DIGITAL FIRST PRIMARY CARE

LONDON BOROUGH OF HACKNEY HEALTH SCRUTINY COMMITTEE, 12th MARCH 2019

A BRIEFING NOTE FROM GP ACCESS LIMITED

GP Access Limited is grateful to the Committee for the opportunity to provide information about our *askmyGP* digital triage system and its underlying philosophy.

Our first concern is for patients as looking after them must be the core purpose of the NHS and any health care system, including ours.

Background

It is hard to escape from news that the NHS is facing unprecedented demand on its services and staff.

Primary care and specifically General Practice are under particular pressure. The features of this pressure include:

- High demand for face to face (f2f) consultations that overwhelms supply.

- An average length of consultation that often exceeds the standard ten-minute slot, leaving patients who do get appointments waiting.

- High volumes of did not attends (DNAs) or, other words, wasted appointment slots.

- Patients often unable to get through to their practice, particularly at peak times.

The consequences include long waiting lists for patients and stress for the whole practice team that can be exacerbated by abuse from frustrated patients.

The Government is placing a great emphasis on the provision of digital solutions to meet these challenges. The options include online access to self-help (e.g. the NHS website), online booking of appointments or repeat prescriptions and video consultations.

We agree but also strongly believe that, whatever solutions are put in place, there is a need for patient demand to be understood and triaged at an early stage. This is to ensure that only patients who <u>need</u> to see a GP or other clinician have access to that healthcare professional.

For general information about our approach, please visit https://askmygp.uk/ .

GP Access Limited

GP Access Limited was incorporated in October 2011 and was originally devoted to the introduction of telephone triage into UK General Practice.

The unique contribution that GP Access made was a structured change management programme, supported by a suite of performance analysis tools to support practices during the change process and provide a before/after comparison of performance post-launch.

This process enabled GPs to contact patients to discuss their request for f2f appointments in the light of the GP's clinical judgment and the patient's medical history. This equipped GPs to determine the most appropriate response to meet the patient's need. Only around a third of requests required a f2f slot, saving considerable amounts of GP time and allowing a faster response.

Based on the rationale at Appendix 1, the company launched in March 2015 a new online tool called *askmyGP* to enable patients to submit requests (NB not book appointments online) at any time. We are now on Version 3 of the tool.

What is *askmyGP*?

It has always been our view that clinical judgment is at the heart of the triage process.

Consequently, *askmyGP* is not an appointments system and does not use artificial intelligence (AI) software that diverts patients.

Online booking has an immediate attraction but carries the significant disadvantage that it is another way for unfiltered demand to get an appointment, often resulting in patients with more serious needs unable to get an appointment and a high proportion of DNAs.

Equally, we are not a software vendor. There is no software for practices to download. The system is operated via a secure portal. In addition, the latest version goes well beyond simple triage facilitated by modern technology.

askmyGP is now a complete workflow solution for the management of patient need, regardless of list size, demographic or practice structure. It is SCCI0129 and IG compliant and indemnity is unaffected. It supports consistent triage and clinical decisions via a single workflow. It is accessible via any web browser.

The principle of a single workflow (what we call total flow), i.e. all demand being entered into the system, was pioneered by some of our user practices at their initiative. This is now our routine recommendation to all practices committing to using our service. Our User Group of GPs and practice managers provides a forum for users to discuss and propose this kind of change to our system. We have adopted most of the changes with what is seen by our users as impressive speed.

The approach (and its attendant statistical analysis) is applied to all demand, regardless of whether it arrives in the practice online, by telephone or walk-ins.

Access for patients

Informed consent and registration are straightforward for patients and proxies, e.g. parents and carers. Those unable to access the service online can still place requests by phone/walk-in if required, ensuring equity regardless of channel used.

Where a request stems from a telephone call or walk-in, a receptionist will create it for the patient, gathering information using the same questions that the patient would answer if they were online. Clearly, however the request is submitted, the greater the information provided the more efficient the process is likely to be. We do recognise that some patients might be unwilling to disclose details of their symptoms or problem, but this can be recorded on the request.

