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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Wednesday 24 March 2021
10.00 am
Virtual Committee

Members:
Councillor Mrs Aspinall, Chair
Councillor James, Vice Chair
Councillors Sam Davey, Vacancy, McDonald, Nicholson, Parker-Delaz-Ajete, Tuffin and Tuohy.

Members are invited to attend the above virtual meeting to consider the items of business overleaf.

This meeting will be webcast and available on-line after the meeting. By attending the meeting, councillors are consenting to being filmed during the meeting and to the use of the recording for the webcast.

The Council is a data controller under the Data Protection Act. Data collected during this webcast will be retained in accordance with authority's published policy.

For further information on attending Council meetings and how to engage in the democratic process please follow this link - Get Involved

Tracey Lee
Chief Executive

Health and Adult Social Care Overview and Scrutiny Committee

1. Apologies

To receive apologies for non-attendance submitted by Committee Members.

2. Declarations of Interest:

3. Minutes **(Pages 1 - 4)**

The Committee will be asked to confirm the minutes of the meeting held on 27 January 2021.

4. Chair's Urgent Business

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

5. Health and Adult Social Care System Performance Report **(Pages 5 - 12)**

6. Covid and the impact on health inequalities - verbal

7. General Practice Update and Econsult **(Pages 13 - 84)**

8. Restoration and Recovery of Services **(Pages 85 - 90)**

9. Work Programme **(Pages 91 - 94)**

Health and Adult Social Care Overview and Scrutiny Committee

Wednesday 27 January 2021

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor James, Vice Chair.
Councillors Sam Davey, Deacon, McDonald, Nicholson, Parker-Delaz-Ajete, Tuffin and Tuohy.

Also in attendance: Craig McArdle (Strategic Director for People); Anna Coles (Service Director for Integrated Commissioning); Ruth Harrell (Director of Public Health); Sarah Gooding (Policy and Intelligence Officer); Rob Sowden (Senior Performance Officer); Dr Shelagh McCormick (NHS Devon CCG), Ross Jago (NHS Devon CCG); John Finn (NHS Devon CCG); Darryn Allcorn (Chief Nursing Officer for NHS Devon CCG and Senior Vaccination Officer) and Amelia Boulter (Democratic Advisor).

The meeting started at 10.00 am and finished at 12.08 pm.

Note: At a future meeting, the Panel will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

68. **Declarations of Interest**

There were no declarations of interest made by Members in accordance with the code of conduct.

69. **Minutes**

Agreed the minutes of the meeting held on 2 December 2020.

70. **Chair's Urgent Business**

There were no items of Chair's urgent business.

71. **COVID-19 Update from the Director of Public Health**

Ruth Harrell (Director of Public Health) provided an update on Covid-19. It was reported that:

- the current position for Plymouth was 241.5 per 100,000 compared 382 per 100,000 in England. The rate was continuing to fall in Plymouth and there was enough data to see this drop as a proper trend;
- they were now seeing the new variant in Plymouth and the control measures were the same for this new variant;
- it takes 3 weeks for body to build up immunity after the vaccination.

Questions from Members related to:

- what more advice can you give to residential homes to help residents and staff to protect them from Covid?
- what were the timescales on the changing of ppe?
- what psychological support were staff receiving within the care home setting?

The Committee noted the Covid-19 update and gave their thanks to Ruth Harrell and the team for their work.

72. **Winter Flu Vaccination Programme Update from the Director of Public Health**

Ruth Harrell (Director of Public Health) provided an update on the winter flu vaccination programme. It was reported that:

- there was a challenge delivering vaccinations within schools and were undertaking targeted communications to ensure these vaccination were taking place;
- the uptake for the over 65s was over 80%;
- in summary they had seen an increase in Plymouth and was likely to be the best year for the uptake of the flu vaccination.

Questions from Members related to:

- have more vaccines been procured and when does this period of vaccination end?
- was there any data on people killed by flu and/or killed by Covid?

The Committee noted the update on the winter flu vaccination.

73. **Policy Brief**

Sarah Gooding (Policy and Intelligence Officer) was present for this item and referred to the report in the agenda pack.

Questions from Members related to:

- the Department of Health's announcement on the vaccination programme and what was the perspective of the policy officer on working with local councils?
- priority groups for vaccinations and were teachers included within these priority groups?
- 600 million to upgrade and refurbish NHS Hospitals and whether any of the Plymouth facilities were within that programme?

The Committee noted the Policy Brief update.

74. **Integrated Performance Report**

Rob Sowden (Senior Performance Officer) was present for this item and referred to the report in the agenda pack. It was reported that:

- there was a strong system approach to dealing with outbreaks;

- positive performance on outcomes for people using services over the last 12 months which includes people that had receive reablement support/services;
- adult safeguarding inquiries continued to be above the benchmark in comparison to other local authorities.

Questions from Members related to:

- adult safeguarding and not being asked about preferred outcome had increased to 28%? Was this the patient or the family?
- covid outbreaks within the domiciliary care setting?
- how many people employ their own personal assistants?
- whether packages of care were sufficient?
- what was the impact of people not choosing to go into a care home because of Covid-19?

The Committee noted the Integrated Performance Report and requested a briefing paper on care home settings and ensuring people feel safe within their own when receiving care.

75. **COVID Vaccination Programme**

Darryn Allcorn (Chief Nursing Officer for NHS Devon CCG and Senior Vaccination Officer) was present for this item and referred to the report in the agenda pack. It was reported that:

- the vaccination programme had moved at pace with 86,000 vaccinations taken place across Devon since December;
- in Plymouth all sites were up and running across the city with the hospital as a well-established hub. Home Park opened on Monday to care staff and opened to the public yesterday;
- they were working with NHS England for access to pharmacists;
- all care homes across the city to be completed by 24 January 2021;
- the ambition to complete priority areas 1 to 4 by the 14 February and based on supply and capacity they were well on track.

Questions from Members related to:

- the recruitment of volunteers and how successful this had been?
- were more volunteers needed?
- had there been any dialogue with the council to ensure that the best sites were being used?
- the fear of needles and supporting this cohort and was there an alternative to needles?
- the process of follow ups on failed appointments?
- carers and timescales for vaccinations for this cohort?
- how do you ensure people receive the right messages with regard to the vaccination programme on the protection between the vaccination and immunisation coverage?
- how do people unable to get out have their vaccination?
- vaccinations for nursery workers and teachers?

The Committee noted the Covid Vaccination Programme report. It was agreed:

1. To look at the priority list to include carers for vaccinations and to manage this at a local level;
2. To seek the views and local knowledge from Ward Councillor on facilities that key stakeholders could consider for the vaccination programme.

(This agenda item was moved to facilitate good meeting management.)

76. **Restoration and Recovery of Services**

John Finn (NHS Devon CCG) was present for this item and referred to the report within the agenda pack. It was reported that:

- the elective system for Devon was above plan. Diagnostics Devon system below plan but has now been corrected;
- outpatients was above trajectory but non face to face was below and needed to undertake further work to increase this;
- this position would deteriorate over the next 4 weeks with increased numbers in Covid patients and staff being moved from elective work to Covid work.

Questions from Members related to:

- what was meant by the lessening of PPE in theatres?
- orthopaedic procedures and having to wait 52 weeks and how often were the waiting lists reassessed?

The Committee noted the Restoration and Recovery of Services report and requested a further update at the March meeting.

77. **Work Programme**

The Committee discussed the work programme and items for inclusion on the work programme:

- Scrutiny Management Board to discuss when best to undertake scrutimy on mental health and CAMHS.
- Dental health would be on the Health and Wellbeing Board agenda on 4 March 2021. The Oral Health Needs Assessment when completed by NHS England to be circulated to all Councillors for comments/questions.
- Invite Dr Paul Johnson, NHS Devon CCG to the March meeting to provide a response to the letter regarding GP practices.
- Briefing paper on the Alliance Contract to be circulated to the committee.
- Implementation of health and wellbeing hubs to be discussed in the next municipal year.
- Completion of the vaccination programme and how the hubs could support this programme.

HEALTH AND ADULT SOCIAL CARE SYSTEM PERFORMANCE

FEBRUARY 2021

1. INTRODUCTION

The purpose of this report is to inform members of the latest performance against a number of key indicators that provide a view of how care is being delivered to the people of Plymouth in light of the COVID-19 emergency. The pandemic has had an impact on how performance is reported and this has limited the ability to provide benchmarking information like we have done so previously.

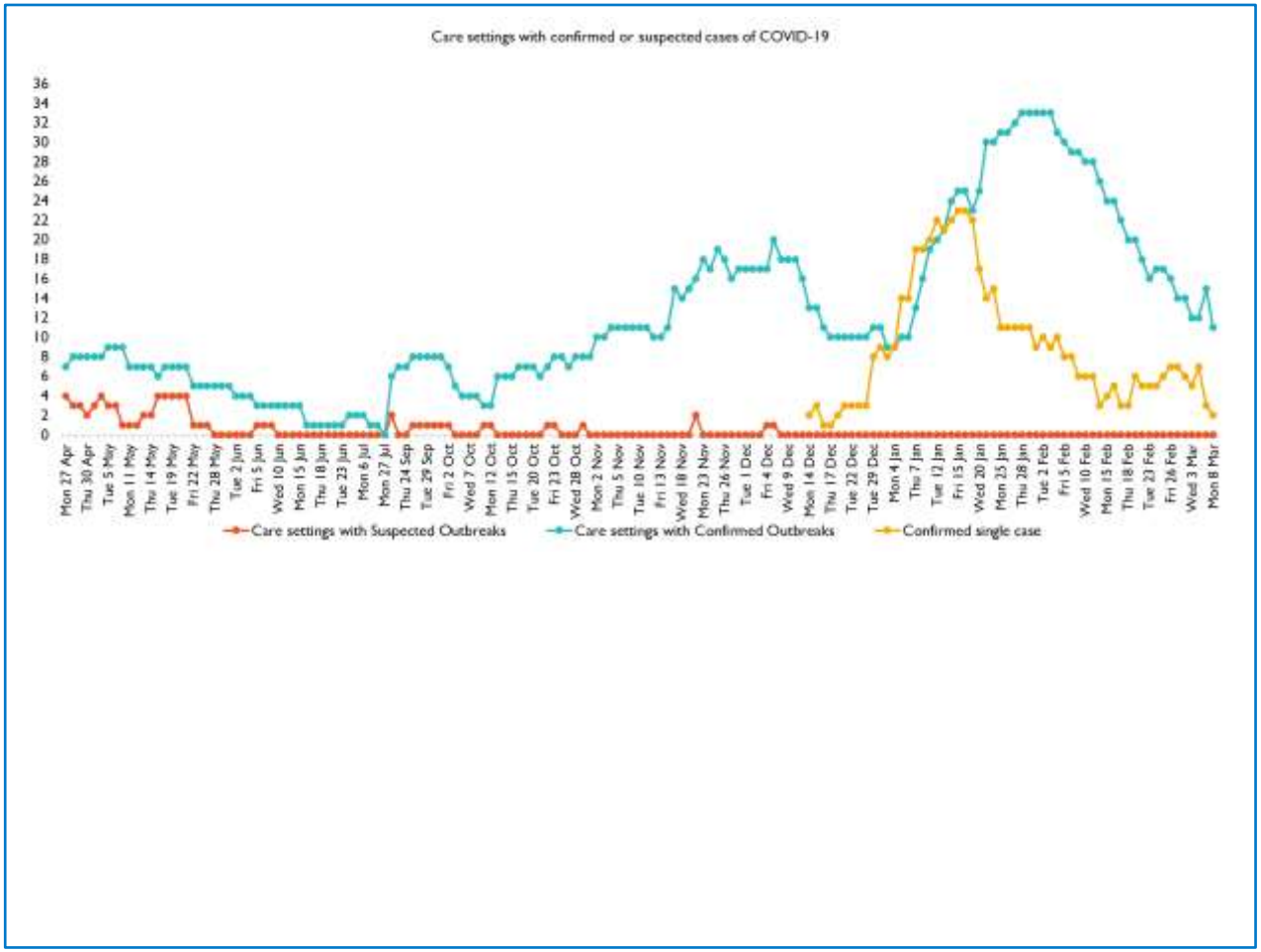
The indicators in this report are;

- Number of COVID-19 outbreaks within Care Settings
- Admissions to Residential and Nursing Care Homes
- Community Based Care
- Reablement
- Adult Safeguarding
- Referral to Treatment

Report for period to: 8 March, 2021	**Measure:** Care Setting Outbreaks	

Performance Indicators

	Fri 26 Feb	Mon 1 Mar	Tue 2 Mar	Wed 3 Mar	Thu 4 Mar	Fri 5 Mar	Mon 8 Mar	Trend
Total number of care settings	0	0	0	0	0	0	0	▲ ▼
Care settings with suspected outbreaks	16	14	14	12	12	15	15	▲ ▼
Care settings with confirmed outbreaks	7	7	6	5	7	3	3	▲ ▼
Care settings with one confirmed case	19	19	20	22	21	22	23	▲



Performance Insights

In total there are 97 care homes in Plymouth; those with confirmed or suspected outbreaks of COVID-19 will be closed to new residents and visitors. Local protocols are in place upon notification of an outbreak. A care home is declared to be in outbreak when two or more cases are confirmed, whilst a home will also be declared out of an outbreak on the 29th day after the date of the latest positive test.

The number of outbreaks within care homes has reduced by three compared to last week; the number of outbreaks was 9 on 8 March. There are no homes with a suspected outbreak, although there are two further homes with at least one confirmed case. This means that the percentage of care homes with a current COVID-19 positive case is 9.3%, down on last week.

In addition to these outbreaks there are a further two confirmed outbreaks; one within Domiciliary Care/ECH care settings and one within a Supported Living setting.

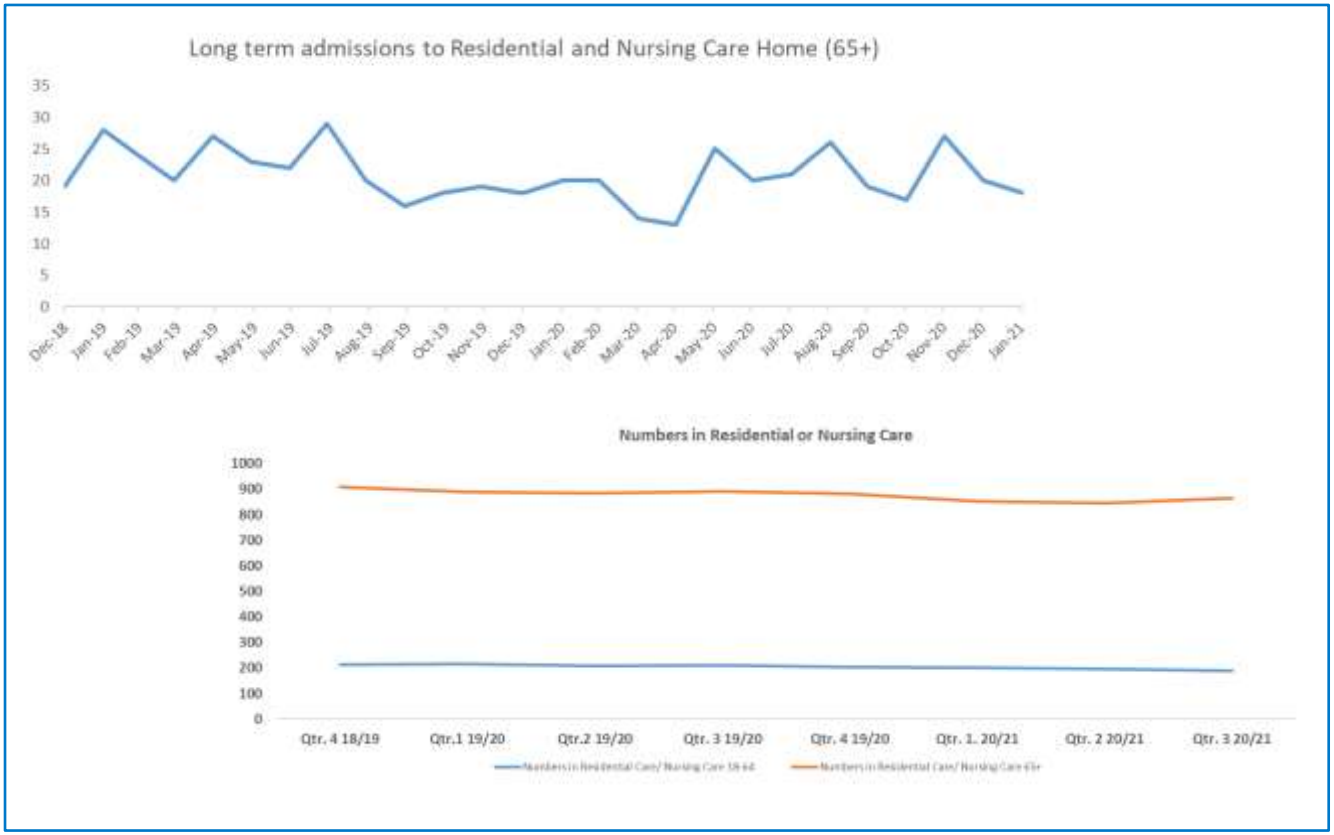
The total number of confirmed outbreaks across care settings is 11, which is three less than last week.

Our care settings support some of our most vulnerable residents and unfortunately during the pandemic a number of these had outbreaks. With partners, the Council provided 'wrap around' support in a coordinated way that ensured residents, care home management and staff are assisted during an outbreak. We have provided access to information on best practice, and supported through weekly bulletins and monthly webinars to ensure that our providers have access to the most up to date guidance.

Report for period: February 2021	**Measure:** Care Home Numbers	

Performance Indicators

	August	September	October	November	December	January	February	Trend
Long term admissions to Residential or Nursing Care (18-64)	1	1	1	3	1	2	2	▲ ▼
Long term admissions to Residential or Nursing Care (65+)	21	26	19	17	27	20	18	▼
	Qtr.1 19/20	Qtr. 2 19/20	Qtr.3 19/20	Qtr. 4 19/20	Qtr. 1 20/21	Qtr. 2 20/21	Qtr. 3 20/21	
Numbers in Residential Care/ Nursing Care 18-64	216	209	212	204	201	197	190	▼
Numbers in Residential Care/ Nursing Care 65+	889	885	891	882	853	848	864	▲



Performance Insights

In 2019/20 the number of long term admissions to residential/ nursing care dropped, falling from 305 in 2018/19 to 239 (-66),

The downward trend in admissions for those over 65 has slowed in 2020/21. Between April 2020 and the end of February 2021 there have been 220 admissions where a completed assessment has been recorded, this is a decrease of 12 over the same period in 2019/20. Increases over the past few months means we are on a trajectory to have seen a similar number of admissions to 2019/20 by the end of the year 2020/21.

