communications & Education** - To co-design patient communication that help citizens understand the changes taking place around access to primary care and the benefits it can bring to them and their families.

6) **Cloud Telephony** – There will be a significant investment in cloud telephony for Surrey Heartlands practices over the next 12 months which will support the implementation of the co-designed model of access.

7) **Increased support for community mental health –** A separate report updating on the implementation of the Community Mental Health Programme in Surrey is also coming to this Committee on 3 March. The programme includes rolling out GP Integrated Mental Health Service / Mental Health in Integrated Care Systems (GPimhs/MHICS) teams across all Primary Care Networks in Surrey by 2023/24. GPimhs/MHICS

provide quick and easy access in primary care to patients with significant mental health issues and their carers whose needs are not met by the Improving Access to Psychological Therapies services (IAPT) and do not meet criteria for adult secondary care. This is therefore an opportunity for early intervention before patients may become further destabilised and unwell.

37. The key access challenges that have been identified are summarised and mapped against the key areas of work either planned or underway to address them. This table can be seen in Annex 5, along with a Venn diagram summarising it versus the key stages of the patient journey (Access, Triage and Consultation Mode).

Conclusions:

38. Feedback regarding access to primary care from different stakeholders across Surrey Heartlands over the last 18 months has included many consistent themes. The recent qualitative research from Barnham and Raynor has validated this and added additional insight to help support a co-design programme of work to help address the challenges highlighted.

39. We are currently aligning existing work underway to help address these issues as well as identifying additional areas needed. These will be informed via a co-design approach. The plans are being closely co-ordinated to ensure a cohesive and joined up approach. This will help develop and deliver an access model for primary care which will continue to develop and evolve, taking advantage of new innovations and technical developments as they arise.

Recommendations:

40. To invite Committee members to provide feedback and comments on the outlined approach.

41. To encourage Committee members to share information about this work with citizens as and when relevant, helping promote the associated engagement and co-design activity. The Surrey Heartlands team will link in with the Surrey County Council Communications team to facilitate this.

Next steps:

42. The 'Work Underway to address challenges' section above and detail in Annex 5 summarises the work planned and the identified challenges it will address.

43. An additional piece of research will be commissioned to help understand more about the experiences of some additional groups with specific needs, to support the insight phase.

44. We will be progressing with the co-design development, including the establishment of a citizen co-design community with which to validate assumptions and explore possible solutions.

45. This robust process will help create a set of the requirements for the remote consulting procurement which is taking place this year. That will help make sure that the requirements for aspects such as online and video consulting, SMS messaging and websites meet the needs of our citizens as far as possible. It will also lay out the expectations of the supplier in terms of development.

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