Patients may choose self-care advice from the NHS website and are clearly warned about not using *askmyGP* in emergencies. A free text interface records patient ideas, concerns and expectations and patients can attach a photograph to their request, if they wish. This was introduced early this year and is already proving popular. Interestingly, the use of video consultations has not been significant with only 1% of requests being resolved in this way.

Members may wish to experience the patient interface by visiting our demonstration site at https://bramleysurgery.co.uk/.

Practice response

Practices have access to a range of tools to respond to requests for helps. These provide real flexibility to tailor the response to the patient in line with clinical need but also, as far as clinical judgment allows, patient preferences.

The channels for the response include messaging, video, telephone and f2f consultation. *askmyGP* maintains the role of practitioners at the heart of decisions, reinforcing the relationship between patients and their practice team. A diagram of how the approach works is attached as Appendix 2.

The system is based on requests being assigned to an individual for a response. In some cases, this assignment may be to a group, e.g. an admin team. Good practice, again derived from our users, is that this initial sift is done by a GP. Requests may be reassigned if appropriate, e.g. a GP having reviewed a request may reroute it to a nurse.

The workflow is managed via a portal, as already explained. A dashboard provides a complete overview of the demand coming into the practice that day and provides access to patient requests. A view of the dashboard is provided in Appendix 3. There is the option to flag requests as urgent or immediate and this immediately highlights them on the system.

Practices go through a comprehensive change management programme resulting in patient response times of minutes and an ability to offer same-day f2f appointments, if needed.

Performance

In the 45 practices using *askmyGP*, the number of requests being handled now stands at 13-14,000 per week.

But volumes are not the most important part of the picture. We are delivering a service that is making a real difference to the lives of patients and GPs. To hear GPs talking about their experiences please view the videos from:

- Dr Barry Sullman, Balaam St Surgery in Plaistow, London with a list size of 6,000.

- Dr Sue Arnott, Burnbrae Medical Practice in Shotts, North Lanarkshire. List size of 5,000.

- Dr Steve Kell, Larwood Health Partnership, a five-site practice in Nottinghamshire with a list size of 32,870.

But what of patients? Our practices are providing response times in minutes (median time-to-complete = 89 minutes, n = 92,115). The chart at Appendix 4 provides the figures for the eight weeks

ending 25th February 2019. Requests taking more than 24 hours to complete will include requests where the GP is awaiting a response from a patient, requests submitted outside working hours (patients are alerted to the fact that responses will take longer) and, perhaps, where a request has been assigned to a GP or other member of the practice team who is not working that day.

High uptake by patients (some practices as high as 80% online) reflects the utility of *askmyGP* for both patients and practices and the quality of our change management provision. Patients are provided with a feedback facility to give us their views of the system directly. The feedback on the latest version of the system (v3 launched in September 2018) is overwhelmingly positive. The chart at Appendix 5 shows the proportion of patients scoring the system as better than then previous system up to 28th February 2019.

One issue that is raised by GPs is the fear that demand will increase as access for patients is improved. Our experience is that this is not the case. The chart at Appendix 6 shows that weekly demand for our total flow practices after launch as a percentage of the busiest week (including tests before launch) is flat. The dip in all the practice records is the Christmas week.

What we can also see is that the overall proportion of online requests from patients increases with their personal use of the system. This implies a growth in confidence in both the practice response to demand and our approach. The chart at Appendix 7 shows the figures for our total flow practices and highlights this in more detail.

The benefits to practices include a reduction in stress and the possibility, through the reduction in telephone calls or the use of locums as examples, to reduce costs.

Continuity

Continuity is seen as important by both GPs and the Government.

Interestingly, our experience suggests that 75% of patients when asked to express a preference choose to see any GP rather than a named GP. Nevertheless, as Appendix 8 shows, continuity where patients have expressed a preference can be achieved for the majority.

It should be noted that, where a different team member from the one selected closes the request, this might be for perfectly sound clinical reasons, e.g. a GP reassigning a request to a nurse practitioner or vice versa as described above.