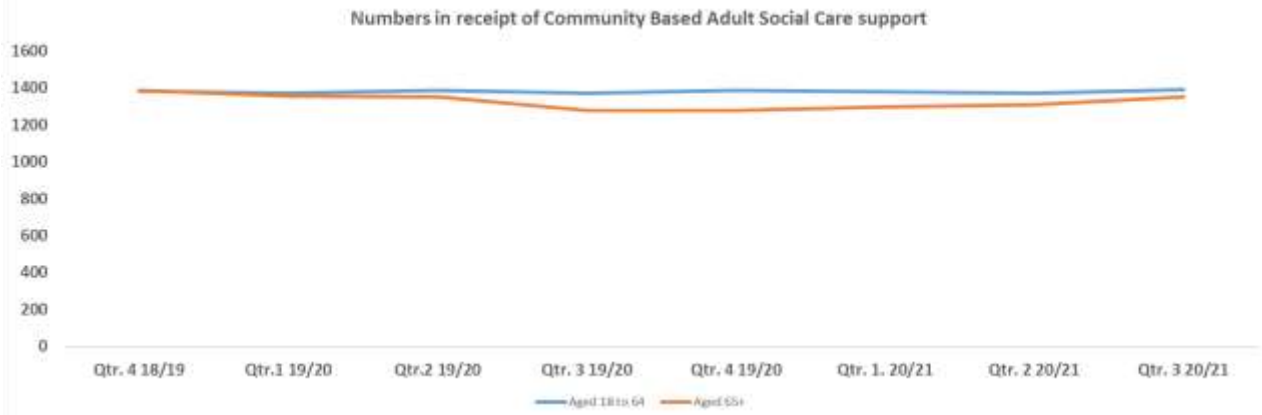
This year we have recorded an increase in the number of long term admissions of those aged 18 to 64, between April 2020 and February 2021 there have been 21 admissions, compared to 15 over the same period in 2019/20.

Overall, numbers of people in care home settings remains static, and in line with national COVID-19 Discharge guidance a number of people will be in receipt of care within homes but currently funded by the NHS. These will not be included in these figures but are being monitored.

Report for period: December 2020	**Measure:** People receiving Community Based Care	

Performance Indicators

	Qtr.1 19/20	Qtr.2 19/20	Qtr. 3 19/20	Qtr. 4 19/20	Qtr. 1. 20/21	Qtr. 2 20/21	Qtr. 3 20/21	Trend
Numbers in receipt of Community Based Care (18-64)	1372	1385	1370	1385	1379	1372	1390	▲
Numbers in receipt of Community Based Care (65+)	1355	1349	1275	1276	1298	1308	1349	▲



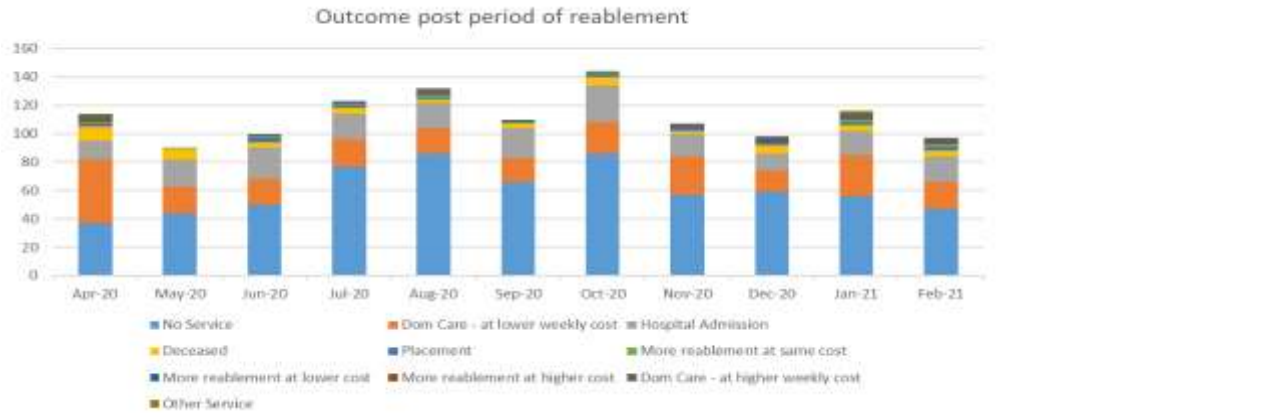
Performance Insights

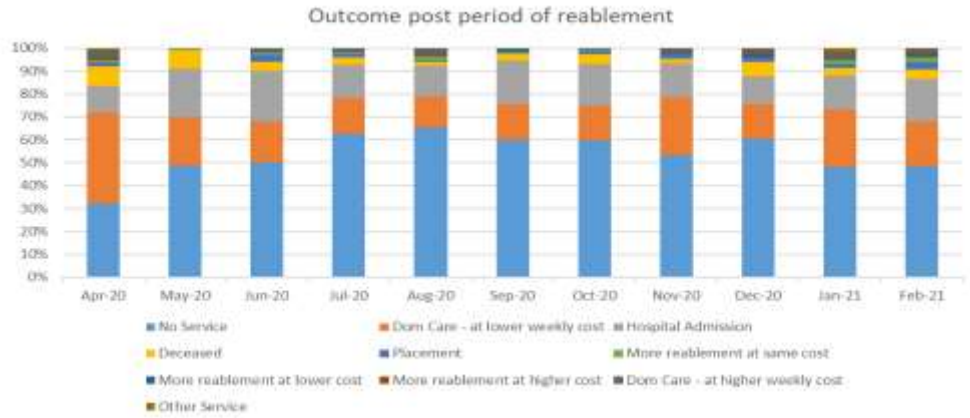
As complexity and need increases, ensuring that demand on services is well managed is a key priority for Adult Social Care.

An approach which includes a strengthened gateway to care with direct links to the community and voluntary sector, Wellbeing Hubs and access to Healthcare has delivered a more integrated model of care. Improved access to advice and information along with timely access to a reablement approach will enable more people to live fully independent lives in their communities without the reliance on long term care. This has enabled us to maintain client levels.

During quarter three of 2020/21 there were 2,739 individuals who accessed community based care, this is higher than Q3 of 2019/20 when we saw reductions. The numbers receiving community based care are also up on last quarter, an increase of 59 (+2.2%) but the longer term steady trend is at present being maintained.

Report for period: February 2021	**Measure:** Reablement Service	





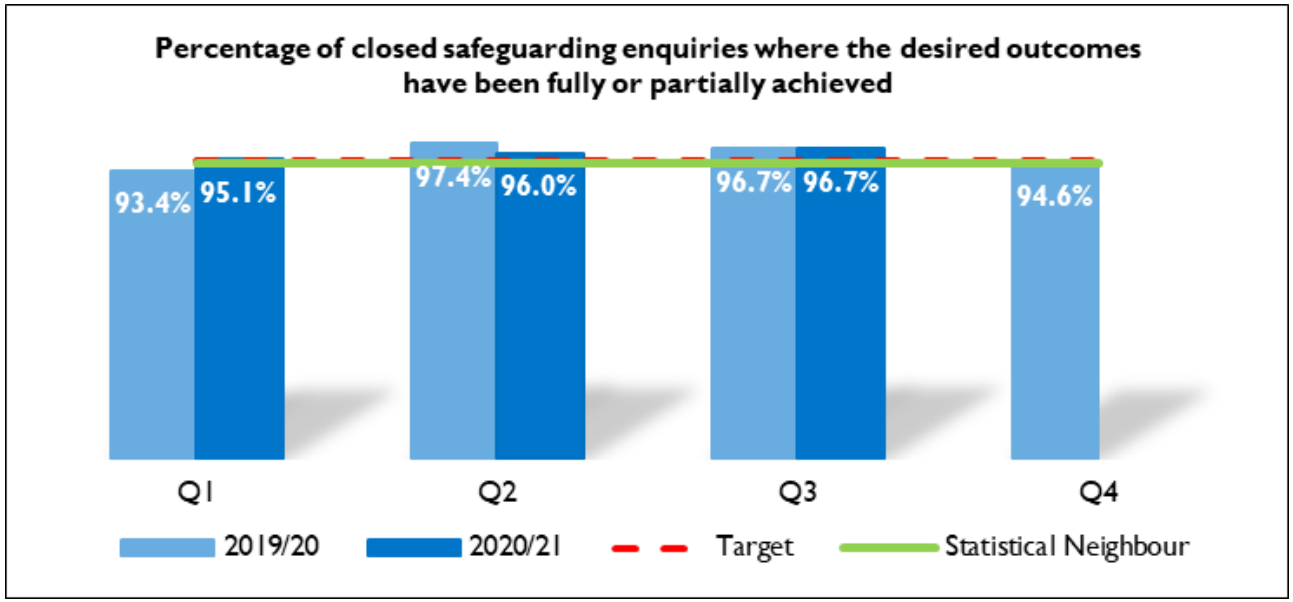
Performance Insights

The Independence at Home service monitors its activity and outcomes on a weekly basis and presented here is a monthly breakdown of outcomes to reablement. The increased availability of and better access to reablement packages over recent months has been key to keeping the number of people accessing long term community based support on a static trend in the face of increased complexity of need.

Between April the end of February 1,231 outcomes to reablement have been recorded. On average 54% of these cases the individual in receipt of the reablement has left the service fully independent requiring no further service.

Of those individuals who go on to require long term care, the majority go on to a package that is at a lower cost to any previous package received. On average each month 20% of all outcomes will be a package of Domiciliary Care that is at a lower weekly cost.

Report for period: Quarter three 2020/21	**Measure:** Adult Safeguarding Outcomes	



Performance Insights

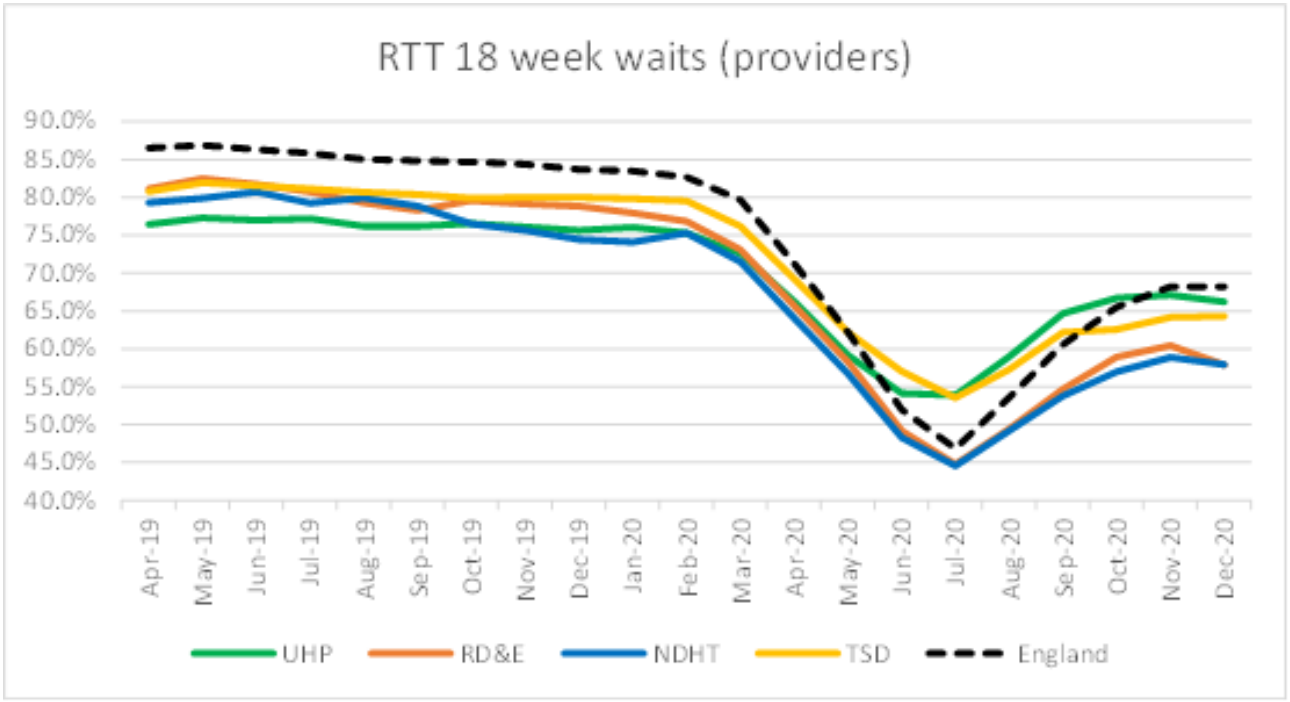
Making Safeguarding Personal (MSP) is a person-centred outcome focus to safeguarding work that aims to support people to improve or resolve their circumstances. This is an indication of how well we are meeting the person's desired outcome, but not necessarily a measure of the degree to which they have been safeguarded.

Between 1 October 2020 and 31 December 2020, 234 individuals were the subject of a completed safeguarding enquiry. 153 of which expressed a desired outcome at the start of the enquiry (65% compared to 73% in Q2), the percentage of people not asked about their preferred outcome increased to 28% (18% in Q2). We will look into this further in our regular meetings with Adult Social Care managers.

The percentage that has been either fully or partially achieved is 97.0%, this exceeds the 95% target and continues to be above the average of our CIPFA groups of similar local authorities. The percentage fully achieved increased to 71% (65% in Q2).

Safeguarding activity, performance and outcomes are monitored on a quarterly basis by the Safeguarding Assurance meetings and the Adult Safeguarding Board.

Report for period: December 2020 | **Measure:** Referral to Treatment waiting times



Performance Insights

December data shows a worsening position for RTT 18-week performance, falling from 61.5% to 60.3% at an STP level, compared to the target of 92% and national performance of 68.2%.

Waiting lists have risen in December for all providers except NDHT. The table below shows the RTT waiting list movement between November and December by provider:

	RD&E	NDHT	UHP	TSD
November	43746	13492	30292	26638
December	48005	13354	31294	28030
Variance	**4259**	**-138**	**1002**	**1392**

The number of long waiting patients also continues to increase, with numbers waiting over 52 weeks rising quickly at all providers in December as can be seen in the table below. Breaches are expected to continue to rise in January.

During this period all trusts have been impacted by increased COVID activity and loss of capacity due to outbreaks on wards.

	RD&E	NDHT	UHP	TSD
November	3401	1290	1445	1277
December	4237	1358	1596	1435
Variance	**836**	**68**	**151**	**158**

Work closely as a network to manage resources. There will be a centrally collated STP waiting list to support provider trusts, all of whom are clinically prioritising their waiting lists to ensure that the patients with the greatest clinically are treated first.

GENERAL PRACTICE UPDATE AND ECONSULT

Health and Adult Social Care Overview and Scrutiny Committee

Date:	24 March 2021
Title of Report:	**General Practice Update and Econsult**
Lead Member:	Choose a Councillor
Lead Strategic Director:	Choose a Director
Author:	Dr Paul Johnson, Chair, NHS Devon CCG / Jo Turl, Director for Out of Hospital Commissioning NHS Devon CCG
Contact Email:	ross.jago@nhs.net
Your Reference:	PC 20/21 Plym
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

This report has been requested by the Chair in response to the Healthwatch presentation considered by the Panel in December 2020.

Recommendations and Reasons

The Committee is requested to –

1. Note the report;
2. Identify councillor champions for involvement in review and feedback sessions pertaining to e-consult.

Alternative options considered and rejected

None. As a relevant NHS body, NHS Devon CCG has a duty to attend before a local authority when required (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out its health scrutiny functions.

Relevance to the Corporate Plan and/or the Plymouth Plan

By working with NHS bodies to maintain oversight of health and care services in Plymouth the committee is supporting the Democratic and Co-operative values of the Plymouth City Council, alongside objectives in the *"Healthy City"* Chapter of the Plymouth Plan.

Implications for the Medium-Term Financial Plan and Resource Implications:
This update does not give notice of any required decision which may require expenditure or resource allocation which impacts upon the Local Authority.

Carbon Footprint (Environmental) Implications:
None arising from this report.

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:

None arising from this report.

Appendices

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**

Background papers:

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: N/A											
Please confirm the Strategic Director(s) has agreed the report? N/A Date agreed: 10/06/2019											
Cabinet Member signature of approval: N/A Date: 10/06/201											

NHS
Devon
Clinical Commissioning Group

1. Introduction

1.1. Primary Care Teams across the Devon system have responded magnificently to the initial impact of the coronavirus pandemic and the subsequent vaccination programme.

1.2. Huge progress has been made against our Primary Care Strategy in just 12 months, at a time that general practice and the wider health and care system has been under considerable pressure during the COVID-19 pandemic.

1.3. Transformative workstreams were already underway in primary care when the impact of the pandemic started to become clear. This meant that Devon's GP practices were already in a strong position to manage and respond to the challenges of working in a pandemic, such as access to online consultations and partnership working in developing Primary Care Networks.

1.4. This report sets out progress made in respect of the Plymouth Primary Care Prospectus, Devon System Primary Care Strategy and additional information requested by the committee concerning the use of the e-consult online consultation system.

2. Plymouth Primary Care Prospectus Update

- Following the CCG funding of BMJ advertising with a particular 'push' into Plymouth practices, 6 GPs have been recruited into Plymouth. Due to successful recruitment (10 Devon-wide - this includes the 6 in Plymouth) funding will continue for 21/22.

- CARE GPN leadership Programme has commenced Devon-wide. This is a fully funded programme with a specific offer from the CCG to support backfill. Very good uptake with 22 nurses participating, 3 from Plymouth practices. This has proven to support retention and wellbeing.

- GPN retention vanguard programme – although Devon-wide this will have a focus on where retention is needed most so will have a weighting to Plymouth Deep End practices. This offer is for nurses who are within 2 years of registration and for the most senior, experienced practice nurses who are towards the end of their career.

3. Devon Primary Care Strategy Update

3.1. The strategy sets out our ambition and vision for general practice over five years (2019-2024). It describes how we will support GP practices in Devon to provide accessible and coordinated care, with a skilled and motivated workforce who can respond to the current and future needs of our population.

3.2. Around 90 per cent of interactions in the NHS take place in primary care and our GPs are the first point of contact with the NHS for most people. The strategy focuses on the future delivery of general practice, but primary care is formed of a much more diverse workforce than just those within GP practices. Involvement of all providers, including

pharmacists, dentists, optometrists, allied health professionals and the voluntary sector, will ensure we have sustainable primary care in the future.

3.3. Our strategy relates to those medical services provided by general practice and defines how a series of actions and enablers in general practice will positively impact on pressures faced by the wider system.

3.4. Our vision is that primary care in Devon will offer each local community a wide and flexible range of information, support and services to enable people to live happy healthy lives.

3.5. To do this, we must address a number of challenges. Increasing demand, difficulties in recruitment and retention, estates and IT. The strategy outlines five priorities that will revolutionise general practice.

The five pillars of the strategy

3.6. Since publication of the strategy, a further pillar has been added, recognising the importance of **clinical leadership**, and the ambition is to have a lead clinician for each pillar.

3.7. We are now in year one of the five year strategy and this paper sets out the progress we have made on each of the five pillars, plus the addition of the new clinical leadership pillar.

3.8. The original five year aims and plans in the strategy are set out below, with an update on the progress that has been made one year on.

Better Access

Aims	Progress one year on
• We will ensure the needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at	• Full Extended Access coverage across Devon • Access to direct booking into extended hours available shortly

weekends where there is demand or a need.	
• We will adopt a 'digital first' approach. Where possible, the first contact with general practice services will be digital, there will be digital connectivity between organisations.	• Online Consultations are now offered by 122 GP Practices in Devon (final practice underway) • All practices in Devon offering video consultations, significant increase in contact via SMS.
• Everyone can expect that their personal and medical history is available wherever they touch health and care systems. They will be supported digitally for self-care and technology will be doing some of the routine work previously undertaken by staff.	• GP Medical history made available through Summary Care Record Additional Information and GP Connect
• Devon will continue to lead the way in digital innovation. The Digital Accelerator project will be expanded in scope to cover the whole of Devon, allowing convenient access to primary care by delivering online consultations and better utilisation of resources. To facilitate this, new workforce models will be developed for GPs and other clinicians to deliver online services, scalable across the county and beyond.	• Digital Accelerator expanded to cover all Devon as part of COVID-19 response • Blueprint from Digital Accelerator adopted nationally • Work now underway on new workforce models
• We will enable GP practices to embrace and embed the functionality of the NHS App, supporting patients to access self-care, clinical advice, book appointments, order repeat prescriptions, access their medical records, choose preferences for data sharing and organ donation.	• NHS App available to all Devon patients • Devon has the second highest number of NHS App downloads in the country

Workforce

Aims	Progress one year on
• We will work closely with partners, including the Academic Health Science Network, both Exeter and Plymouth Medical Schools, Plymouth and Exeter Universities and the Devon Training Hub, to take forward emerging action plans drawn up in response to our improving understanding of anticipated workforce needs and also barriers to commencing a career within primary care settings.	• Restoration of links post-COVID response • Links with STP workforce lead to support capacity and capability gaps • Planning of workforce programme with STP, universities and Devon Training Hub • Considering digital change in service delivery and future options • Updated PCN workforce with roles coming online earlier

• This will include actions to address career attractiveness, recruitment to and retention within associated professions, and the offering of opportunities that vary from the traditional models. • We will undertake a capacity and capability analysis which will identify any skills gaps and shortages to inform development needs and also enable us to work effectively with training providers to provide an effective pipeline of skills in readiness to meet future requirements. Where skills gaps are identified, we will consider first the opportunity to improve service delivery through digital solutions while also enabling our clinicians to work at the top of their licence.	• PCNs underspend from 2019 being utilised to support recruitment across networks
Working in partnership with the PCNs we will: • Attend local, regional and national job fayres promoting Devon as a place to work • Continue to build on the success of the GP retainer scheme • Make the GP fellowship scheme available across Devon • Expand the portfolio and rotational working opportunities to staff working in general practice • Work with the PCNs to develop a range of flexible working approaches • We will continue to participate in the international recruitment of GPs initiative • We will continue with supporting implementation of the 10-point practice nurse plan • Continue with the NHS England retention scheme • Expand the GP post training fellow pilot to cover the whole of Devon	• Supporting practice nurse plan • Continuing to support retainer scheme • Working closely with the Local medical Committee (LMC) and the British Medical Journal (BMJ) to advertise GP vacancies • Attending the BMJ Live Jobs Fayre virtual event. • Mentoring and fellowship - Two-year programme of support • GP returners • General Practice Nurse (GPN) 10 - point plan

Primary Care Networks

Aims	Progress one year on
• Support PCNs in the delivery of the network enhanced service	• Primary Care Networks (PCNs) launched in July 2019. There are

• Enable Clinical Director leadership and empower PCNs to take their place in the developing Local Care Partnerships (LCPs)	now 31 established networks functioning across Devon • Each PCN has an agreed plan which identifies their development needs, which are underpinned by a maturity matrix. We are supporting each PCN to utilise their development fund allocation • Project manager support - establish appropriate and beneficial business leadership including governance processes

Population Health Management

Aims	Progress one year on
• We will create a cultural change which understands the power of data to drive a virtuous cycle of quality improvement. This will not be done in isolation but as part of the wider system and links in with the One Devon Data Set. All PCNs will receive data to inform decision-making and meet the needs of the population they cover. PCNs will develop population-specific services in response to this. • We will empower patients who are willing and able to self-care with support and information through the new social prescribing workforce. We will also strive to reach those most vulnerable in our population and work with them to improve their health. • There will be a wider range of affiliated community-based professionals providing care and support as part of an enhanced patient offer. This will be both at practice and network level. Where appropriate patients will be directed to voluntary sector personnel both to deliver care and facilitate self-care using available technological solutions where appropriate. Clinical record keeping will wherever possible be on a shared clinical system.	• Rapidly roll out learning and tools identified through Primary Care Network pilots • Support PCNs to adopt a Population Health Management (PHM) approach • Address inequality and variation in quality and outcomes • Rapid tests of change - paused during COVID but restarting again now • Impact of COVID--19 has been disproportionate on a number of groups • Linked data into Covid risk groups • Many PCNs keen to adopt PHM approach - those outside pilot need support • We have started to build the capacity and capability. • Availability of population Profiles required for better understanding and targeting of local need

Estates and Infrastructure

Aims	Progress one year on
• Develop a Devon-wide primary care premises strategy.	• Primary Care strategy approved by CCG Primary Care Commissioning Committee • Estates Manager vacancy filled • External support sought to deliver plans to implement strategy

Clinical Leadership

Aims	Progress one year on
• Recognise leadership talent – experience clinicians and new leaders • Connect clinical leaders and develop their leadership role • Engage with leaders to prioritise high-impact care areas • Maximise opportunities for health improvement with Population Health Management initiatives • Maximise benefits of clinical leadership at all levels • Clarify governance for decision-making • Define engagement processes to ensure practices have a voice	• Devon Primary Care Networks (PCNs) agreed and Clinical Directors in place • Four locality based collaborative boards with representative chairs developing connections into system discussions • Strategic clinical and place-based leads employed by the CCG • A clinical CCG Governing Body Chair and an STP Medical Director for Primary Care • Regular constructive communication with GP provider representative, the Local Medical Committee (LMC) • Improving and developing relationships with Local Optical Committee (LOC), Local Pharmaceutical Committee (LPC) and Local Dental Committee (LDC)

4. Plymouth Health and Adult Social Care Scrutiny Committee - Key Lines of Enquiry eConsult

4.1. eConsult enables NHS based GP practices to offer online consultations to their patients. This allows patients to submit their symptoms or requests to their own GP electronically and offers around the clock NHS self-help information, signposting to services, and a symptom checker.

4.2. eConsult is intended to be used by patients seeking non-urgent medical advice. Non-urgent is defined as conditions that are not immediately life-threatening emergencies such as severe chest pain, breathlessness, severe bleeding, acute confusion, loss of consciousness, uncontrolled fitting, anaphylaxis and stroke.

4.3. Patients using the system are required to be registered to an NHS GP surgery that has deployed the eConsult system. This is to ensure that the reviewing clinician has full access to their NHS medical record and is able to hold a dialogue with the patient if necessary before making any management decision.

4.4. This is in-line with the recommendations made by the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) with regards to remote consulting.

4.5. eConsult is not intended for immediate medical emergencies due the potential delay in diagnosis when a clinician reviews the report. A patient disclaimer, explanation and confirmation box are presented at the start of the process to warn patients of this risk. Additional safety control measures have been implemented that include red flag questions embedded within the questions sets. If these questions are triggered, the process stops, and the patient is signposted to urgent or emergency services.

4.6. Responses to several key lines of enquiry raised by the committee are detailed below.

What patient feedback/review has been completed since the launch of e-consult?

4.7. The Devon Digital Accelerator (DDA) programme team has used a variety of avenues to collect feedback since the early implementation of e-consult.

Healthwatch

4.8. The DDA programme fully funds the Healthwatch Digital Health Devon programme. This programme is specifically set up to provide support to patients who would like to use eConsult and other online services.

4.9. Prior to the pandemic, using Healthwatch volunteers, practices in Devon hosted events in surgeries where patients could use the technology to learn and gain confidence in using the online systems available for patient access. Since the beginning of the pandemic, where possible such sessions are being held remotely, with a view to return to “in-person” events when possible.

Oxford University Research

4.10. The Devon Digital Accelerator has partnered with Oxford University research, to understand how remote consultation may affect vulnerable patients. This is an ongoing piece of research carried out in Plymouth by Plymouth University seeking to understand the impact of online consultation on health inequalities.

Insight Work

4.11. Several pieces of insight work have been commissioned through the DDA and provided by ICE Creates Ltd a behavioural research company. These have been hugely informative of patients’ thoughts and feelings towards online consultation and what we need to do as a system to support them further. Two pieces of insights to note are:

- 1000+ patient study into Plymouth, focusing on high users of primary care, low digital ability (Appendix 1)
- Homeless and vulnerable patients (Due for completion w/c 15th March 2021)

Liaison with charities and organisations who support vulnerable patients

4.12. The Devon Digital Accelerator continues to work with charities and organisations, either regarding specific patients access issues, or more generic, widespread issues.

4.13. For example, an interpreter contacted the DDA to express a concern about how the access points caused issues for deaf patients. This feedback enabled a wider conversation with the Deaf Association, who supported the programme with

understanding where online consultation would and would not be suitable for patients who are deaf.

4.14. Alongside our surveys we are also planning a number of workshop events which will direct and shape the next stages of the digital transformation. These workshops will encompass the patient and staff voice and we would very much welcome the input of local councillors.

What were the main findings and how has the service responded and adapted to this feedback?

4.15. Feedback from our engagement work has suggested that patients have valued the support available in accessing, in response the Devon Digital Accelerator funded Healthwatch's Digital Health Devon Programme in full at the cost of £47,000 for 2020/21.

4.16. We have also found that patients are often unaware of their ability to engage digitally or from where and whom they can access online services. In response the system is planning further communication campaigns to promote online consultation alongside the offer for support in its use.

4.17. Feedback has also shown that early communications concerning online consultation gave the impression that online consultation was the 'only' way to engage with a surgery. We have amended our communication in response to ensure patients are clear and confident that this is an 'additional' avenue available but patients can still call their surgery as before.

In light of reviews has the original EIA been updated?

4.18. Each practice holds an EIA which sits alongside the wider DPIA which is also created at practice level. A Clinical Safety Case report is held at CCG level. All Models enable patients to not only send an online consult, they can also phone in to the surgery if online consultation is not for them, and where restrictions allow, also walk in to surgery, to ensure no barriers are created for patients accessing services.

Are there any specific cohorts who are not taking up-consult?

4.19. Whilst limited data is available from clinical systems for such research, we are able to glean from the voices and information available to us is that remote consultation is gaining traction and being embraced in ever greater numbers of patients

Number of online consultations submitted: Jan 19 – Jan 2021 (Devon STP)	
2019	89,006
2020	540,669
2021 (January only)	60,301

Age using eConsult of all submitted eConsults Jan 19 – Jan 2021					
Age	**<15**	**15 - 24**	**25 - 44**	**45 - 64**	**65 +**
% total	7	15	35	30	11
Population	188174	145265	283549	334037	295737
Pop as %	15	11	22	26	23

Usage by gender of all submitted eConsults Jan 19 – Jan 2021	
Male	32%
Female	68%

4.20. Every patient who submits an eConsult is provided with the option to feedback on how they have found the experience. This is optional, so not all patients provide feedback, but this means we have requested feedback from **689,976** patients to date, from January 2019 – January 2021.

4.21. Feedback varies but is between 1-4% per month from the survey. On average, we receive around 1000+ pieces of feedback from patients across Devon per month, with a high during April 2020 of over 4000 in.

4.22. Feedback is provided to the CCG and is also provided to each practice every month so they are able to action any feedback and make amendments where required, but also to provide staff with confidence which comes from positive feedback. The feedback is helping to shape future communication campaigns to raise awareness of online consultation and where help can be sought from patients need it.

4.23. Every month, each practice will receive an overview of critical areas along with the feedback. Patient feedback suggest those that are using the service are largely positive about their experiences and outcomes and are recommending to others. This is also reflected in the increasing uptake of using the tool as a means of contacting their surgery.

Month - Year	patients who were satisfied with the service	patients who would recommend the eConsult service to family and friends	patients who did NOT have to contact the GP practice or any other health service for the same problem in the week after consulting online	patients who said they were contacted by the stated response time
Jan-20	69%	68%	70%	88%
Feb-20	61%	63%	73%	85%
Mar-20	69%	69%	77%	85%
Apr-20	84%	83%	85%	92%
May-20	84%	84%	81%	94%
Jun-20	78%	77%	80%	91%
Jul-20	77%	76%	77%	91%
Aug-20	72%	70%	78%	89%
Sep-20	72%	70%	76%	89%
Oct-20	72%	70%	76%	89%
Nov-20	74%	74%	76%	90%
Dec-20	76%	73%	77%	91%
Jan-21	76%	76%	76%	90%

What additional measures have been put in place for those identified as digitally excluded

4.24. **Online consultation is an additional way to contact a GP, but not the only way**. Patients are still able to phone practices and walk in where permitted. The DDA team have identified that there are patients who would be interested in using online consultation, but may lack the technology, training or motivation to do so. As previously referred to in this report, the team have funded the Healthwatch Digital Health Devon programme to ensure that practices and patients are supported in having training and support available for patients who want to learn to use their own technology to get online.

4.25. The DDA is also currently coming to an end of a piece of research with patients who are classed as homeless to understand whether they want to engage digitally and if so, where they would feel comfortable engaging. We understand some do not feel comfortable with going to local libraries to use devices and further work is underway with hostels and organisations that these patients engage with, to provide them with a place they feel comfortable to undertake online consultation activities.

4.26. Patients with British Sign Language as a first language may struggle to use online consultation and other online forms due to the text and no associated signing videos. Practices have been advised that online consultation is possibly not a suitable tool. Charities supporting Deaf patients have suggested that if videos of a person signing the question could be embedded in to the online consultation tools (eConsult and others) this would make the system much more accessible for this patient group. This has been feed back to the suppliers.

4.27. All surgeries have the ability to add a patient on to an appointment list if they are unable to complete an online consultation. In addition, several practices have taken this further and flagged patient records to ensure even quicker support for their needs when requiring a GP appointment.

Is the average length of time to get through on the telephone monitored? If so, what is the average time?

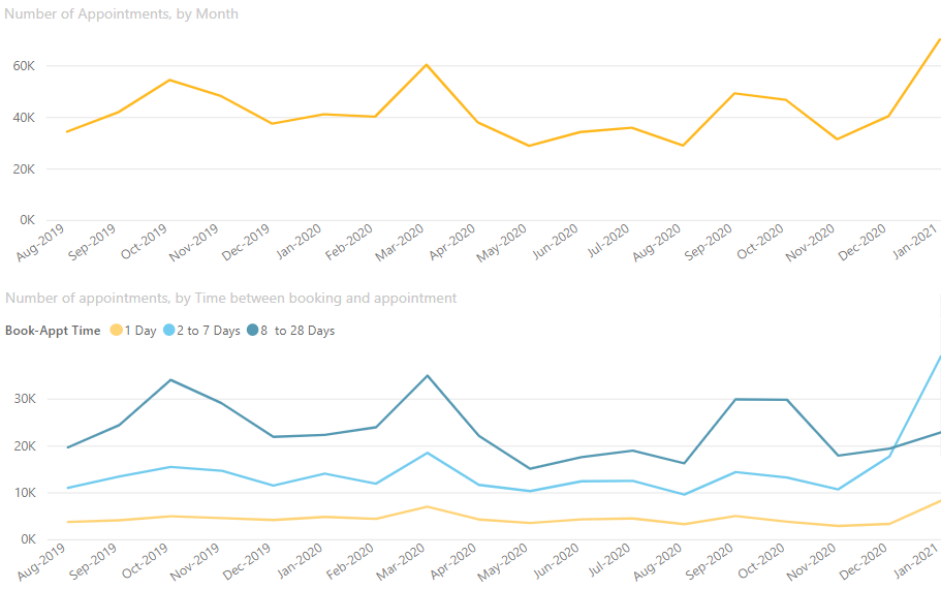
4.28. Some practices have installed a specific software that can monitor the length of time it takes to get through on the telephone. However, this isn't routinely installed by practices and requires a certain level of infrastructure. In addition, there is no formal contractual requirement for practices to monitor this and accordingly no opportunity to record this data.

4.29. GPs are however, mindful of this, particularly throughout the pandemic, and consequently have taken steps to offer patients additional routes of entry such as online consultation. There are mitigations of risk in the event of patients experiencing delays on getting through on the telephone, such as options to call 999 in an emergency.

What is the average waiting time for routine GP appointments?

4.30. Covid-19 has led to a fundamental change to how primary care is delivered. Patients are now offered assessments appropriate to their needs, which may be in the form of an online consultation, via the telephone or face to face.

4.31. Data on GP appointments in Devon from NHS Digital illustrates the correlation between Covid-19 surges and demand for GP appointments. The data shows that whilst patients have been required to wait more than eight days for appointments across 2020, this position has now changed and more than half of appointments take place between 2 and 7 days after booking.



NHS Digital: Appointments in General Practice – Devon STP (accessed 14/03/21)

4.32. All practices are committed to assessing and responding to submitted eConsults by the next working day, which could include offering appointments where required, prioritising where possible as indicated by the information supplied in the eConsult by the patient

5. Recommendations

That the Committee –

1. **Note the report**
2. **Identify councillor champions for involvement in review and feedback sessions pertaining to e-consult**

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September 2020

What needs to happen to increase uptake of e-Consult?

Full Report

Research by ICE for NHS Devon on behalf of the Devon Digital Accelerator programme

Crafted especially for you by team ice

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Executive summary

OVERVIEW & METHOD

e-Consult is an alternative option for accessing primary care. More than 90% of Devon practices have signed up to e-Consult, yet not everybody uses the platform, which may be due to where they live, their age and their digital literacy skills.

The research objective was to explore:

"What needs to happen to increase uptake of e-Consult in Devon?"

Research was gathered with over ***1,000 patients and professionals across Western Devon.***

A total of 1,045 patients completed an open-ended survey and 41 patients and 10 primary health care professionals took part in a depth interview.

The depth and breadth of insight findings have been triangulated to provide both prospective and retrospective evidence of what needs to happen to increase e-Consult uptake and consider differences between key patient groups.

KEY FINDINGS

"More convenient way of getting in touch with doctors, from the comfort of home rather than waiting in a queue. The doctor can call you back already knowing what your issue is"

"The principle is there, but the process of how you access the information and get through it is cumbersome"

"Giving them something beforehand will take away the scariness of it, when people are unsure what it will be like because it's completely new to them"

"my dad, he still has a brick phone, so you can imagine he wasn't that willing, but once I sat down with him and we did it together, he was impressed in the end"

What influences patients behaviour?

The COM-B model[1] suggests that a persons capability, opportunity and motivation to use e-Consult will influence their choice when accessing primary care:

The insight shows that most patients have the ***capability*** (necessary skills) to use e-Consult, including many elderly patients who are percieved to be digital illliterate yet have internet access, they simply require support to *show* them how to use e-Consult.

The ***opportunity*** to do an e-Consult is granted to most patients who can access and afford the Internet. Yet the needs of vulnerable patients who don't have WiFi or the best phone and are at risk of digital exclusion must be considered.

For a patient to choose e-Consult, they must be ***motivated*** to use it more than any other competing option, like calling the practice.