Core questions of the review

We believe that our approach, the lessons that we have leaned on the way and the data gained from talking with practice teams has provided us with a real body of knowledge. We would answer your review questions in the following way:

a) **How can the NHS safely integrate digital approaches to primary care with existing health and care pathways whilst not unfairly destabilising existing GP services?**

A key principle of our work is that we are here to assist and work with practices. Existing GP services are not destabilised. We work with existing practices bringing the benefits of digital first standards. Our approach does not interfere with the operation of clinics, for example, and some

practices have taken the opportunity to stand back and reassess how they work as a practice. This is not destabilisation but responding to the opportunities presented by new ways of working.

b) How can digital developments facilitate better outcomes for patients?

We measure outcomes continually. Queues disappear and the vast majority of can be offered same day service. Continuity with named doctor is also built into the system and measured. This enables practices to get the best out of the system. Speed of access and flexibility of response can only facilitate the provision of appropriate care.

c) How can they ensure better access and better outcomes for ALL equality groups and how can digital solutions improve how demand is managed and how unmet demand is assessed?

Because the system enables complete workflow management, GPs are far more efficient and unmet demand disappears. GPs choose who needs to be seen face to face, typically only 30%. Total flow ensures that all demand is put through the same approach, ensuring equity of treatment. This cannot be said of online booking.

d) Digital solutions cannot be silos and how can they fit within a 'whole system' approach and how can they help the development of more 'whole system' approaches?

We totally agree with this sentiment. We adopt a whole system view of the practice operation, of which digital is one component, but our intervention is not only adding software, it is system change.

e) How can digital solutions deal with safeguarding issues in relation to vulnerable patients?

Around 80% of our requests are from patients, 15% from parents and 5% from carers on behalf of others. Wherever a patient is associated with another as a parent or carer the relationship is flagged up whether the parent or child is called up. Our system is also used in conjunction with the clinical system. It does not replace any it.

f) How might digital enable the development of a more Systems Approach to improving primary care across health, social care and third sector providers?

Very good question. This is what we aim to do wherever we can work with numbers of practices in a locality, as we are doing for example in Weston-Super-Mare or in deed multi-site practices such as the Larwood Health Practice. We are already considering how we might support the working of the new Primary Care Networks. Because our system is standalone in its core operation, we can work with practices operating any clinical system. Our data analysis tool can also use data from any of the clinical systems.

g) What is the demand for primary care and what is the unmet demand, and can digital primary care approaches perhaps assist with the latter?

We have 7 years of data on demand which is key to our work. It means we can predict with high precision the demand in GP by day of week, even by hour. This means the system can be designed

both with the right capacity and for very rapid response. It turns out that demand is then flat, it does not rise as service improves and all demand is met, as already discussed.

h) This has had a degree of success as the numbers are small and it is in London only. If this is scaled up nationally where will all the additional doctor time come from?

We work with around 45 practices in England, Scotland and Wales across a range of practice types, sizes and demographics. The approach means that the online requests are not additional activity, but activity displaced from telephone and walk-ins. The segmentation of demand means that the response is more appropriate to the needs inherent in each request.

Summary

While the pressure to use online services is coming from Government, the reality is that it can make the lives of patients and GPs better.

But online access of itself will change nothing. Only if that demand is managed through a workflow approach and that approach is supported by the segmentation of demand, however, will the full benefit to patients and practices be realised.