Busy phone lines have created dissatisfaction with the 'default option' to call the practice, and many patients favour e-Consult because its quick and easy, available anywhere, any time and confidential between patient and doctor.

Yet many patient, particularly patients with long-term conditions, found e-Consult long-winded and frustrating when they hit a 'red flag' and were redirected to acute care. At this point ***patients have already made a decision that the GP is the best place to go, leading many to ignore the redirection and 'fudge' the form*** to get through or cancel the e-Consult and default to calling the practice.

What support and information do patients need?

Patients need support *before* they need to access primary care, because it's more difficult to learn something new when feeling unwell or in pain.

Elderly patients and patients with mental health problems and learning difficulties would benefit from an easy to follow, visual 'handy guide' to prepare and guide them through the process.

Additionally, practical support and guidance to do an e-Consult from GP practice staff and family/friends would help equip patients with the necessary skills and confidence to complete an e-Consult

1. Mitchie et al (2011) *The behaviour change wheel: A new method for characterising and designing behaviour change interventions*

Contents

1 Introduction

e-Consult enables NHS based GP practices to offer online consultations to their patients. It allows patients to submit their symptoms or requests to their own GP electronically, and offers around the clock NHS self-help information, signposting to services, and a symptom checker.

More than 90% of Devon's practices have signed up to e-Consult[1], and there has been a significant rise in uptake of the platform since the outbreak of coronavirus in March 2020.

The Devon Digital Accelerator (DDA) programme aims to drive and support the use of online consultation in Devon GPs. They are keen to understand the impact of this change and explore what needs to happen to enable and support more patients to use online consultation effectively, while recognising the potential difficulties facing some individuals, particularly those without Internet access or with complex needs.

This research has been carried out to explore the motives and barriers to using e-Consult among patients from a range of backgrounds. It explores what needs to happen to increase the use of e-Consult among patients in Devon and considers the influence of factor such as age, area, digital literacy, and long-term conditions.

The overall objective for this project is to understand what needs to happen to increase uptake of e-Consult, and specifically to understand:

- Participants attitudes, beliefs and experiences of primary care access including the use of e-Consult.
- How the covid-19 pandemic has influenced a change in access to primary care and identify what needs to happen to ensure this desired change is sustained long-term.
- The barriers and enablers to increasing uptake of e-Consult and how this might differ depending on participants demographic characteristics.
- Ideas for early campaign concepts including types of communication channels, information and support that is important for increasing e-Consult uptake.

[1] NHS Devon CCG 'patients and GP practices in Devon embrace new technology'. Available at: www.devonccg.nhs.uk/news/patients-and-gp-practices-in-devon-embrace-new-technology

Methods

2 Method

2.1 Overview

A large-scale survey was distributed to patients with support from 17 GP practices across 6 Primary Care Networks (PCNs) in the Western Devon locality.

In total, 1,045 patients completed the survey, and 41 patients and 10 primary health care professionals took part in a depth qualitative interview.

Qualitative and quantitative research with over 1,000 patients and professionals have yielded rich insights from a broad, diverse and robust sample.

2.2 Recruitment methods

ICE Creates worked with practices to reach participants and invite them to complete an online or telephone questionnaire. Selected participants were invited to take part in qualitative interviews.

We worked key team members across a range of GP practices to invite patients to complete the survey – either online or via a telephone survey. GP practices promoted the research on their website, social media and text.

In addition to working with GP practices, we worked with Healthwatch Plymouth to engage harder-to-reach patients.

Participants who completed the survey had the option to register their interest to take part in qualitative research. Participants were selected using purposive sampling to ensure a diverse qualitative sample (see section 2.2.5).

2.3 Interviews with Health Care Professionals

A total of **10 depth interviews** were conducted with primary health care professionals to explore their experience and views regarding e-Consult.

Professionals were recruited from the following practices, many of which helped us reach our patient sample:

- Beacon Medical Group (Beacon Group PCN)
- Mayflower Medical Group (Mayflower Group PCN)
- Devonport Health Centre/ Peverell Surgery (Waterside Health Network PCN)
- North Road West Medical Centre (Drake Medical Alliance PCN)
- Oakside Surgery (Sound PCN)
- Tavyside Health Centre (West Devon PCN)

And included professionals in the following roles:

- Practice Manager/ Deputy Practice Manager
- Admin Team/ Receptionists
- GP Partner
- Digital Project Lead
- Patient experience and communication Lead
- Social prescriber

2.4 Sample characteristics: Large-Scale Survey

A total of 1,045 participants completed a large-scale survey that included open-ended questions to explore patients' attitudes and experience of accessing primary care, with a focus on e-Consult. These findings are discussed in section 3.

Key patient demographics were captured such as gender, age, registered practice, area they live and whether they had a long-term condition or disability. The large-scale survey was open to all patients so no hard quotas were set. The demographic profile of the survey sample is presented here:

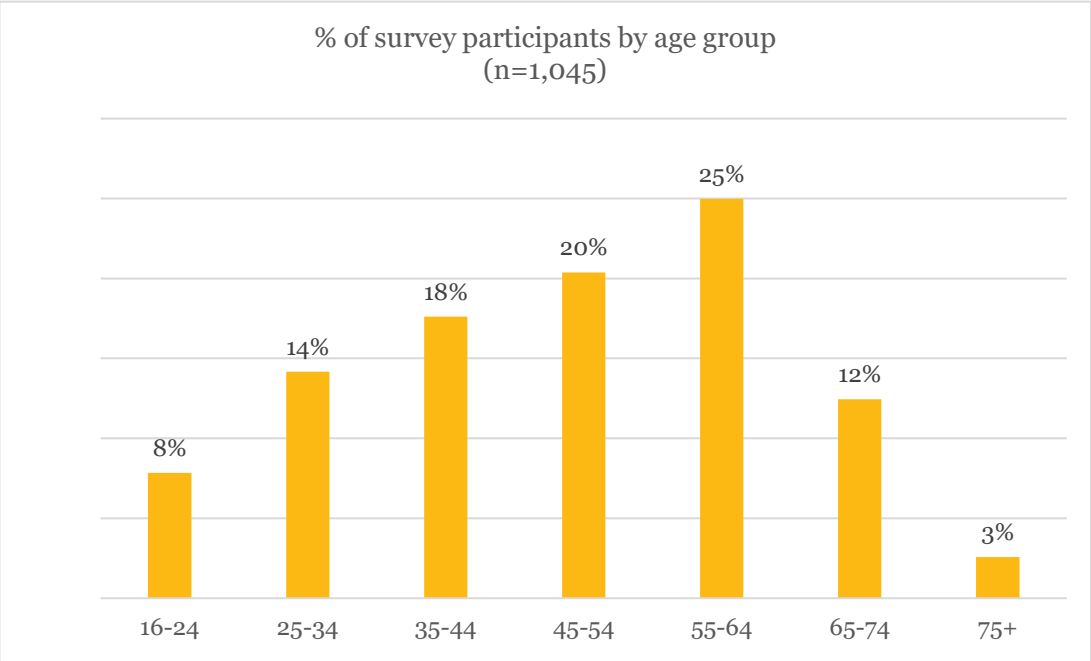
2.4.1 Gender

The sample of 1,045 was:

- 76% female
- 23% Male
- 1% Other/prefer not to say

2.4.2 Age

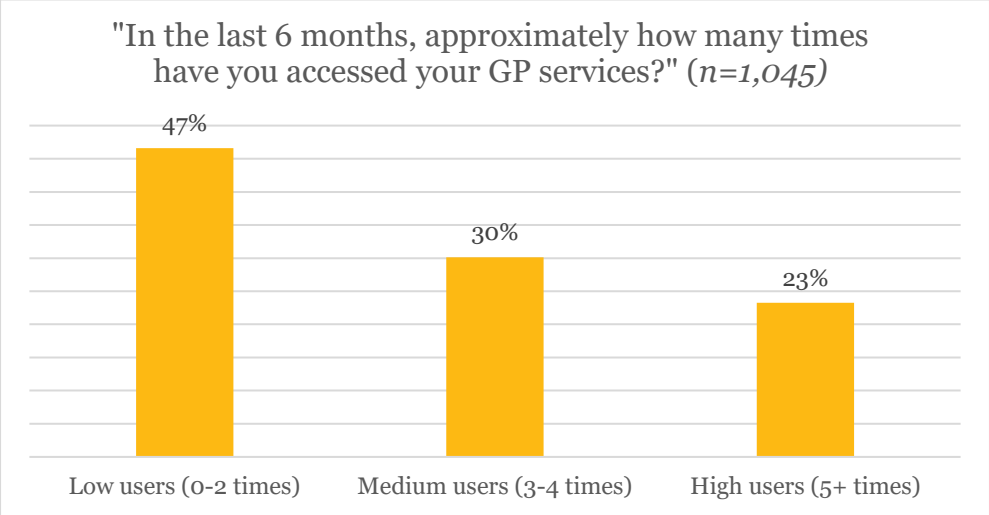
The age make-up of the survey sample is shown below. Approximately, 1 in 4 survey participants were aged 55-64, which pays credence to the notion of "Silver Surfers" – an emerging demographic of those who are 50+ and perceived as less digitally engaged, but are in fact capable of using technology.



2.4.3 Frequency of primary care access

Participants were asked how many times they access their GP in last 6-months. To allow for sub-group analysis, participants who accessed 0 – 2 times were classified as 'low users of primary care', 3 -4 times 'medium users' and 5+ times 'high users'.

The breakdown of low, high and medium users is shown below.



2.4.4 Long-term conditions and disabilities

Out of the total sample (n=1,045), 60% of participants had a long-term condition and 19% had a disability.

2.4.5 Digital literacy

Participants were asked how much they agreed with the statement "*I know how to use a laptop, tablet, or phone to access the internet and find information*". Participants responses were pooled as follows:

Participants response	Classification
Strongly agree ***Agree***	*Digitally enabled*
Neutral ***Disagree*** ***Strongly disagree***	*Not digitally enabled*

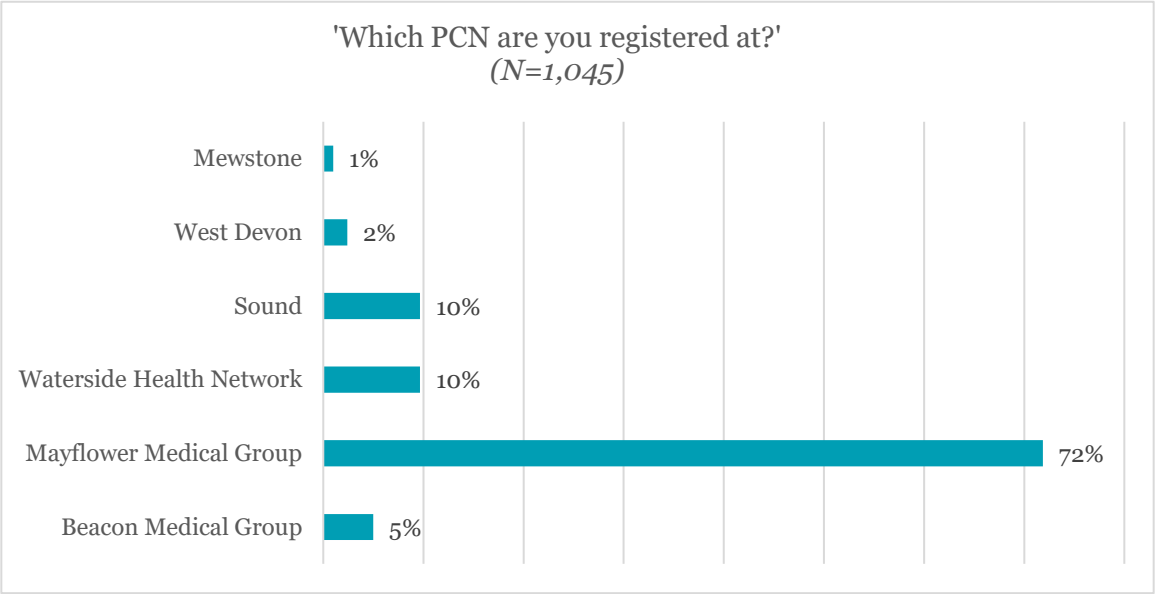
Using the classifications above, 91% of participants self-reported that they were digitally enabled and 9% were not digitally enabled.

2.4.6 Area and GP practice

Survey participants were asked where they are registered as a patient. The survey sample was representative of patients registered at 17 GP practices across 6 out of 9 Primary Care Networks (PCNs) in the Western Devon locality.

The final sample also included a mix of patients who lived urban and rural areas, including: Tavistock, Devonport, Ham, Ivybridge, Westpark Ernestle, St Budeaux, Lipson, Plympton, Keyham, Plymstock, Prince Rock, Mutley and Central Plymouth.

The following figure shows the proportion of patients in our sample that were registered at a GP practice within each of the 6 PCNs*.



The GP practices that were represented are:

- Beacon Medical Group
- Ernsettle
- Mannamead
- Collings Park
- Mount Gould
- Stirling Road
- Trelawny
- Church View Surgery
- Wembury
- Oakside Surgery
- Friary House
- Yelverton
- Peverell Park
- Budshead
- Tavyside Health Centre
- Devonport Health Centre
- Abbey Surgery

**Please note, there was a considerably higher representation from Mayflower due to the methods they deployed to reach patients. When recruiting for the qualitative sample, ICE endeavoured gain representation from a range of practices.*

2.5 Primary Insight: Sample characteristics

Based on ICE's vast experience of conducting qualitative research – which includes previous qualitative research projects conducted on behalf of Devon STP - ICE anticipated that 40 depth interviews would be appropriate to reach the point of conceptual saturation for Devon STP practices and patients.

A total of **41 participants** took part in a *45-60 minute* depth telephone interview, intended to explore participants attitudes, beliefs and experience in relation to primary care access and e-Consult.

ICE researchers used 'clean language'[2] (non-leading questioning) and laddering techniques throughout, to continually explore the 'why' behind the decisions and behaviours that the participants had retrospectively or prospectively reported.

A tailored discussion guide was created to answer the research objectives and explore:

- Experience of accessing primary care
- Motives to choose primary care over other health services
- Attitudes and beliefs towards e-Consult
- Motives, barriers and needs in relation to using e-Consult
- Experience of using e-Consult

The final sample was selected in line with recruitment quotas that were informed by a brief data review[3] and designed to ensure a representative and diverse sample. The sample breakdown is provided here:

2.5.1 Gender

The sample of 41 was:

- 25 females
- 14 Males
- 1 Other/prefer not to say

A higher proportion of females were recruited, to correlate with the higher proportion of female patients using e-Consult in Western Devon[3], in which *69%* of registered female patients made e-Consultations compared to *31%* of males.

[2] Sullivan W. and Rees. J (2008) 'Clean Language: Revealing Metaphors and Opening Minds'. Based on David Grove theory of clean language. Available here

[3] Recruitment quotas and data review available on request.

2.5.2 Age

In line with recruitment quotas, a range of age groups were represented in the qualitative sample. The most represented age group was patients aged 65+ to ensure the views of older patients who are widely perceived to be digitally illiterate were accounted for.

Age bracket	Count of Participants
16-24	5
25-44	9
45-64	13
65+	14
Total	41

2.5.3 Frequency of primary care access

Participants were asked how many times they access their GP in last 6-months. To allow for sub-group analysis, participants who accessed 0 – 2 times were classified as 'low users of primary care', 3 -4 times 'medium users' and 5+ times 'high users'.

The breakdown of low, high and medium users is shown below.

Frequency	Count of participants
Low user (0-2 times in 6 months)	16
Medium user (3-4 times 6 months)	11
High Users (5+ times in 6 months)	14

2.5.4 Long-term conditions and disabilities

Out of the total sample (n=41), 60% of participants had a long-term condition and 27% had a disability.

2.5.5 Digital literacy

Using the classifications described in section 2.4.5, the qualitative sample included patients who were digitally enabled (66%) and not digitally enabled (34%).

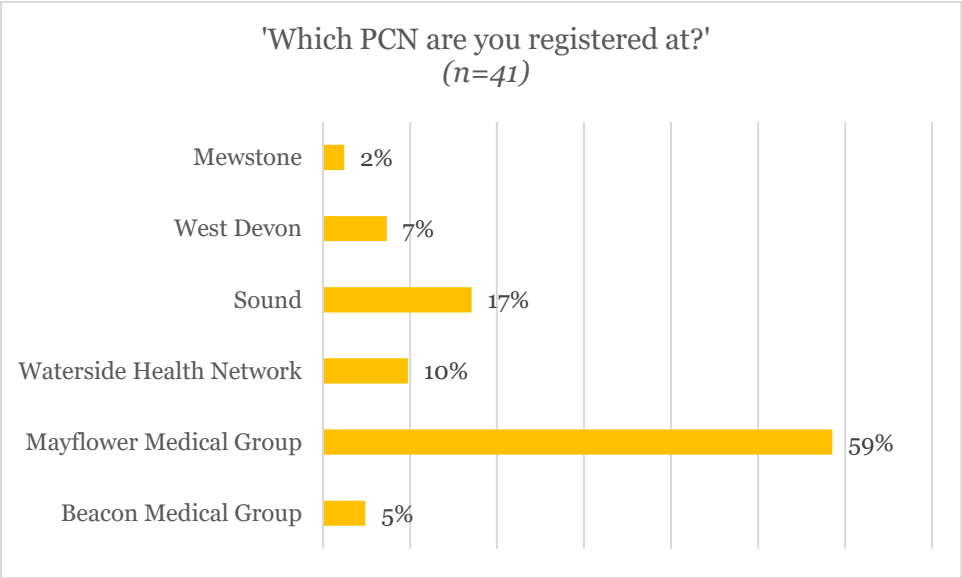
Owing to the nature of the e-Consult online format, it was important to ensure patients who have lower levels of digitally literacy were represented to ensure our sample was inclusive and to ensure digital barriers to access e-Consult were fully explored.

2.5.6 Area and GP practice

The qualitative sample was representative of patients registered at 8 GP practices across 6 out of 9 Primary Care Networks (PCNs) in the Western Devon locality. Not all participants from every practice registered their interest to take part in qualitative research, but nevertheless a diver sample was recruited.

The following figure shows the proportion of patients in our sample that were registered at a GP practice within each of the 6 PCNs.

The final sample also included a mix of patients who lived urban and rural areas, including: Plympton, Lipson, Keyham, St. Budeaux, Plymstock, Prince Rock, Mutley, and Tavistock.



The GP practices that were represented are:

- Beacon Medical Group
- Tavyside Health Centre
- Oakside Surgery
- PevereWatersll Park
- Church View Surgery
- Trelawny
- Friary House
- Mount Gould

2.6 Informed consent

All participants were required to provide informed consent to take part in this project and were informed that all data will be anonymised by removing person identifiable information. Therefore, no person identifiable details are included in this report.

2.7 Data analysis

Thematic analysis was used for all the data collected; this is one of the most common forms of analysis in qualitative research . This form of data analysis allows for the recording of patterns to develop relevant themes specific to the research question.

The large-scale survey featured open-ended questions which provided qualitative insights at scale. This was followed by in-depth interviews to fully answer the research questions. A thematic analysis of the large-scale survey responses and depth interviews has allowed all the research to be triangulated. Differences between sub-groups have been reported when they occur.