Ian Barratt
GP Access Ltd
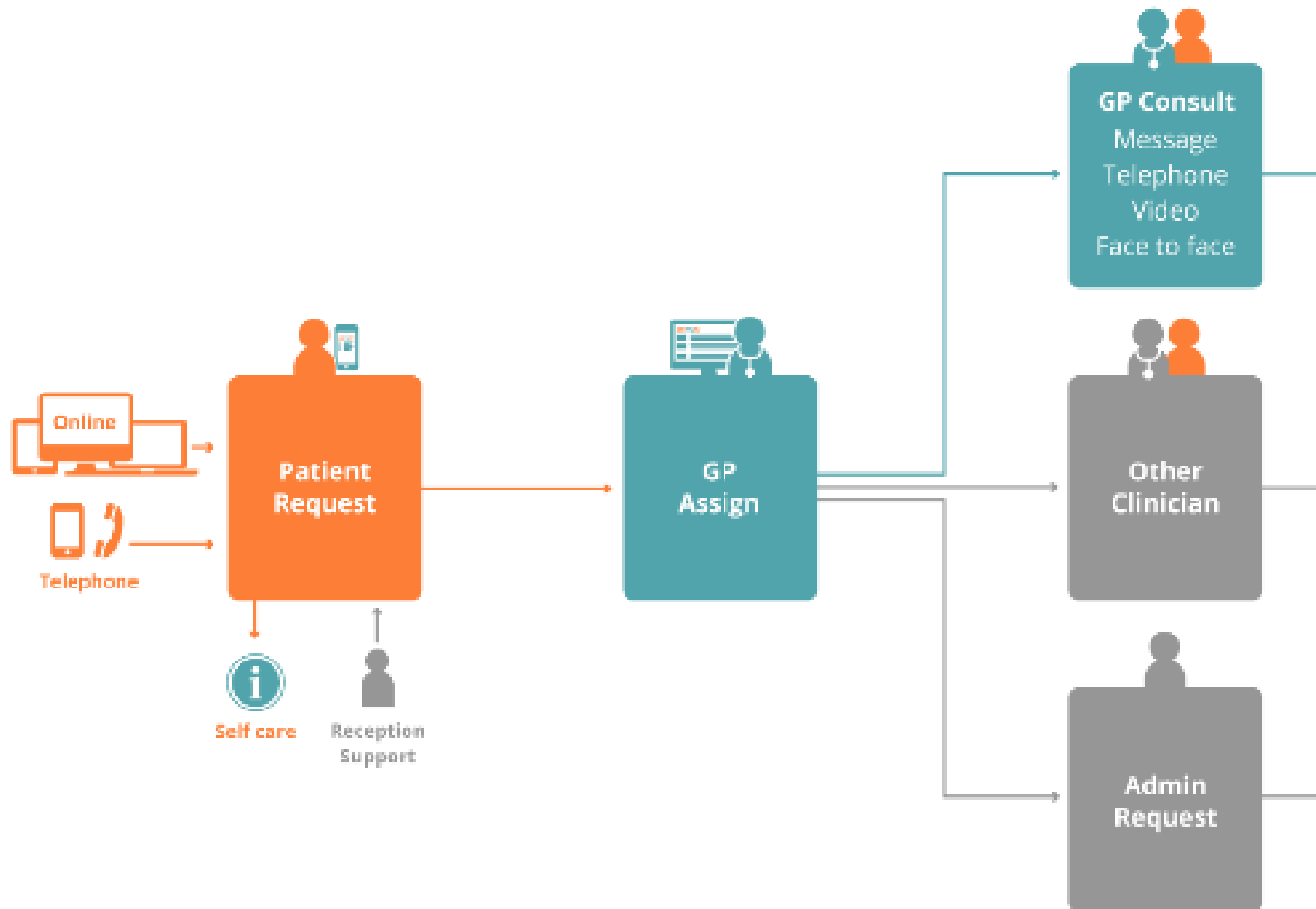1st March 2019

Appendix 1 – Rationale for online triage

Appendix 2 – How the approach works

Appendix 3 – The practice dashboard

Appendix 3 – The practice dashboard

askmyGP

Bramley Demo - not for patients

- Home
- Dashboard
- Requests
- Patients
- Staff
- Settings
- Reports
- Isabel
- Guide
- Send Feedback