Insight findings

3 Survey findings

Layout of findings

A total of 1,045 patients completed an open-end survey which has provided key insights into how local patients access their GP and their attitudes and experiences of using e-Consult.

The findings from the survey are presented in the following sections:

- How do patients access their GP?
- Would patients use e-Consult in future?

Please note, if a theme was elicited consistently across the different target audience groups, then findings are pooled across the study sample. Differences between sub-groups are described only when they occur.

3.1 How do patients access their GP?

Participants were asked if they had accessed their GP in the last 6-months. Out of all survey participants, a total of 944 participants had accessed their GP in the last 6-months and a high majority had used e-Consult (80%).

Notably, approximately 1 in 2 participants who had used e-Consult to access their GP, had also called the practice (43%, n=410. Many participants who had both telephoned and used e-Consult expressed that the platform was easy and "a million times more convenient than having to phone and wait in a queue", which indicates that dissatisfaction with busy phone lines may lead many patients to use e-Consult. This was further explored during the primary insight and is discussed in section 4.1.3.2.

Approximately only 1 in 10 participants accessed their GP by walking into their practice, which is considerably lower than the number of people who used e-Consult and telephone. This pattern may in part be due to the coronavirus restrictions. A small number of patients also accessed their GP in 'other' ways including:

- Arranged blood tests/ routine vaccinations
- Emergency services
- Signposted by NHS App
- Sending a letter to surgery

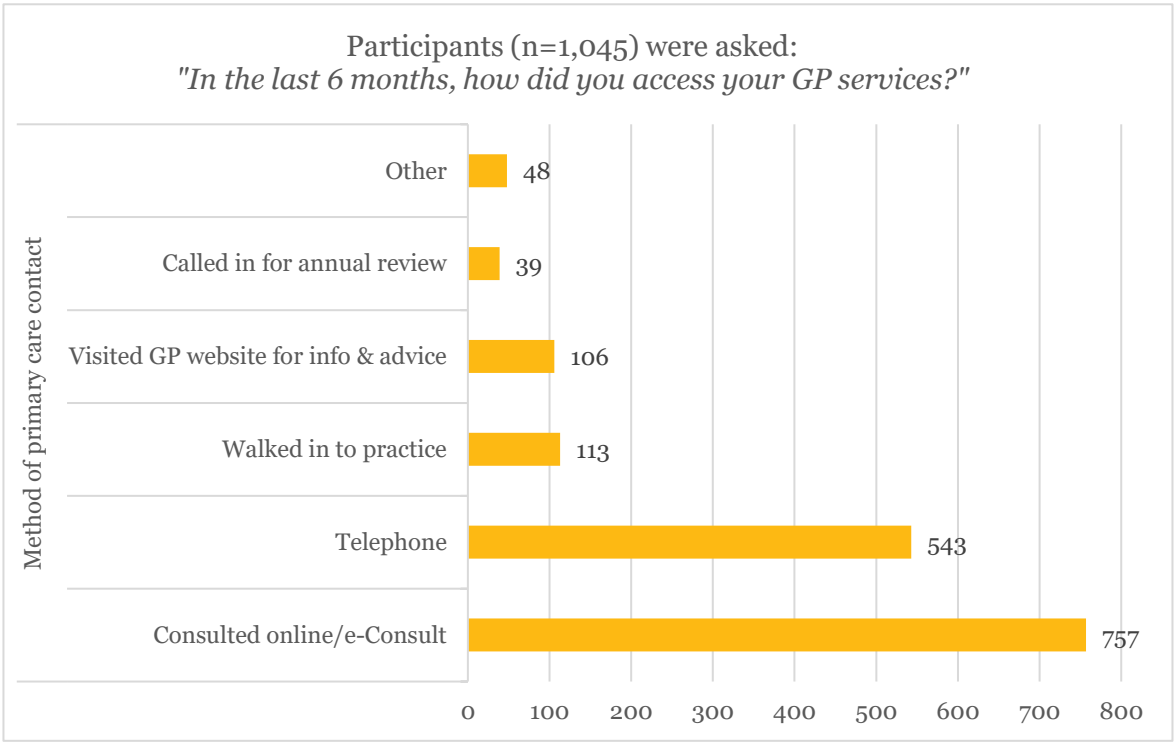


Figure 1: This chart shows how patients accessed their GP service in the last 6 months.

3.2 Would patients use e-Consult in future?

Participants who had used e-Consult (n=757), were asked if they would consider using it again in future and approximately 2 in 3 people said they would.

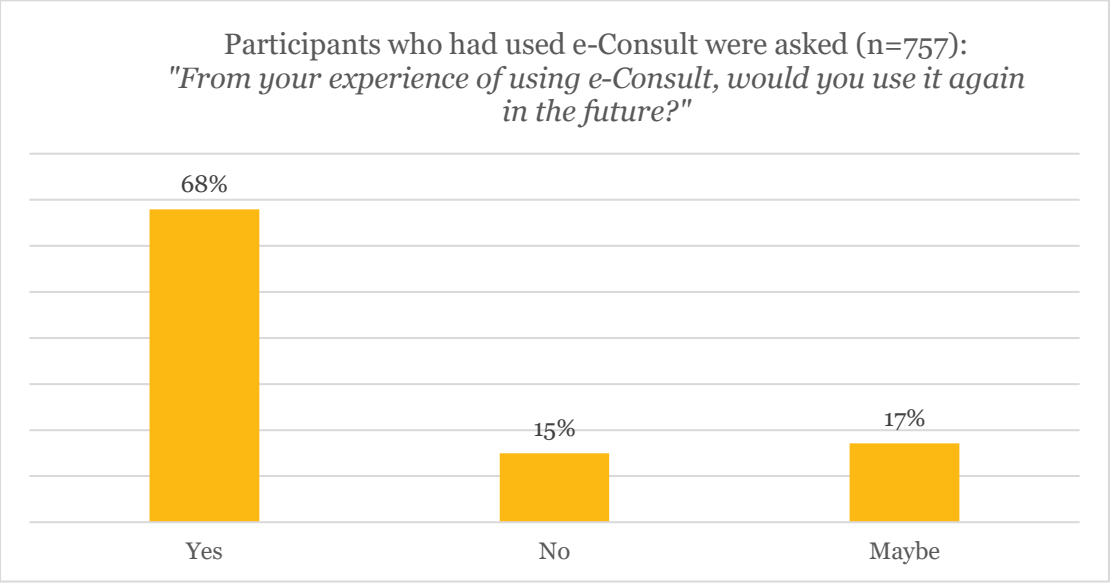


Figure 2: This chart shows the % of participants who would use e-Consult again.

3.2.1 What motivates patients to use e-Consult again in future?

Many participants described e-Consult as a form that was easy to use, quicker and less stressful than calling the practice/waiting on hold and could be accessed 24/7 at a time that suited them around work and personal commitments.

"I found it easy to complete and was able to do it at any time, weekend/evening rather than working hours which is fine if non urgent. Also got speedy response and thorough questions" (Survey participant)

Even participants who self-identified as having low digital literacy skills (see section 2.4.5), preferred using e-Consult because it was less frustrating than calling the practice. The dissatisfaction with alternative options, like calling the practice, is discussed in section 4.1.3.2.

Many participants were pleased with the outcome of their e-Consult, particularly if they received a timely call back. Other participants who lived in more rural areas or who had limited mobility, were pleased they didn't have to travel to the practice for an appointment and that their concern could be dealt with remotely.

Some survey participants said they preferred to use e-Consult because they prefer to write down their concern rather than speaking to someone on the phone (see section 4.2.3.3) or because it was private and confidential between the doctor and patient (see section 4.1.3.3.2). In addition, some survey participants aged 25 – 44 expressed the benefits of being able to submit an e-Consult discreetly at work from their phone or laptop, which was more private than a phone call.

"I thought it was very easy to navigate the system online and straight forward to complete. It is more discrete writing it down in the form, I can do it in my lunchtime, and no one would know, rather than having to discuss the nature of your problems over the phone. I received a call back from the doctor within two hours of having completed the e-Consult! I was thoroughly impressed with the system." (Survey participant)

3.2.2 What deters patients from using e-Consult again in future?

Out of those participants who had used e-Consult in the last 6-months (n=757), 17% said they were unsure and 15% said they wouldn't use e-Consult again (see Figure 2).

Approximately 1 in 3 patients were unsure or certain they wouldn't use e-Consult again.

Reasons for this often related to functionality of the platform, noting that it took too long to complete, was repetitive and not always easy to understand. Many questioned whether the GP would "bother reading all this".

Additionally, many were dissatisfied with the outcome of their e-Consult, particularly if they didn't receive a call back (discussed further in section 4.2.4.5). Participants didn't believe their concern was adequately addressed when they received a short text message without the opportunity to discuss further with the doctor.

Others said they were instructed to call the practice, which left them wondering "why didn't I do this in the first place?".

Of those patients who did receive a call back, many aged 25 – 44 said they missed the call due to being at work and thought the timeslot was reasonable but "too vague". This is discussed further in section 4.2.4.4).

"Very long process and not always the correct options that I need, also a very repetitive form. Due to work I can't wait around for a doctor to call me and can easily miss the call" (Survey participant)

3.2.2.1 What deters patients with long-term conditions specifically

Out of all survey participants (n=1,045), approximately 2 in 3 patients had a long-term condition (LTCs) (see section 2.4.4)

While the majority of survey participants with LTCs said they would consider using e-Consult, many still voiced frustration with using e-Consult, because they were often redirected to acute care after hitting a 'red flag' regarding a symptom that was related to their condition, rather than something that required urgent care/treatment. As discussed in section 4.2.4.1, patients would then either 'fudge' the form to complete the e-Consult, cancel the e-Consult and call the practice, or follow the instructions to call NHS 111 and be left dissatisfied when they were redirected back to the GP.

"It never works. I have high blood pressure and it always directs me to 111 or 999" (Survey participant)

Additionally, many participants believed the e-Consult form was too complicated and long winded in proportion to their needs, which was simply a routine query for their known LTC.

"I have long term problem and only want to catch up with my GP. E-Consult was not helpful in this instance" (Survey participant)

Patients with long-term conditions are more likely to be dissatisfied with e-Consult and more likely to be high users of primary care.

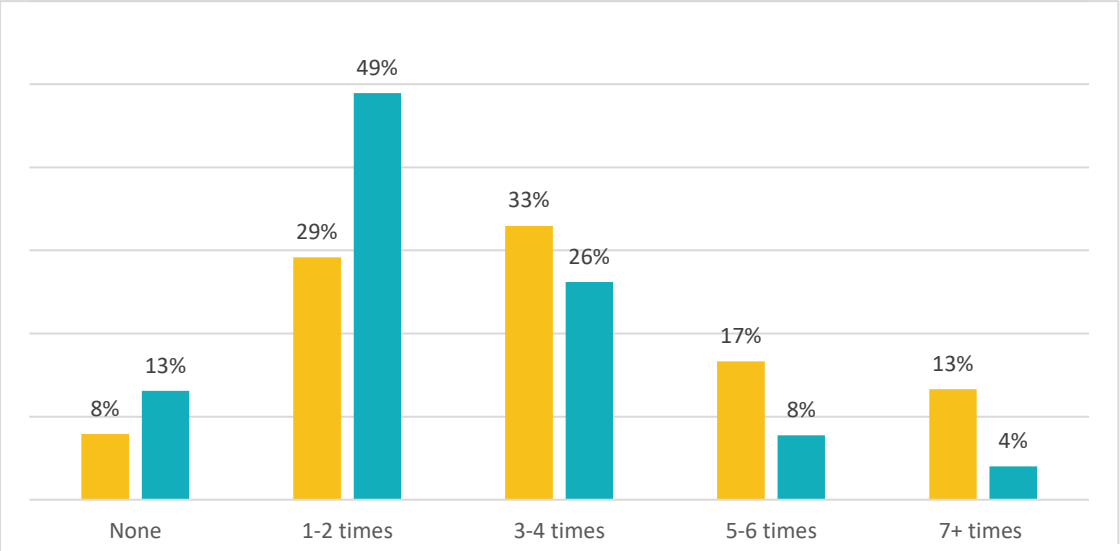


Figure 3: This chart shows how often patients with LTCs accessed their GP compared to patients without LTCs

Figure 3 shows that patients with LTCs use primary care more than patients without LTCs. As reported in section 2.4.3 participants who accessed their GP 5 or more times in the last 6-months have been categorised as high users of primary care.

This chart shows that out of those participants with long-term conditions (n=631), 1 in 3 are high users of primary care compared to patients without long-term conditions, where approximately 1 in 10 patients are high users.

These findings suggest that patients with LTCs are more likely to be high users of primary care and be dissatisfied with e-Consult due to the nature of their condition. Therefore, it will be important to consider addressing their needs specifically to encourage repeat uptake among this patient cohort.

3.2.3 Would patients who haven't used e-Consult in the last 6-months use it in future?

Some survey participants had not used e-Consult in the last 6-months (n=288) and can be considered 'non-users' for the purpose of this report. Out of all survey participants (n=1,045), 10% of patients hadn't accessed their GP at all, and 18% of patients had accessed their GP but didn't use e-Consult.

Non-users (n=288) were then asked if they would consider using e-Consult the next time they access their GP.

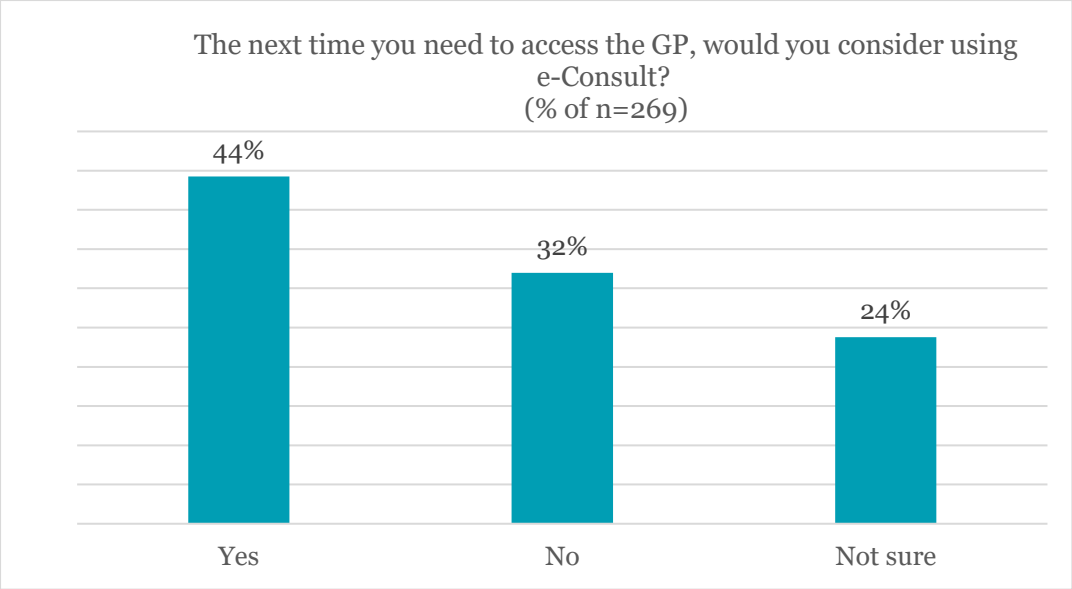


Figure 4: This chart shows the % of non-users who would use e-Consult in future

For the 44% who answered 'yes', ease and convenience was a prominent theme for willingness to use e-Consult in the future. Similar to the motives in section 3.2.1, non-users reported dissatisfaction with busy phone lines and the ability to use e-Consult when it suited them around work and family as key motives.

For the 56% who were unsure or certain they wouldn't use e-Consult in future, many reported low confidence, knowledge and skills to access e-Consult online independently. Others said they wanted to speak/see the doctor and that a thorough consultation could not happen through a form.

"I would like to see my own GP who knows me, I don't know how to use e-Consults and don't have access to a computer" (Survey participant)

Low knowledge, confidence and skills to access e-Consult online independent is a key reason why patients might not try e-Consult in future.

Non-users (n=288) were asked if they knew how to use e-Consult, to assess whether patients perceived themselves to have the necessary knowledge, confidence and skills. 54% said yes, 40% said no and 6% didn't answer.

From further data segmentation, Figure 5 shows there is a slight correlation between capability and age. Out of all non-users that said they do know how to use e-Consult, 50% were aged 55 and above, compared to non-users who didn't know, where 67% were aged 55 and above. This suggests support to equip patients with the knowledge, confidence and skills to use e-Consult may need to target older adults (see section 5.1.2).

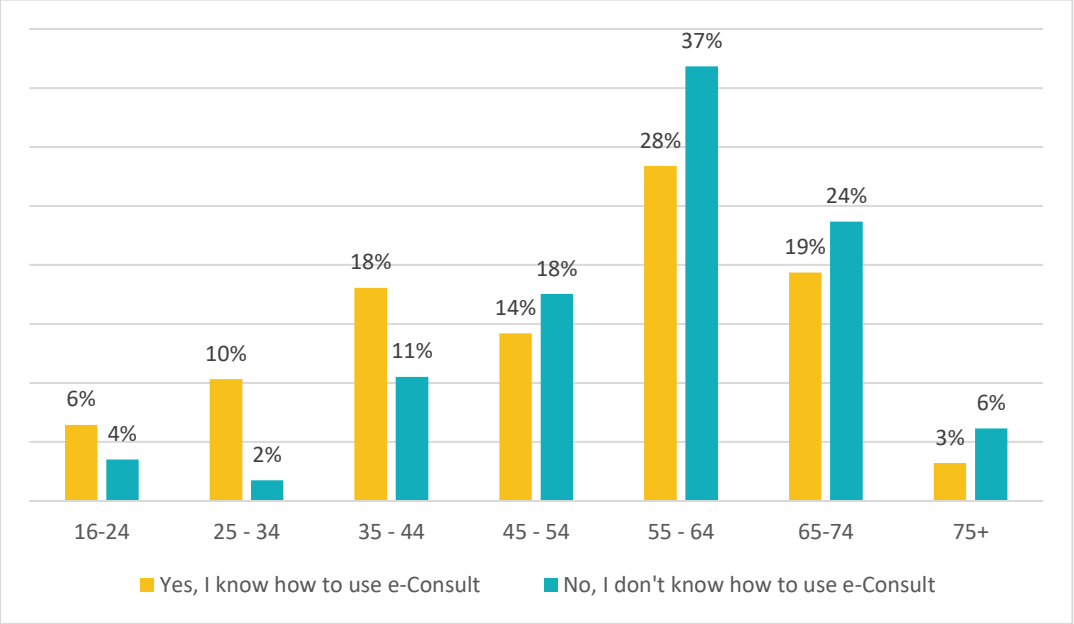


Figure 5: This chart shows % of patients who have the capability to use e-Consult split by age group

4 Primary Insight findings

Layout of findings

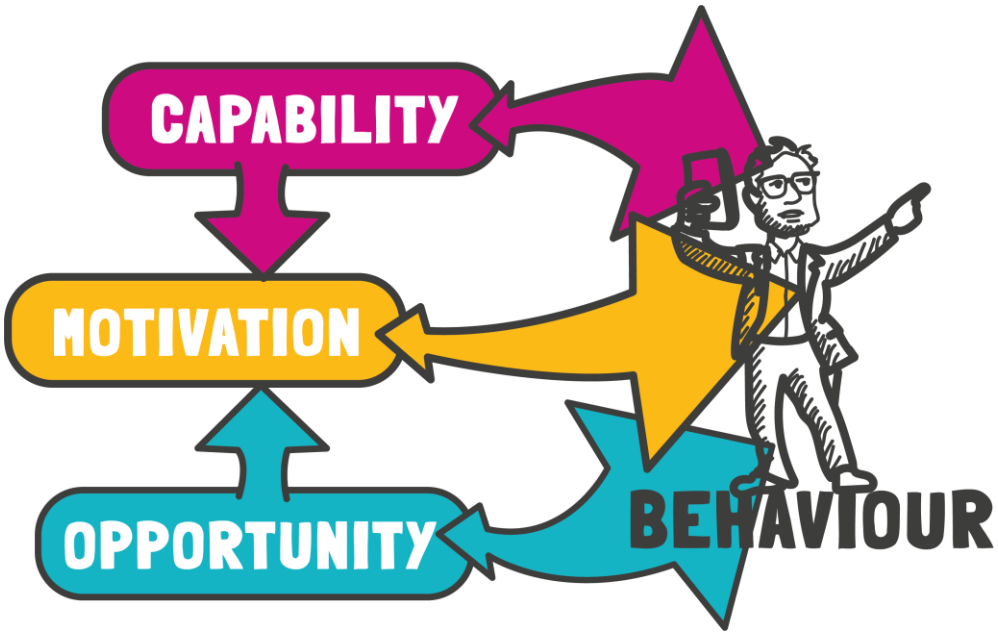
The findings from the research activities are presented in the following sections and have been triangulated to provide both prospective and retrospective evidence gathered from patients and health care professionals. The findings have been pooled into the following three sub sections:

- What influences patients' behaviour?
- Experience of using e-Consult
- What support and information do patients need?