Ian Barratt
Logout

Demand & Capacity

Site: All Sites

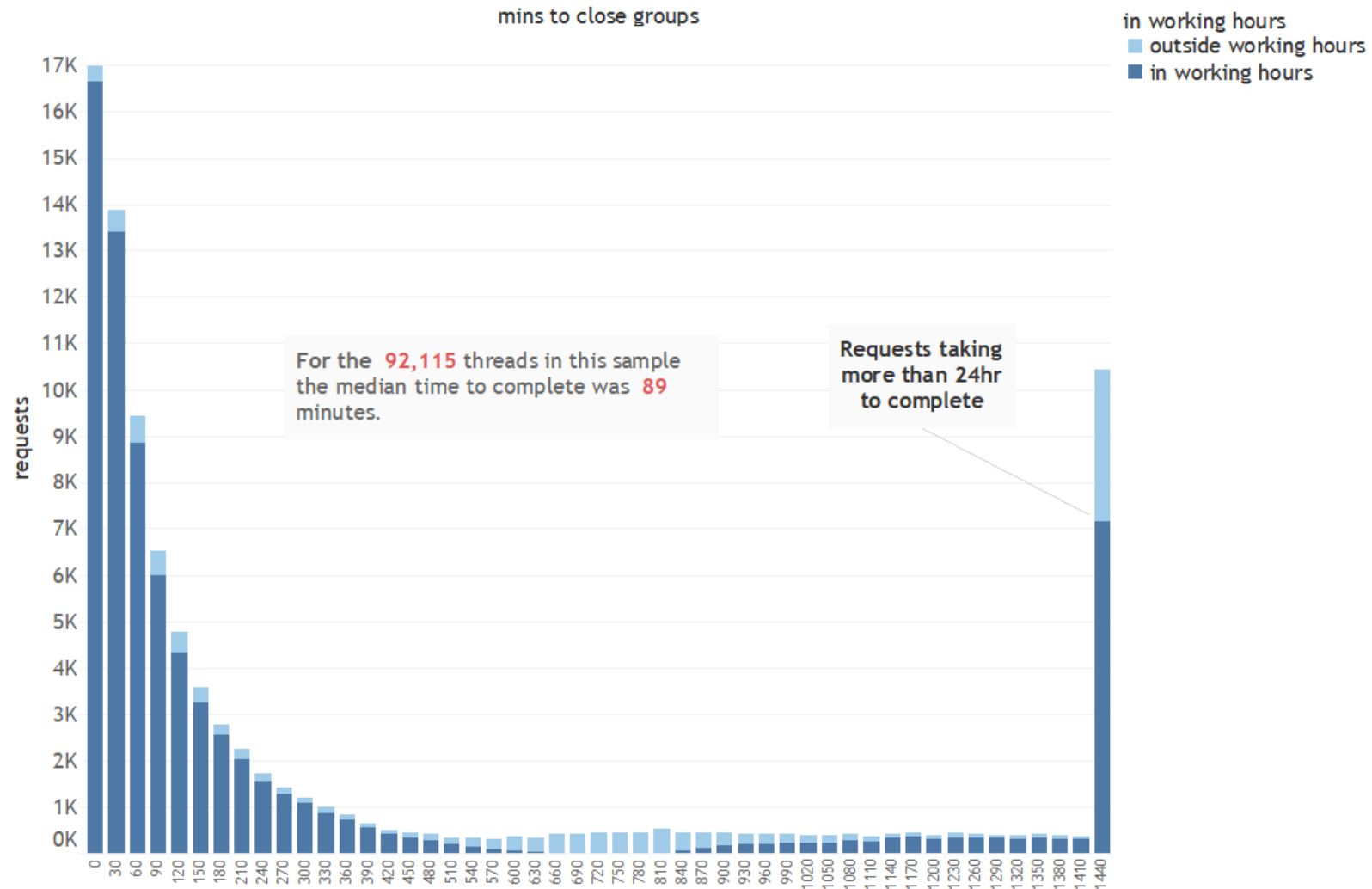| New	Assigned	Waiting	New today	Completed today
3	93	0	0	0

					Thursday 28th	Friday 1st	Monday 4th	Tuesday 5th	Wednesday 6th
Predicted Demand					160	140	310	210	108
Estimated Capacity					224	142	335	190	235

| | Now | | So far today | | | | | | |
Clinician	Assigned	Waiting	Assigned	Completed	Thursday 28th	Friday 1st	Monday 4th	Tuesday 5th	Wednesday 6th
James Grieve									
Tom Dodd	1	0	0	0	24	37	50	25	50
Andy Walker	3	0	0	0	40	10	25	25	15
Russett									
Ian Barratt	10	0	0	0	30		60	50	45
Steve Black	10	0	0	0	80	20	50	40	50
Julia Cawthorne	6	0	0	0					
Debbie Ford	7	0	0	0		25	50		25
Rufus Helm	4	0	0	0			50		
Harry Longman	8	0	0	0	50	50	50	50	50

Edit Demand & Capacity

Appendix 4 – Response times

distribution of completion times latest 8 weeks
all providers

mins to close groups

in working hours
- outside working hours
- in working hours

For the **92,115** threads in this sample the median time to complete was **89** minutes.

Requests taking more than 24hr to complete

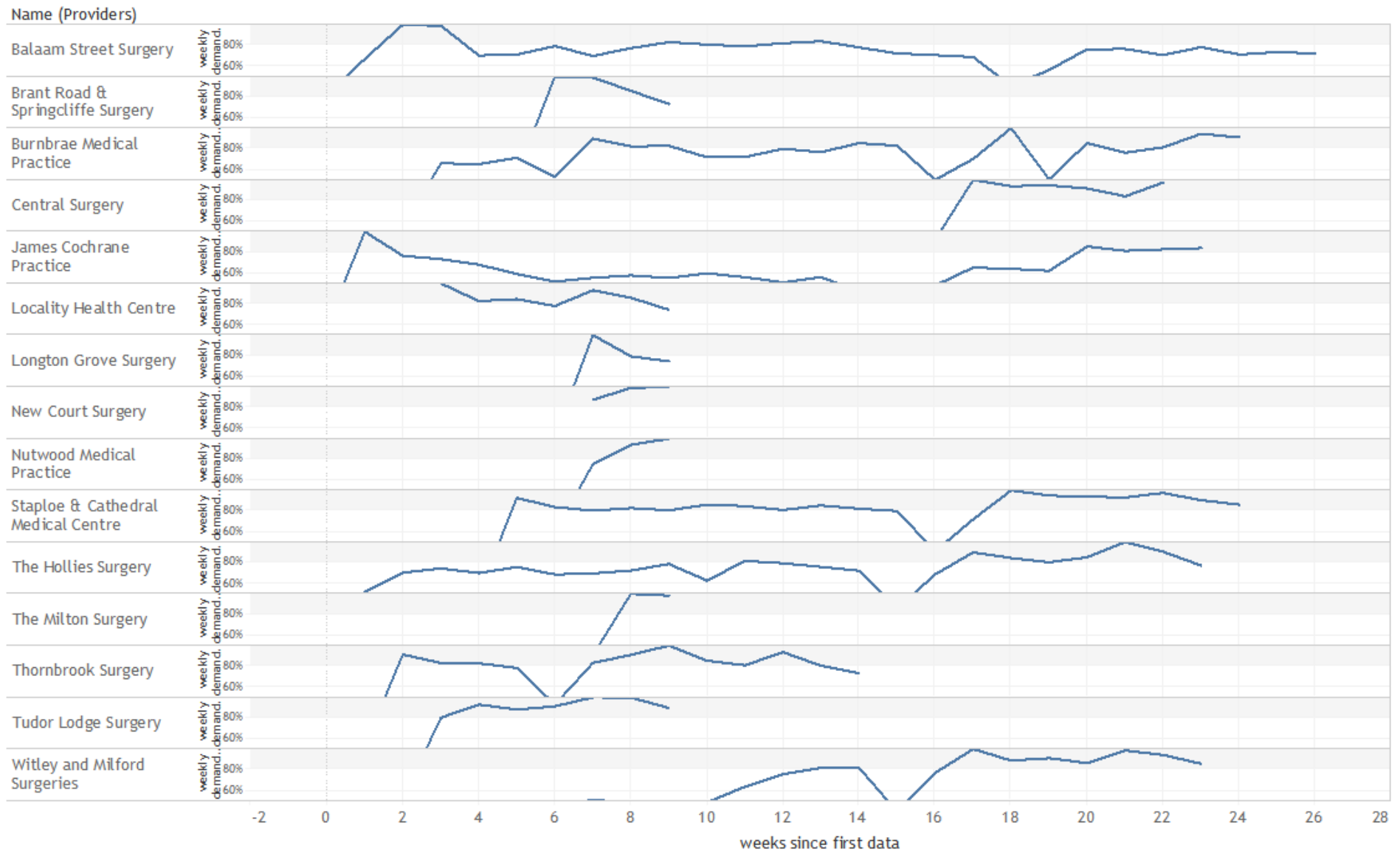**Appendix 5 – Patient satisfaction**

Overall patient feedback askmyGP v3
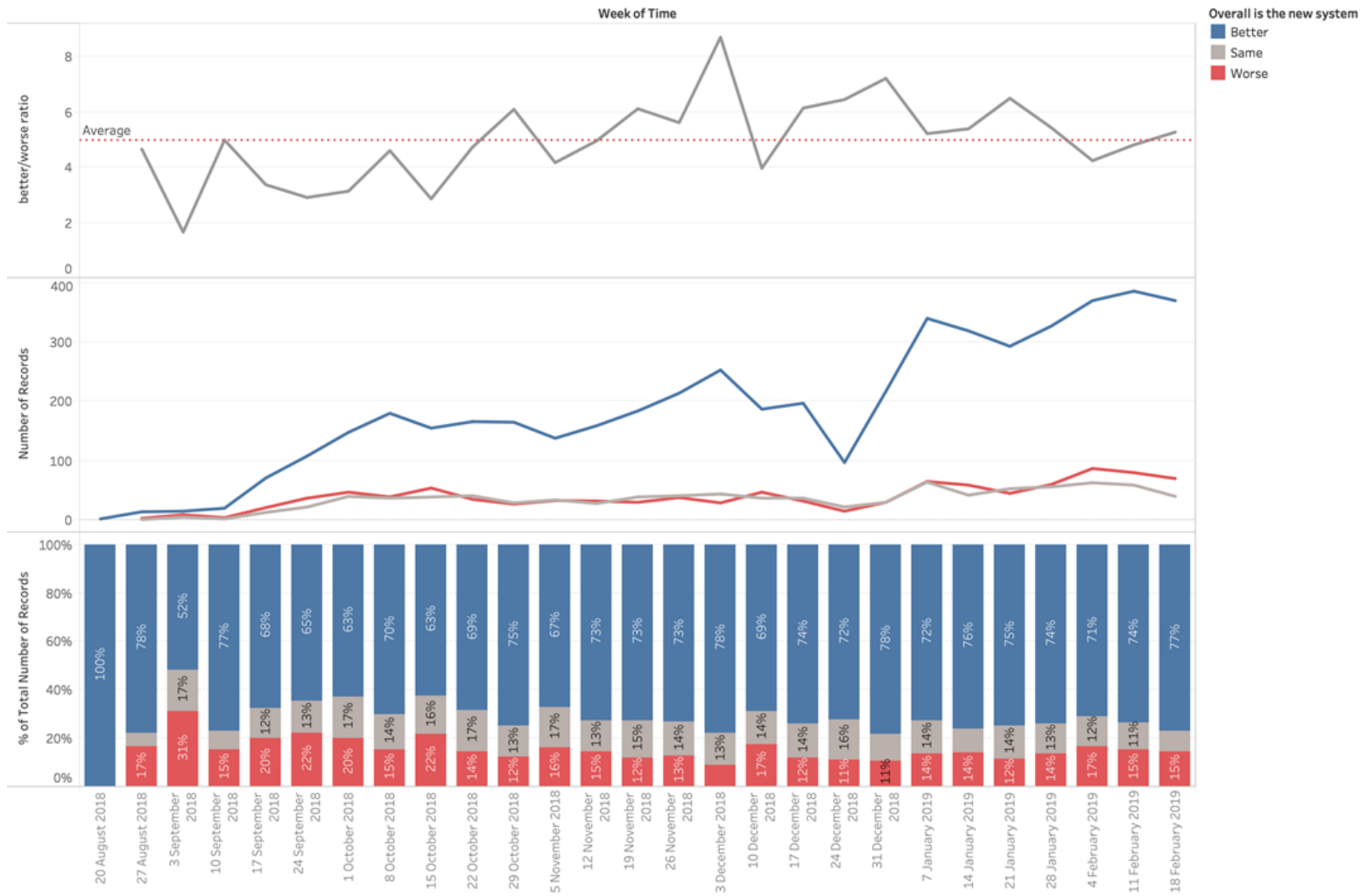
Appendix 6 – Trends in demand

weekly demand as % of busiest week by no. weeks since first askmyGP activity (including tests before launch)
total flow practices, complete weeks