Please note, if a theme was elicited consistently across the different target audience groups, then findings are pooled across the study sample. Differences between sub-groups are described only when they occur.

4.1 What influences patient's behaviour?

The decision to use e-Consult is a choice made by patients that is influenced by several factors. The well-established ***COM-B model*** suggests that for a person to enact a behaviour (B), three conditions need to be present: capability (C), opportunity (O) and motivation (M)[4].



The COM-B model recognises the interplay between different factors that influence behaviour; stating that a particular behaviour will occur only when the person concerned has the capability and opportunity to engage in the behaviour and is more motivated to enact that behaviour than any other competing options.

The factors that influence whether patients will use e-Consult or not are discussed in relation to the three necessary conditions required to change behaviour: capability (C), opportunity (O) and motivation (M)[5].

Adopting the COM-B model will help ensure a social marketing approach/intervention is designed to facilitate these conditions and effectively influence patient's behaviour.

[4] Mitchie et al (2011) *The behaviour change wheel: A new method for characterising and designing behaviour change interventions.* Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3096582/

[5] Mitchie et al (2011) *The behaviour change wheel: A new method for characterising and designing behaviour change interventions.* Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3096582/

4.1.1 Capability

In the COM-B model, **capability** is defined as an individual's psychological and physical capacity to engage in the desired behaviour. To be capable, a person needs to have the necessary knowledge and skills to complete the action.

Most patients are digitally enabled (see sections 2.45 and 3.5.5) and have the knowledge, confidence and skills to use e-Consult, owing to the widespread use and advances of digital technology.

However, many participants expressed concerns that not everyone was digitally literate, which would be an immediate barrier to using e-Consult. Interestingly, most participants perceived elderly people to be digitally illiterate, yet the insight suggests many elderly patients aged 65 +, do have a computer, tablet, or smart phone. It was discussed that they used their technology to carry out certain tasks (e.g. send an email or Facetime their grandchildren) and all-importantly were *shown* how to do it. These participants said they would struggle to do an e-Consult because they didn't know how, but in a similar way that they were shown how to email or Facetime, there is a potential for patients to learn how to use e-Consult if they receive the right support. The value of hands-on support for increasing capability is discussed in section 4.3.3.

Additionally, a small number of participants who were 65+, had mental health problems or learning difficulties (e.g. dyslexia, low literacy skills) expressed low confidence in their ability (known as 'self-efficacy') to articulate their concerns and successfully complete an e-Consult independently online.

"The first time you try anything new it's a challenge, never mind when you're feeling unwell! I do think it would be a struggle for me I'm afraid and I'd worry I'd done the whole thing all wrong" (P03)

Patients who do not possess the necessary skills and confidence to use e-Consult are at risk of digital exclusion, therefore efforts to equip patients with the necessary knowledge and skills will help increase their confidence and ability to complete an e-Consult.

4.1.2 Opportunity

In the COM-B model, **opportunity** is defined as all the factors that lie outside the individual that make the behaviour possible or prompt it, including both the physical and social opportunity. Each component will be discussed in turn.

4.1.2.1 Physical opportunity

Most UK adults can access or afford digital devices, data and Wi-Fi and therefore have the **physical opportunity** to use e-Consult online.

However, according to recent statistics, 10% of the UK adult population are "non internet users"[6] and are at risk of being digitally excluded because they only have a basic phone and cannot afford a computer, tablet, smartphone, internet data or Wi-Fi.

A small number of participants fell into this category and said that they had no choice but to call the practice.

Importantly, patients who cannot access e-Consult because they cannot afford or access the internet, may also not be able to afford phone credit. As a result, call waiting times may lead some of the most vulnerable patients to drop from calls and not access their GP[7].

This suggests that while most patients can access e-Consult, attention must be given to accommodate the most vulnerable patients who are at risk of digital exclusion.

4.1.2.2 Social opportunity

According to COM-B, **social opportunity** is afforded by the social and cultural environment that influences the way people think and act. *Social norm theory* states that people have a strong tendency to conform to group patterns and expectations. The attitudes and behaviours of 'other people like me', influences a person's behaviour and choices in order to conform to the social norm within their social setting[8].

Many participants believed online consultation was socially acceptable due to the widespread use digital technology for everyday tasks. The example of online banking was frequently mentioned, to highlight how services that were traditionally done in person or on the phone, had become normal to do online.

However, those participants who disapproved of e-Consult, expressed that "it's not just me" and that friends and neighbours had the same view.

Other participants said they knew people registered at other practices who didn't have to use e-Consult, which further reinforced the notion that it wasn't the social norm. This led to further reluctance to use e-Consult because "if they don't have to why should I?"

"Are they all going this way? Do some people have it better than me?" (P28

[6] ONS (2019) *Exploring the UK's digital divide*. Available at: www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage

[7] BMJ (2020) *Offline and left behind: how digital exclusion has impacted health during the covid-19 pandemic*. Available at: www.blogs.bmj.com/bmj/2020/07/03/offline-and-left-behind-how-digital-exclusion-has-impacted-health-during-the-covid-19-pandemic/#:~:text=A%20person%20may%20be%20digitally,literacy%2C%20culture%2C%20and%20ethnicity.

[8] UNICEF. *What are Social Norms?* Available at: www.unicef.org/protection/files/4_09_30_Whole_What_are_Social_Norms.pdf

"You don't want your patients to think they're getting a less of a service than anyone else, because every surgery is doing it differently or not at all" (HCP)

This suggests that a social marketing approach may consider framing e-Consult as the social norm to help influence people's attitudes and behaviours, owing to people's tendency to want to conform to behaviours and actions they perceive to be socially normal and accepted.

4.1.3 Motivation

In the COM-B model, both capability and opportunity will often influence a person's **motivation** to perform a behaviour or action. In general, the more capable we are (or believe we are) in enacting a behaviour and the more conducive the environment, the more motivated we are to do it.

Importantly, a person must be motivated to enact the behaviour (e.g. use e-Consult), more than any other competing option (e.g. call the practice and book an appointment).

Motivation in this sense considers how a person's attitudes, beliefs, and cognitive biases influences their behaviour and choices.

This section will explore patient's motives for using e-Consult by considering firstly, what motivates patients to access primary care in the first place? Secondly, by exploring the decreased motivation to access the GP by calling the practice (the default option and competing behaviour) and thirdly, by exploring the factors that increase motivation to use e-Consult.

4.1.3.1 What motivates patients to access primary care?

In order to understand what motivates patients (now and in future) to use e-Consult it is important to know what is driving them to access their GP in the first place, particularly as opposed to accessing other services of self-care.

The insight suggests that patients are motivated to access the GP because they want a diagnosis and further advice or treatment/medication from a doctor or nurse, to give them confidence and reassurance that they are "proceeding to deal with their issue in the best way". Other patients' access for routine appointments like blood tests or vaccines, or to get a sick note or get a status update on their prescription or test results.

"If you're not sure, and think your symptoms are linked to something else it gives you opportunity to discuss your issues in their entirety and be assured what they recommend is for the best" (p05)

Importantly, at the point at which patients try to access the GP they have already made a decision that the GP is the best place to go.

When exploring access to other services, participants said they would access their pharmacy and self-care if they knew what their issue was and what treatment/remedy was needed.

They would bypass the pharmacy if they perceived their issue to be "serious enough" to warrant GP access (if they were unsure what their issue was or what to do next) and/or if they needed medication that wasn't available over the counter or would need to be paid for without a prescription.

"It's a step more serious when you can't explain what it is or why you're feeling that way, that's why you need to ask a doctor for advice" (P02)

Some participants had been to the pharmacy for advice only to be signposted to the GP, leading them to "cut out the middle-man" and go direct to the GP next time. A small number of participants also voiced a sense of entitlement in being able to access the GP at anytime.

The insight suggests that patients have made a judgement about how 'serious' and 'urgent' their concern is, which is intrinsically linked to patient's perception of how quickly they need to receive advice/treatment.

At the point at which patients call the practice or complete an e-Consult they have already made a decision that this is the best place to go, explaining why many patients may ignore redirection to acute care when using e-Consult (discussed in section 4.2.4.1).

4.1.3.2 Decreased motivation to call the practice

The default option is calling the practice, yet when faced with busy phonelines patients consider e-Consult as an alternative choice.

The insight suggests that patients may experience default bias (the tendency for people to opt for the more familiar default option – see section 5.2.1.1) when making a decision about how to access their GP. Many participants expressed that they wanted to access the GP "the same way they always had" - calling the practice and booking an appointment.

In the context of primary care access, the insight suggest that many patients opt for the default option and call the practice. It is only after being dissatisfied with busy phonelines and long queues, which was described as "frustrating" and "something to dread" that they considered other choices (e-Consult).

A small number of participants who lived in more deprived areas said they used e-Consult because it was free to access on their phone and saved "using all my credit" by being on hold to the practice. (Importantly, people with lower socio-economic status will face this same barrier to access e-Consult if they do not have internet or a smartphone).

"When I phoned up one morning, I was 17th in the queue and I heard about it [e-consult] on the loop message, so I gave it a go" (P09)

The difficulty in calling the practice left some participants feeling "scared" that e-Consult seemed to be the only way to access the GP because it was "near impossible" to get through on the phone, compounded by the fact that walking in to the practice to book an appointment is not currently an available option.

"It's like driving against the traffic, you can't get anywhere, it's scary to think this e-Consult is the only way" (P04)

This suggests that while it may be beneficial to position e-Consult as the best choice, it will be important to consider the potential negative impact on patients who feel they don't have a choice and that e-Consult is their only option due to barriers in calling the practice.

4.1.3.3 Increased motivation to use e-Consult

4.1.3.3.1 Convenience

Many participants were motivated to use e-Consult because they could "do it on the sofa", 24/7, at a time that suited them, rather than calling the practice to book an appointment in a restricted timeframe (e.g. 8am weekdays).

"More convenient way of getting in touch with doctors, from the comfort of home rather than waiting in a queue. The doctor can call you back already knowing what your issue is" (P37)

Some participants who lived in rural areas were also motivated to use e-Consult if it meant avoiding the need to travel far to their practice.

4.1.3.3.2 Privacy

While contacting the GP over the phone, many participants didn't feel comfortable disclosing personal information to the receptionist, and at times had experienced receptionists asking intrusive questions. Being able to tell the doctor about their concern in confidence was important to many patients and was a key motive to use e-Consult.

"She asked why I was taking the medication in the first place, well, that's not her question to ask!" (P02)

4.1.3.3.3 Impact of Covid-19

The survey findings detailed in section 3.1 show that the number of patients walking into practices is considerably lower than telephone and e-Consult, which may in part due to Covid-19.

This is explained during the primary research, as many participants said they used e-Consult to reduce the need to visit the GP or leave their house during the pandemic, particularly if they, or a person they lived with, was shielding.

Others said they were mindful of the pressures on the health system due to Covid-19 and were motivated to use e-Consult to avoid putting extra burden on the system for lower level concerns.

Notably, while many participants could understand the benefit of e-Consult within the context of Covid-19, there was uncertainty as to whether e-Consult was intended to be a temporary solution or permanent fixture. This indicates that a social marketing approach will need to help communicate the changing role of e-Consult during and after the Covid-19 pandemic.

"Is it just the way they do it now? or is it only like this because of Covid?" (P17)

4.2 Experience of using e-Consult

In the survey, participants were first asked if they had recently accessed their GP. Out of all participants, a total of 944 participants had accessed their GP in the last 6-months and 80% had used e-Consult (discussed further in section 3.1). During the qualitative interviews, researchers further explored patients experience of using e-Consult.

This section will explore:

- How did patients find out about e-Consult?
- How did patients access e-Consult?
- Benefits of use
- Challenges of use

4.2.1 How did patients find out about e-Consult?

Participants had low knowledge of e-Consult, yet nearly everyone had heard about e-Consult

While many participants had low knowledge of e-Consult and its purpose, nearly all participants had heard about e-Consult in one of the following ways:

- Via the 'on hold' automated message while trying to call the GP practice or were informed by the receptionist, which led many participants to redirect to e-Consult.
- Via text message which was perceived as an appropriate channel for health-related messages (of note, this view was held by many participants aged 65+ who often received informative texts from their GP practice).
- Visited the GP website to find the phone number and e-Consult popped up instantly.
- Received a leaflet or had seen advertisements in the practice
- Signposted to e-Consult by NHS 111 or emergency services
- Word of mouth

These communication channels will be important to consider for a social marketing approach to reach patients using channels that they are familiar with and that are appropriate for public health-related messaging.

4.2.2 How did patients access e-Consult?

Most participants accessed e-Consult online and for others, the GP receptionist completed the e-Consult on their behalf over the phone.

Most participants accessed e-Consult independently online and for others, the GP receptionist completed it on their behalf over the phone. Many said the receptionist was helpful, asked simple questions and made it very easy, however some felt uncomfortable disclosing personal information to the receptionists.

Other participants said their experience of speaking to receptionists was varied. Some participants said receptionists were helpful and would happily complete the e-Consult over the phone, whereas other receptionists would signpost to e-Consult online. Participants said this made it even harder to access the GP as the receptionists were the "gatekeepers" and didn't always give an alternative route to access for those patients who had difficulty using e-Consult online.

This suggests the need to ensure practices have dedicated admin team that can support patients to use e-Consult.

4.2.3 Benefits of using e-Consult

Many participants reported the benefits of using e-Consult, including ease, convenience, privacy and the preference to write down their concerns rather than speak to someone. Each benefit is discussed in turn.

Notably, nearly all participants who found e-Consult beneficial mentioned areas for improvement which are discussed in section 4.2.4.

4.2.3.1 Easy and convenient

Many participants who were digitally literate, discussed that e-Consult was straight-forward, logical and quicker and less stressful than calling the practice (discussed in section 4.1.3.2).

Participants of working age (aged 25 -54), found it beneficial to access e-Consult at a time that was convenient for them around their family and work commitments, rather than "being on the phones at 8.30am".

"I can do it when I want, it's handy and easy because you're on your sofa, on your laptop doing it when you have the time, rather than needing to be queuing on the phone at 8.30" (P03)

"It's at your fingertips, sat at home with a cup of tea not having to wait for the surgery to open at 8am!" (Health care professional)

A small number of participants (aged 16 – 24), also said it was convenient being able to access advice via e-Consult that they would have previously obtained by booking a nurse appointment "to explain it all to me". This saved them time and effort, while giving them all the information they needed to make an informed decision about what to do next.

Some participants of working age had little time or flexibility to accommodate a GP appointment and were satisfied when their issue was resolved without a telephone/face-face consultation (e.g. receiving an email with advice or a prescription). Opposingly, for other patients not receiving a telephone/face-face consultation was far from a benefit, and in fact a source of dissatisfaction (discussed in section 4.2.4.5).

4.2.3.2 Privacy

As discussed in section 4.1.3.3.2, privacy of information between the doctor and patient is a key motive for using e-Consult.

Additionally, some participants aged 16-24, said e-Consult was a discreet way to access the GP if they didn't want their parents/caregivers to know about their reason for access (e.g. contraception). It was noted by health care professionals that e-Consult cannot be used by teenage patients (e.g. aged 13 – 17) without their parents/caregivers being notified.

It will be important to consider whether it is possible for e-Consult to facilitate private interaction between younger patients and doctors to help ensure younger people get the right advice and medication/treatment they may need.

4.2.3.3 Prefer to write down their concern

Many participants including younger patients (aged 16 – 24) and patients with mental health problems, said they preferred to write down their concern rather than speaking to someone on the phone.

It was widely discussed that being able to take their time and write down their concern, allowed patients to fully explain their concern in their own words and focus on what was important to them. Additionally, the ability to not have to speak to someone was a key benefit for patients with high social anxiety.

Importantly, while this was beneficial for some, for other patients (e.g. with learning disabilities), writing down and articulating their concern was a barrier to using e-Consult (discussed in section 4.1.1).

"It empowers and encourages patients to prioritise what they want to talk about and state what's wrong in their own words" (Health care professional)

4.2.4 Challenges with using e-Consult

Nearly all participants who had used e-Consult reported some degree of challenge when using the platform. Importantly, many participants recognised the use-value of e-Consult and believed it would be an effective tool to access their GP if some of the challenges experienced were addressed.

"The principle is there, but the process of how you access the information and get through it is cumbersome" (p04)

4.2.4.1 Redirection to acute care

e-Consult directs patients to seek more acute care if they "hit a red flag" regarding a condition/symptom that may require urgent intervention[9]. This happened most often for patients with long-term conditions, who knew their symptoms were related to their long-term condition and didn't warrant acute care. Many participants said it was "frustrating" or "annoying" when they were re-directed to NHS 111 or 999 and resulted in patients enacting one of the following behaviours:

Ignored the notification and proceeded to "fudge" their answer (e.g. change their pain score) to complete the e-Consult.

As discussed in section 4.1.1, at the point at which patients try to access the GP, including via e-Consult, they have already made a decision that the GP is the best place to go. This may explain why the most common course of action was to "fudge" the answer to get through to the GP. Problematically, this may lead patients to provide potentially inaccurate information to their GP as a result.

"I know my condition, I know this wasn't an emergency, I started to lie on the form but when it came up a second time I scrapped it all together and called the GP" (P17

Cancelled the e-Consult and called the practice stating that e-Consult flagged their concern as serious.