Name (Providers)

Balaam Street Surgery

Brant Road &
Springcliffe Surgery

Burnbrae Medical
Practice

Central Surgery

James Cochrane
Practice

Locality Health Centre

Longton Grove Surgery

New Court Surgery

Nutwood Medical
Practice

Staploe & Cathedral
Medical Centre

The Hollies Surgery

The Milton Surgery

Thornbrook Surgery

Tudor Lodge Surgery

Witley and Milford
Surgeries

weeks since first data

Appendix 7 – Online usage increases with individual patient usage

mix of demand source by frequency of system use
total flow practices, 2019

uses per patient

demand source
- Null
- online carer or parent
- online patient
- telephone

uses per patient	telephone	online patient	online carer or parent
1	59%	30%	11%
2	47%	41%	12%
3	41%	47%	12%
4	34%	55%	11%
5	30%	59%	
6 or more	20%	72%	8%

Repeat uses of askmyGP are more likely to use the online system rather than phone access
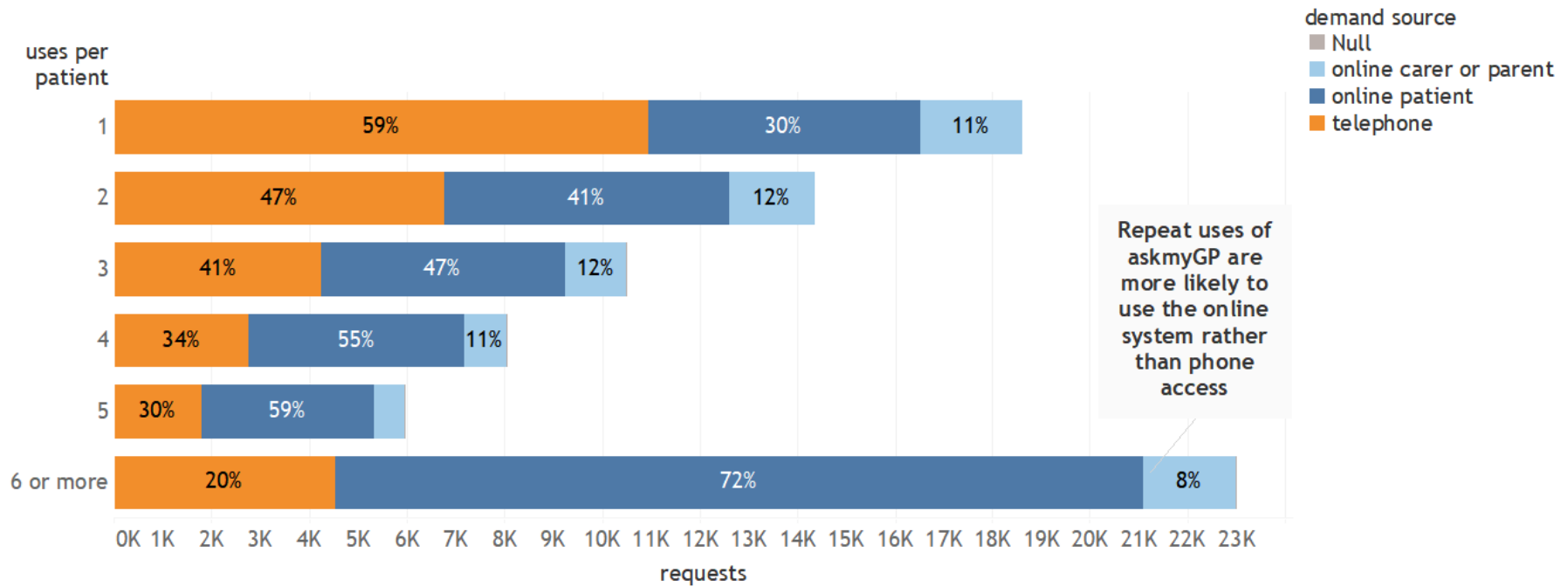
requests

Appendix 8 – Continuity

Continuity: did patients get the staff they requested?
Based on requests where patients stated a preference and chose a named member of staff (the majority of
patients didn't want to request a specific member of staff)