Some participants said they cancelled e-Consult and called the practice, explaining that they had been redirected, but that they still wanted to access their GP. As a result of the concern

[9] e-Consult 'How it Works' – Available at: www.econsult.net/primary-care/how-it-works

been flagged as 'serious', receptionists may then feel obliged to give the patient an appointment.

Health care professionals raised concerns about the sensitivity of e-Consult and the knock-on effect as patients could then bypass the triage process and be put on a GP telephone list.

Furthermore, if patients cancel e-Consult, call the GP and achieve their desired outcome (e.g. an appointment) they will be more likely to bypass e-Consult in future and call the practice direct.

"I didn't bother [ringing NHS 111] because it wasn't urgent. In the end I cancelled the form and rang the surgery to speak to someone… a paramedic called me back and prescribed me what I needed. I picked it up from the pharmacy later that day" (P03)

Followed the re-direction (e.g. to NHS 111).

A small number of participants said they called NHS 111 when prompted and were left frustrated when they were advised by NHS 111 to access their GP. This led patients to call the practice and often expressed dissatisfaction and frustration in trying to get through to the right service.

4.2.4.2 Redirection to self-care advice

A few participants were redirected to self-care advice while completing an e-Consult but ignored this instruction as they had already made the decision to contact their GP. This suggests the need to support patients to access self-care advice before they begin the process of accessing their GP.

"This advice box popped up and that's nice to know but really if I'm halfway through the form, chances are I've already decided I want to see a doctor" (P24)

4.2.4.3 Relevance of all the questions

Many participants described e-Consult as long-winded and repetitive because of the amount of questions they were required to answer.

Participants said **the list of symptoms was not exhaustive**, which led patients to select symptoms that applied the most, but "didn't fit the bill".

Additionally, having to select a tick box and then describe their symptoms in their own words, felt repetitive. Participants suggested having a catch-all "other" tick box to allow patients to accurately describe their concern and avoid misleading the GP.

These findings suggest that the algorithms built into e-Consult via tick boxes may negatively impact the users experience and will be important to consider in recommended changes to the platform.

"I wouldn't have to tick boxes in an appointment, I'd simply speak to the GP in my own words so why can't I do that here?" (P23)

"If I write down that my back hurts, I don't need to tick the box that "my back hurts" because I've already explained it" (P37)

Many participants said the form took longer than expected to complete. They believed **some of the questions were irrelevant to their concern** (e.g. asking about family history for a concern related to depression), repetitive and "long-winded", particularly for simple requests such as checking progress on a prescription. Others said it would be easier to upload a photo rather than write down every detail but didn't always have the option to do this.

"Sometimes you wonder, wouldn't it be quicker for me to just ask this of the GP in one sentence?" (P35)

"If you said you had a lump that was scaly, hot and red, it would ask how scaly? How hot? How red? Surely, it's easier to take a picture or for the doctor to look at it for a second! (P27)

Health care professionals noted that some patients had figured out how to fill in the bare minimum to process an e-Consult quickly, which brought into question the value of an extensive form.

4.2.4.4 Low knowledge of what happens next

The insight suggests that patients had limited knowledge of what happens after an e-Consult. They didn't know who received their e-Consult, how it was processed and how the practice prioritised responding to all the e-Consults they received (there was a perception prioritisation was based on seriousness of the concern).

Furthermore, while patients were informed they would be contacted before 6pm the next working day, they didn't know exactly when this would be or what would happen if they missed a call back – which they were worried about in case they had to "start the process over again".

"What if I'm on the landline? If I'm in the shower? Will they try again? I ended up ringing the surgery again to A) check they'd got my e-Consult and B) make sure the GP hadn't already called and I missed it" (P03)

"If someone like my mum in her 80's knows roughly when the doctor will call, they can look at the clock and think it's too early, without worrying whether they've missed the call" (P17)

A few participants said they didn't receive a confirmation of receipt or a call back after completing an e-Consult. As a result, they had to follow up with the practice to find out the status of their e-Consult and know what to do next. This was a frustrating experience and led them to disregard e-Consult next time they needed to access their GP.

To the contrary, one participant reported that they missed a call and the practice rang back a second time which demonstrated "they do care and want to help you", making it easy for the patient by reducing the need for them to follow up.

Participants themselves suggested that it would be beneficial to receive confirmation of receipt from the practice and an estimated timeslot 'like a Tesco delivery' to give reassurance that their e-Consult was being processed and to ensure they were available to answer the phone and get their concern resolved in a timely manner.

In cases where patients missed the call, they would expect the practice to try another communication channel or provide clear instructions of what would happen next.

"It's like if you miss a parcel, they leave a note and tell you where to pick it up from or if they're going to try redeliver" (P06)

Clear and concise patient-facing communication about what happens after an e-Consult and what to do if they miss a call back will be important for reducing the number of patients chasing the practice, which will both increase demand on GP receptionists and leave patients feeling dissatisfied with e-Consult because of the extra effort required to follow up.

4.2.4.5 Unmet expectations

What patients expect to happen after an e-Consult is linked to what motivates them to access primary care. As discussed in section 4.1.3.1, many patients (but not all[10]) want to speak to the doctor and expect to receive a call back or be able to book an appointment.

"It's a tool to describe your symptoms with a view to getting an appointment with your doctor" (P05)

Owing to this expectation, many patients will be left dissatisfied when their expected outcome does not happen. One participant confused e-Consult with an online booking system and was frustrated when they didn't get an offer of an appointment at the end.

[10] See section 4.2.3.1

Other said they received an email with written advice or details of a prescription, with no opportunity to speak to the doctor. In these instances, patients wanted to know why a decision had been made and discuss it with the doctor.

A small number of participants aged 65-74 also expected to have continuity of care and were dissatisfied when they received a call from a different doctor who didn't know their history.

"How can the doctor have judged my needs based on the form and without running that decision past me? I then had to fuss with ringing the surgery and insisted that I spoke to the GP" (P42)

These findings suggest that the disparity between what patients expect to happen and what actually happens, results in patients being dissatisfied with the outcome of their e-Consult. This is likely to lead patients to consider an alternative way to access primary care next time, particularly if their core motive is to see the doctor.

4.3 What support and information are needed to increase uptake?

Support and information is essential to equip patients with the knowledge, skills and confidence to use e-Consult.

A series of questions were asked to explore what advice, information and support patients would need to use e-Consult. Participants spoke both retrospectively from their experience and prospectively, about what would help them or somebody else in future. Notably, many participants naturally put themselves 'in the shoes' of a family member, friend or neighbour who was elderly or who "didn't do tech".

The insight so far demonstrates that patient who have a positive experience of e-Consult are more likely to use it again, than patients who have a negative experience.

Health care professionals discussed that it is vital to ensure patients experience is "bulletproof" and acknowledged the importance of support and information for equipping patients with the knowledge, skills and confidence to use e-Consult and have a positive experience and outcome.

4.3.1 When do patients need support?

Remember, we are asking patients to do something new and make a choice at a time when they are likely to be feeling unwell and fatigued.

Some participants aged 65 + discussed that learning something new was effortful and near impossible at a time when they were feeling unwell or fatigued. This suggests patients need support and guidance *before* they need to access primary care, to help prepare and equip patients with the knowledge, confidence, and skills to use e-Consult.

"We get frustrated because it's like no one's hearing us, we still understand the old system and we're happy with that so we don't get confused… if we are to use something new they need to have patience with us and help us learn how to do it, because it will be near impossible to do when I'm not feeling well" (P07)

4.3.2 Support tools and resources

4.3.2.1 How-to-guide

Several questions were asked to prompt participants to discuss 'what needs to happen' to enable more patients to use e-Consult. Many participants suggested that an easy, simple and visual 'how-to-guide' could support patients by walking them through the process step-by-step. It was discussed that this would help make the platform more familiar, allay their fears and increase patient's confidence and knowledge by demonstrating what it will be like, well

before they needed to use it. Others said it could also act as instructions, to guide patients through the process while they completed the e-Consult.

"Giving them something beforehand will take away the scariness of it, when people are unsure what it will be like because its completely new to them" (p09)

"a quick and easy leaflet for patients to follow it through step by step and know they're doing it right" (HCP)

Across the insight participants suggested information that would be important to include within this type of guide:

- Health care professionals said patients needed to be aware that they will need an active email address, which they are instructed to fill in at the end of an e-Consult
- Clear signposting to support options if an individual needs help or advice
- FAQ that are important to patients including:
- What is e-Consult?
- How long will it take to complete?
- What will happen after I complete it? (Who will receive/process my e-Consult? Who will contact me, when will they contact me, how will they contact me, what if I miss the call?)

The insight also suggests that elderly patients aged 75+ would benefit from being shown the very first step of how to get onto the interEnet on their device and enter the website address that would give them direct access to e-Consult.

"Giving me that website address just now has given me the key to unlock the door" (P39)

Participants suggested that the guide would need to be in simple, universal language and be distributed as physical copies for those patients who do not use email or social media as their main communication method. Health care professionals also said it would be useful to give the physical guide to patients when they register to help set the precedent that e-Consult is part of "how we do things".

"With anything new, keep it simple - it is easy for everyone to grasp then regardless of age and educational standard" (P17)

4.3.2.2 Online resources

Participants suggested the use of video or an interactive guide as an alternative to the physical copy discussed above. Health care professionals discussed that this information could be converted into a short video animation, which they reported as an effective way to disseminate information to patients (e.g. on the website, in the waiting room screens).

4.3.3 Hands-on support

It was widely discussed that patients who didn't have the necessary knowledge, confidence and skills to use e-Consult, would need somebody to support and guide them through the form for the first time.

As discussed in section 4.1.1, many elderly patients aged 65+ who are perceived to be digitally illiterate, do have a computer, tablet or smartphone which they use to carry out certain tasks (e.g. send an email or Facetime their grandchildren). Importantly, they were shown how to do it by a relative or friend, which suggests it is possible for these patients to learn how to do an e-Consult if they receive hands-on support and guidance to show them how it works.

It was discussed that support to do an e-Consult and learn a new skill would empower patients, giving them the confidence and encouragement to do it themselves the next time. Participants with mental health problems said it would give them a boost to learn and accomplish something new.

Further discussion was had about who is best placed to provide hands-on support, which included practice administration/reception teams and family members and friends.

4.3.3.1.1 Practice administration/reception teams

Many participants reported that they found out about e-Consult from speaking to the GP receptionist on the phone. The advice and information patients received was varied; with many being signposted to e-Consult, others receiving information about it and for some, the receptionist completed and e-Consult on their behalf.

Additionally, prior to Covid-19 restrictions, some participants said they had been given an iPad/tablet and walked through the e-Consult with support from the reception team, giving them the knowledge, confidence and skill to complete an e-Consult on their own next time.

Some participants discussed that GP practice staff were well-placed to champion e-Consult and support patients. It was discussed that making this type of support available to the patients who need it would help overcome feelings of "abandonment" and "being left to get on with it".

"Having a champion is an outlet to show you do care and that there is support in place for people who are least confident in using it" (P24)

4.3.3.1.2 Family members and friends

Some participants who had used e-Consult, had either given or received support from family members to complete an e-Consult. It was discussed that having someone to complete the form with for the first time, helped overcome reluctance to use technology once they had done it once and had a positive outcome.

"my dad, he still has a brick phone, so you can imagine he wasn't that willing, but once I sat down with him and we did it together, he was impressed in the end" (P05)

Many participants who expressed low levels of digital literacy said they had a family member or friend who could help them. However, it was discussed that they shouldn't be made to feel like they *have* to ask and "burden" a family member, linked to their desire for independence.

Considerations

5 Considerations for a social marketing approach

Documented within this section are a number of considerations to address the key barriers to e-Consult uptake and support patients to acquire the necessary knowledge, confidence and skills to use e-Consult. All considerations are borne out of the key themes from the insight and will inform future recommendations for a social marketing approach to increase e-Consult uptake in Devon.

5.1 Increase knowledge, confidence and skills

The insight demonstrates that while most patients have heard of e-Consult, many patients have low knowledge of what e-Consult is, its purpose, how to access it, how it works or what happens afterwards.

Informed by the insights, increasing patients' knowledge will help enable and motivate patients to access e-Consult (see section 4.1.1) and set expectations of how it works (user's experience) and what will happen at the end (see section 4.2.4.5).

Efforts to increase knowledge and manage patient expectations are likely to increase e-Consult uptake by equipping patients with the knowledge, confidence and skills to use e-Consult in the first place, and by helping to influence repeat behaviour, which is likely if their first experience meets their expectations.

The recommendations to increase knowledge are:

5.1.1 Develop a 'handy guide' to equip patients with the knowledge, confidence and skills to use e-Consult

As discussed in section 4.3.3, many participants suggested that an easy, simple and visual 'how-to-guide' would support patients by walking them through the process step-by-step. This would increase knowledge and confidence to do an e-Consult and act as a handy guide during the process.

It is recommended that a physical 'handy guide' is developed and distributed in GPs, pharmacies and posted direct to target patient groups; including older adults aged 55+ and patients with known mental health problems and learning difficulties (e.g. dyslexia or low literacy skills). The insight suggests that these patient groups are most likely to need support to complete an e-Consult (see section 4.1.1).

Informed by the insights, the guide should include the following information:

- What is e-Consult? (and why should I use it?)
- What will I need? (e.g. active email)

- The steps I need to take (from entering the URL to submission)
- How long does it take?
- What happens afterwards? (How is my e-Consult processed? Who will contact me? How and when will they contact me? What happens if I miss the call?)
- Signpost to help and support

In addition to physical guides, it is recommended that this information is made available online and signposted to by a social marketing campaign (see section 5.2

5.1.1.1 When do patients need this information?

The insight demonstrates that at the point at which patients are completing an e-Consult, they have already decided that the GP is the best place to go. This helps explain why patients may ignore redirection to acute care when using e-Consult (discussed in section 4.2.4.1). Importantly, it highlights that patients need support to navigate the health care system *before* they need to access it.

It is recommended that a social marketing campaign is established to raise awareness, educate and influence patients *before* they need to use e-Consult. The campaign should signpost to available support tools and guidance, as well as applying behavioural economics to influence patients behaviour (see section 5.2).

5.1.1.2 What channels can be used to reach patients?

To raise awareness, educe and influence patients to use e-Consult a multi-channel approach is needed. Communication channels may include: promotion on GP practice/community websites (e.g. Healthwatch), social media pages, social media adverts, collateral in and around GPs/pharmacies, on prescription forms/bags and via email, text and in the post to target patient cohorts.

5.1.2 Assign e-Consult champions to provide hands-on support

In addition to support tools and resources, it was widely discussed that patients would benefit (and have already benefited) from practical support and guidance provided by GP practice teams, including on the phone and in-person. Extending the provision of support from someone adept at using e-Consult would help many more patients in future.

As discussed in section 4.1.1 and 4.3.3, many patients aged 65+ (who are perceived to be digitally illiterate) do have a computer, tablet, or smartphone which they use for certain tasks (e.g. Facetime grandchildren). Importantly, they were *shown* how to do this, which suggests there is a potential to develop the skills to use e-Consult independent if they receive the right support and are *shown* how.

It is recommended that **GP practices/practice groups assign a dedicated e-Consult champion to encourage colleagues and offer hands-on support to patients**. This

person would champion e-Consult by being the key point of contact within their practice and by supporting other team members to effectively:

- Explain e-Consult to patients and signpost effectively
- Conduct e-Consults on patients' behalf
- Walk patients through the process if they walked into the practice (outside of covid-19 restrictions).
- Deliver workshops to teach and demonstrate how e-Consult works to key patient groups with an opportunity for patients to 'trial run' (outside of covid-19 restrictions).

"You don't want them to feel like the onus is completely on them – that they have to earn their doctor's appointment. We have a duty to support them" (Health care professional)

Of note, this type of support provision is already provided by some GP practices, notably high uptake practices. It will be beneficial to ensure key staff across GP practices in Devon are equipped with knowledge, confidence and skills to encourage and support patients to use e-Consult (this is discussed in section 5.3).

5.1.3 Support provision for vulnerable patients with complex needs

As discussed in section 4.1.2.1, patients who live in poverty, have complex needs and chaotic lifestyles are most at risk of digital exclusion because they cannot afford or access the Internet or have phone credit to call the practice and wait on hold[11].

To ensure the support needs of these patients are considered, it is recommended that e-Consult programme leads maintain links with community organisations/advocacy groups (e.g. Healthwatch and Deep End Plymouth) and involve community leaders in further research. This will ensure the challenges and support needs of patients living in poverty and with complex needs are considered, to inform the best mix of face-to-face and remote access for these groups.

It is also recommend that when vulnerable patients who are known to the practice call up to access their GP because they do not have Internet, that practice staff offer to call them back to save their phone credit and reduce the chance of the call cutting off.

[11] University of Plymouth, Covid-19 research: remote by default. Available at: www.plymouth.ac.uk/research/primarycare/remote-by-default-care-in-the-covid-19-pandemic-addressing-the-micro-meso-and-macro-level-challenges-of-a-radical-new-service-model

5.2 Apply behavioural economics to social marketing

This section discusses a number of key social constructs, heuristics and cognitive biases which are likely to influence patients behaviour based on the qualitative evidence collected during this project. It is recommended that these constructs, heuristics and cognitive biases are applied to a social marketing campaign to positively influence patients behaviour in line with our objectives.

5.2.1 Default option and default pull

In behavioural economics, *default bias* is the tendency for people to prefer things to stay the way they are. This cognitive bias impacts decision-making as people tend to opt for the more familiar 'default option' over the less familiar, but potentially more beneficial, choice.

While the impact of default options on choice is well-documented, the notion of '*default pull*'[12] explains how the presence of a default option prompts a person to consider whether they prefer the default in relation to other choices.

As discussed in section 4.1.3.2, the default option for primary care access is calling the practice. However, patients are likely to consider other options when phone lines are busy and they're waiting on hold. Using behavioural messaging to turn up the dissatisfaction with busy phone lines will prompt patients to consider e-Consult *in relation* to calling the practice without removing this option entirely.

Choice architecture should also be considered when presenting information on primary care access. The term was coined by Thaler and Sunstein (2008)[13] and refers to the practice of influencing choice by "organizing the context in which people make decisions" (Thaler et al., 2013).

It will be important to position e-Consult as the desired choice, without positioning it as the *only* choice in a campaign messaging. One way this can be done is conveying that e-Consult is the quicker option – a key driver that will further motivate patients to choose e-Consult over alternative options.

"I'd say to them use it to make things much faster for you so you can access a doctor much quicker – instead of waiting in a queue. The service will be the same – you will be consulted with by a doctor" (P40)

[12] Dhingra et al (2012) The default pull: An experimental demonstration of subtle default effects on preferences. Available at: www.sas.upenn.edu/~baron/journal/10/10831a/jdm10831a.html

[13] Thaler, R. H., & Sunstein, C. R. (2008) *Nudge: Improving decisions about health, wealth, and happiness.* Available here.

It will also be important to communicate that e-Consult is a permanent choice, rather than "solution" in response to Covid-19 (see section 4.1.3.3.3).

"it's easier to transfer money online than waiting in bank queue, you'll do it and once people realise it's easy enough and it gets the job done (Health care professional)

5.2.2 Behavioural nudges

Behavioural nudges are used to positively influence people's decision-making processes and behaviour in a predictable way. Importantly, nudges are applied by reframing choices without restricting a person's choice. A number of patients believed e-Consult was pushed on them without having a choice, which negatively impacted their view of the platform.

To effectively nudge patients to choose e-Consult, it will be important to not frame it as a mandatory option, rather the desirable option by conveying the salient benefits: Easy, convenient – do it anywhere, anytime to fit in with family, work and social commitments; Private and confidential; Write down in your own words – empower patients to focus on what's important.

Additionally, the insight suggests family and friends are well-placed to support some patients to use e-Consult, yet people don't want to feel obliged to 'burden' their family/friends. Therefore, messages should be framed to nudge patients to seek this support without feeling forced.

5.2.3 Social Norm Theory

Social Norm Theory [14] suggests that people's behaviour can be strongly influenced by their perceptions of how their peers behave. The theory suggests that although many people think of themselves as individuals, people have a strong tendency to conform to group patterns and expectations – sometimes referred to as 'herd behaviour'.

As discussed in section 4.1.2.2, online consultation is widely socially acceptable, but not by everyone. It will be important for a social marketing campaign to help re-frame the social norm by promoting e-Consult as a normal and effective way to access primary care (e.g. Many patients across Plymouth…).

Real life stories (e.g. short articles, quotes or video case studies) of patients who have had a positive experience and who are widely perceived to be digitally illiterate (e.g. patients aged 65+) will be effective in combating myths and reframing the social norm.

[14] Berkowitz, A (2004) The Social norms Approach. Available here

5.3 Create a pull from the workforce

As discussed in section 5.1.2, GP practice staff, including admin teams, communication leads, digital leads, social prescribers and doctors and nurses themselves, are well placed to encourage and support patients to use e-Consult. Therefore, it is essential to create a pull from the workforce to want to promote e-Consult to their patients and to actively seek out training opportunities.

The recommendations to create a pull from the workforce are:

5.3.1 Upskill the workforce

It is recommended that training is provided for key GP practice staff to equip them with the necessary toolkit to encourage, support and empower patients to use e-Consult. This will ensure patients are met with a consistent approach, which will help reinforce the desired behaviour.

While existing training that some practice staff have received has been reported positively, it is recommended that staff with high uptake practices support the co-creation of this training and its content to ensure it is developed with real life experiences in mind.

5.3.2 Conduct further research with the workforce

While a small cohort of health care professionals took part in this research, it is recommended that further research is carried out with primary care health professionals.

This research will provide a depth understanding of the current opportunities, challenges and gaps in online consultation from people who have experienced e-Consult to date; ensuring that any future changes are informed by both the experience of patients and professionals.

This should not only include primary health care professionals, but community leaders and patient advocates who are well-placed to voice the needs of the most vulnerable patients.

5.3.3 Encourage GP practices to send timely notifications

As discussed in section 4.2.4.4, many participants had low knowledge of what happened after an e-Consult. Generally, patients are told they will be contacted before 6pm the next working day and while this was an acceptable timeframe, patients believed it was too vague and that they “couldn’t wait around all day”.

It is well-documented in behaviour theory, that notifications and reminders influence behaviour by providing cues for people, giving reassurance that progress is happening or prompting them to act.

To reassure patients that their e-Consult is being processed and to reduce the number of patients following up, it is recommended that practices are encouraged to send patients timely text reminders once an e-Consult has been submitted. This includes:

- Confirmation of receipt
- Notification that the e-Consult is being processed and if applicable, passed on to the doctor or nurse
- Notification of estimated timeslot to be contacted once the e-Consult
- Once contacted, notify patients of details of what will happen next, including what to do if they have missed a call back.

5.4 Out of scope considerations

The insight highlighted several considerations that are out of scope for this project but should be considered as part of efforts to create the most effective and person-centred online consultation solution for patients in Devon.

5.4.1 Make changes to the platform to enhance patient's experience of using e-Consult and encourage repeat behaviour

As discussed in section 4.2.4, patients experienced several challenges with the functionality of e-Consult, which impacted their overall experience of e-Consult and likelihood of using the platform again.

"In principle an excellent way to contact your GP, it just needs fine tuning so it's relevant to the patient using it, rather than something that you have to bumble through to make sense of it" (P04)

The considerations listed below are out of scope of this project, however it is important to be aware of what types of changes would enhance the user experience if they can be implemented in future.

- Add a clear and concise introduction of e-Consult at the start, to re-anchor to patients motives for using e-Consult (e.g. easy, convenient, quick, private, in your own time) and to give clarity about what e-Consult is and how it works.

- Use choice architecture on the start-up page to 'nudge' users to access advice first before processing a full e-Consult.

- Give an estimated completion time and include a progress bar to manage user expectations and reduce uncertainty of what's to come next in the form. It will be important to divide each section, so users know what to expect and save them writing every detail into the first question.

- Enhance the symptoms list and consider a 'catch all' option (e.g. my symptom isn't listed) to make it easy for patients to enter information that is relevant to them. It is acknowledged that this may impact e-Consult algorithms and it is suggested that an additional user journey is set up to allow patients to enter general free text responses if they select the 'other' option on the symptoms list.

- Alter the message users see when they hit a red flag. As discussed in section 4.2.4.1, many patients, particularly those with long-term conditions, are frustrated when they are redirected to acute care. Most users will proceed to ignore the message and 'fudge' them form or cancel the e-Consult and call the practice.
-

It would be more effective to give users the information that they may wish to consider acute care, but provide users with the choice to cancel the e-Consult or continue with their e-Consult - as this is what behaviour is happening anyway.

- Enable users to select if they have a long-term condition. The insight suggests that patients with LTCs may hit red flags more often than patients who don't (3.2.2.1). It is recommended that the redirection message acknowledges that they have a LTC and then provides them with the same choice to cancel or continue. This will help personalize the experience and convey to the users that their LTCs has been taken into account by the platform.

5.4.2 Consider the potential to allow teenage patients aged 13 – 17 to use e-Consult confidentially

Health care professionals noted the dilemma or allowing teenage patients to access their GP in private (e.g. for contraception) without informing their parent/caregiver.

The insight suggests there is an appetite from younger people to access e-Consult online. Younger people typically find it easy to do and often prefer writing down their concern privately without having to speak to someone. To help ensure younger people get the right advice and medication/treatment they may need and want in confidence, the potential to revise consent permissions should be considered.

6 Closing remarks

This research has provided prospective and retrospective evidence of the key factors which influence patients' decisions and behaviours in relation to primary care access. By exploring what influences patients' behaviours and identifying what support and information key patient groups need, this research has informed key considerations that use behavioural insights, economics and theory.

All considerations are based on the insight findings discussed in this report and will inform future recommendations for a social marketing approach to increase e-Consult uptake in Devon.

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happen

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RESTORATION AND TRANSFORMATION

Health and Adult Social Care Overview and Scrutiny Committee

Date:	24 March 2021
Title of Report:	**Restoration and Transformation**
Lead Member:	Choose a Councillor
Lead Strategic Director:	Choose a Director
Author:	John Finn, Associate Director, In Hospital Care - NHS Devon CCG
Contact Email:	ross.jago@nhs.net
Your Reference:	RR3 Plym
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

This report is in response to the request from the Plymouth Health and Social Care Overview and Scrutiny Committee for an update on the restoration and recovery of services.

Recommendations and Reasons

The Committee is asked to note the report.

Alternative options considered and rejected

None. As a relevant NHS body, NHS Devon CCG has a duty to attend before a local authority when required (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out its health scrutiny functions.

Relevance to the Corporate Plan and/or the Plymouth Plan

By working with NHS bodies to maintain oversight of health and care services in Plymouth the committee is supporting the Democratic and Co-operative values of the Plymouth City Council, alongside objectives in the *"Healthy City"* Chapter of the Plymouth Plan.

Implications for the Medium-Term Financial Plan and Resource Implications:
This update does not give notice of any required decision which may require expenditure or resource allocation which impacts upon the Local Authority.

Carbon Footprint (Environmental) Implications:
None arising from this report.

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:

None arising from this report.

Appendices

Ref.	Title of Appendix	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	2	3	4	5	6	7

Background papers:

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of background paper(s)	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	2	3	4	5	6	7

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: N/A											
Please confirm the Strategic Director(s) has agreed the report? N/A Date agreed: 10/06/2019											
Cabinet Member signature of approval: N/A Date: 10/06/201											

NHS
Devon
Clinical Commissioning Group

1. Introduction

1.1. This paper will provide an update on the NHS Devon CCG programme for Elective Care Restoration, as part of the Devon Phase 3 Restoration Plans.

2. Phase 3 Restoration of elective

2.1. The national Phase 3 guidance (Third Phase of NHS Response to COVID19, dated 31 July 2020) set out an expectation that systems would restore elective activity to:

- 90% of 19/20 levels by October for elective inpatient, day case and outpatient procedures
- 100% of 19/20 levels of MRI, CT and endoscopy procedures (by October)
- 100% of last year's levels for new and follow-up outpatients

2.2. The Elective Care Cell has been broken into 4 workstreams to support the delivery of the Phase 3 and Adapt & Adopt:

- Management of GP referral processes
- Pathway development and GP and patient communication
- https://northeast.devonformularyguidance.nhs.uk/
- https://myhealth-devon.nhs.uk/
- Outpatients
- Surgical Restoration

2.3. This programme focusses on the following priorities and this is incorporated into the Elective Care Cell's workstreams for delivery:

- Theatres - Prepare regional core principles based on national Infection Prevention Control (IPC) guidelines to support systems with practical implementation of relevant measures, including lessening PPE & Cleaning requirements and enabling local decision making to downgrade PPE according to risk.
- CT MRI - Prepare regional core principles based on national IPC guidelines to support systems with practical implementation of relevant measures.
- Endoscopy - Prepare regional core principles based on national IPC guidelines to support systems with practical implementation of relevant measures, including settling time on COVID negative AGP.
- Outpatient - Prepare regional core principles based on national IPC guidelines to support systems with practical implementation of relevant measures. For outpatient transformation, adapt and adopt work complements and helps with rapid implementation of the existing National Outpatient Transformation Programme.
- There are targets to be delivered against each of these priorities and the CCG is required to report weekly to NHSEI against all of these targets.

3. Current Performance

December 2020 Recovery Rates			CCG		STP		TSDFT		RDEFT		NDHT		UHP	
			previous	latest	previous	latest	previous	latest	previous	latest	previous	latest	previous	latest
DEMAND	TOTAL REFERRALS	Plan	85.2%	83.0%	93%	90%	100.0%	95.2%	89.4%	87.9%	89.0%	92.2%	91.1%	88.4%
		Actual	93.3%	102.0%	87%	94%	91.7%	94.9%	70.5%	76.6%	100.1%	94.4%	92.9%	107.9%
OUTPATIENTS	OP NEW (F2F and non f2f)	Plan	84.4%	85.7%	84%	85.2%	93.4%	90.9%	76.6%	81.2%	94.2%	102.8%	83.2%	80.6%
		Actual	91.6%	111.5%	89%	106.9%	96.8%	120.9%	76.6%	67.3%	90.2%	76.9%	99.4%	138.7%
	OP NEW (non f2f)	Plan	29.3%	29.5%	29%	29.5%	25.0%	25.0%	25.0%	25.0%	48.7%	48.7%	29.0%	29.0%
		Actual	19.9%	15.6%	21%	17.0%	18.7%	14.5%	16.7%	16.7%			30.1%	21.6%
	OP FU (F2F and non f2f)	Plan	89.4%	90.8%	91%	90.8%	85.1%	83.9%	79.4%	83.9%	102.3%	115.7%	97.3%	93.7%
		Actual	99.3%	99.1%	98%	98.0%	96.1%	104.7%	74.6%	73.1%	91.0%	82.7%	109.8%	109.8%
	OP FU (non f2f)	Plan	41.5%	44.2%	42%	44.1%	30.0%	35.0%	40.4%	43.6%	63.8%	63.8%	43.7%	44.6%
		Actual	28.5%	26.7%	31%	29.0%	24.3%	20.7%	33.2%	39.5%			38.2%	35.2%
ELECTIVE	DAYCASE	Plan	73.8%	74.7%	78%	78%	77.6%	84.8%	75.8%	76.4%	72.1%	72.3%	82.5%	77.0%
		Actual	115.9%	126.4%	108%	116%	99.0%	97.1%	122.1%	136.9%	111.5%	116.0%	102.1%	113.7%
	ELECTIVE INPATIENT	Plan	66.1%	69.5%	73%	75%	79.4%	78.0%	73.8%	80.9%	83.7%	85.9%	67.8%	63.6%
		Actual	98.2%	106.1%	81%	91%	73.4%	106.7%	75.6%	63.5%	88.8%	101.7%	87.8%	112.4%
	TOTAL INCOMPLETE RTT PATHWAYS	Plan	120,766	124,370	122,578	128,057	29,657	30,686	39,077	40,794	17,944	18,984	35,900	37,593
		Actual	103,970	109,714	120,683	122,582	28,030	27,317	48,005	49,195	13,354	14,476	31,294	31,594
	RTT 52 WEEK WAITS	Plan	6,702	7,261	8,336	10,139	1,821	2,125	1,767	1,816	2,858	4,098	1,890	2,100
		Actual	6,992	8,227	8,626	9,263	1,435	1,509	4,237	4,516	1,358	1,499	1,596	1,739
DIAGNOSTIC TESTS	MAGNETIC RESONANCE IMAGING	Plan	79.4%	83.3%	97%	99%	81.8%	94.5%	100.8%	110.4%	90.8%	62.8%	104.4%	101.5%
		Actual	100.2%	102.9%	88%	86%	99.1%	72.7%	64.6%	76.0%	95.3%	99.0%	98.6%	97.5%
	COMPUTED TOMOGRAPHY	Plan	78.4%	77.2%	83%	92%	85.7%	99.1%	107.1%	109.1%	74.6%	62.2%	66.3%	84.1%
		Actual	117.7%	103.9%	114%	107%	101.4%	87.4%	78.0%	87.7%	131.8%	153.8%	161.1%	129.0%
	NON-OBSTETRIC ULTRASOUND	Plan	58.3%	58.4%	73%	79%	81.9%	99.0%	73.3%	78.4%	76.3%	62.8%	69.0%	78.6%
		Actual	136.6%	127.3%	109%	98%	104.7%	71.5%	102.7%	105.4%	78.6%	109.9%	128.3%	102.8%
	TOTAL SCOPES	Plan	72.0%	73.0%	87%	99%	95.2%	110.0%	85.1%	99.0%	90.6%	101.0%	80.1%	87.7%
		Actual	90.4%	73.0%	77%	73%	52.5%	55.7%	70.7%	66.0%	93.2%	69.9%	110.1%	102.0%

Please note: Diagnostics and Outpatients activity is taken from weekly reporting.
Planned levels are shown as % of last year's volumes.
Both plan and actual activity are shown as the % of last year's volumes.
Green indicates activity better than plan and red below plan.

3.1. The activity above is for the time period December 2020. Over December and into January as a direct consequence of Covid, performance has significantly reduced as the NHS focused on treating COVID patients and keeping patients safe during the second COVID wave. The requirement to significantly increase the number of Intensive care beds and general covid beds required a significant movement of workforce from delivering elective care into COVID capacity resulting in a reduction in elective care delivered.

3.2. Referrals have risen during December 20 into all trusts apart from North Devon where they fell slightly from the previous month. Referrals into University Hospitals Plymouth are now greater than the previous year a strong indicator than primary care is continuing to recover from the impacts of COVID.

3.3. Delivering increasing levels of elective activity in a day case environment is key to elective recovery and day case rates remain above plan in all Devon acute trusts as are elective inpatient volumes in all trusts apart from the Royal Devon and Exeter Foundation Trust.

3.4. All Trusts in December were below planned non-face to face new and follow-up activity however overall outpatient follow-ups are above trajectory. In 2021 the work to increase appropriate levels of non -face to face activity will be a priority for the system wide clinically led STP group focusing on out-patients.

3.5. 52 Week waits at STP level are slightly over plan however below plan for all provider accept RDEFT however this will be adversely impacted further on by the surge on COVID in January. These patient waits represent a negative experience for patients and as the Devon NHS moves from restoration of services to recovery both recurrent and non-recurrent plans to address these backlogs will need to be put in place.

3.6. Similarly, total incomplete pathway volumes remain below trajectory at all Devon providers except RDEFT.

3.7. In parallel to elective care diagnostic provision has been impacted on by the requirement for trust staff to support the second covid surge and MRI and CT are underperforming at TSDFT and RDEFT.

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HEALTH AND ADULT SOCIAL CARE OVERVIEW SCRUTINY COMMITTEE

Work Programme 2020 - 21

Please note that the work programme is a 'live' document and subject to change at short notice.

For general enquiries relating to the Council's Scrutiny function, including this committee's work programme, please contact Amelia Boulter, Democratic Support Officer, on 01752 304570.

Date of meeting	Agenda item	Prioritisation Score	Reason for consideration	Responsible Cabinet Member / Officer
14 Oct 2020	Policy Brief			Sarah Gooding
	Performance Summary			Rob Sowden
	Winter Plan Update			Anna Coles
	Phase 3 Planning			CCG
2 Dec 2020	Update from the Director of Public Health			Ruth Harrell
	Policy Brief			Sarah Gooding
	Healthwatch Update			Tony Gravett
	Workforce Review			Anna Coles
	Adult Social Care Budget			Craig McArdle
	Performance Summary			Rob Sowden
27 Jan 2021	COVID Update			Ruth Harrell
	Flu Vaccination Programme			Ruth Harrell
	Policy Brief			Sarah Gooding
	Integrated Performance Report			Rob Sowden
	Restoration and Recovery of Services			John Finn/Dr Shelagh McCormick
	COVID vaccination programme			NHS Devon CCG
24 Mar 2021	Covid and the impact on health inequalities			Ruth Harrell
	Restoration and Recovery of Services Update			NHS Devon CCG
	Response to letter regarding GP practices			Dr Paul Johnson
	Integrated Performance Report			Rob Sowden
Briefing Papers to be circulated to the Committee -				
Monitoring of the winter plan and any new areas of risks				
Recruitment and retention of GPs				
Select Committee				
Dental Health – Response to the recommendations – 16 December 2020				
Mental Health and CAMHS - Livewell/Public Health				

Future Items
Implementation of health and wellbeing hubs to be discussed in the next municipal year.
Think 111 Service
Alliance Contract
Health and Social Care Workforce
Healthwatch
Adult Safeguarding Board – check when last came to the board
Thrive Programme Update

Annex 1 – Scrutiny Prioritisation Tool

		Yes (=1)	Evidence
Public Interest	Is it an issue of concern to partners, stakeholders and/or the community?		
Ability	Could Scrutiny have an influence?		
Performance	Is this an area of underperformance?		
Extent	Does the topic affect people living, working or studying in more than one electoral ward of Plymouth?		
Replication	Will this be the only opportunity for public scrutiny?		
	Is the topic due planned to be the subject of an Executive Decision?		
	Total:		High/Medium/Low

Priority	Score
High	**5-6**
Medium	**3-4**
Low	**1-2**

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