Dadansoddi ar gyfer Polisi

YMCHWIL GYMDEITHASOL Y LLYWODRAETH

GSR

GOVERNMENT SOCIAL RESEARCH

Analysis for Policy

Llywodraeth Cymru
Welsh Government

SOCIAL RESEARCH NUMBER:
35/2019
PUBLICATION DATE:
30/07/2019

Research into accessing primary care services delivered in a general practice setting

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.

This document is also available in Welsh.

 Digital ISBN 978-1-83876-806-5

Research into accessing primary care services delivered in a general practice setting

A qualitative research study

Authors: Fiona McAllister, Adam Blunt, Catrin Davies - Beaufort Research

Full Research Report: Beaufort Research. Research into accessing primary care services delivered in a general practice setting: a qualitative research study. Cardiff: Welsh Government, GSR report number 35/2019.
Available at: https://gov.wales/accessing-primary-care-services-qualitative-research

For further information please contact:
Social Research and Information Division
Knowledge and Analytical Services
Welsh Government
Cathays Park
Cardiff
CF10 3NQ
Email: Research.HealthAndSocialServices@gov.wales

Table of contents

List of tables

List of figures

Glossary

Acronym/Key word	Definition
National primary care pacesetter programme	The Pacesetters, funded by Welsh Government, aim to stimulate innovation and promote the redesign of primary care services with pace, with a view to learning from those which deliver benefit and to share successes across Wales.
Primary care	Primary care is about those services which provide the first point of care for most people's contact with the NHS in Wales. Primary care services are provided by general practitioners (GPs) and other health care professionals in health centres and surgeries across Wales, including pharmacy, dentistry and optometry.
Primary care clusters	Primary care clusters (also known as GP clusters) are groups of general practitioners working with other health and social care professionals to plan and provide services locally.
Triage	A system where a member of staff responds to a patient’s first contact with the surgery. They may provide advice or direct the patient to the most appropriate health professional or wellbeing care support.

1. Summary of the key findings

Introduction

1.1 Statistics in Wales[1] show an improving trend regarding availability of GP surgery appointments during core opening hours. However, results from the 2017-18 National Survey for Wales[2] do not show a corresponding increase in people's satisfaction with accessing primary care services in a GP setting.

1.2 Welsh Government therefore commissioned Beaufort Research to carry out qualitative research with members of the public to explore perceptions and experiences of accessing primary care services delivered in a GP setting.

1.3 The sample consisted of a broad mix of 66 men and women who took part in focus groups and face-to-face depth interviews across three locations: Cardiff, Carmarthenshire and Gwynedd. Participants had made an appointment at their GP surgery within the last six months. The sample was split between two age bands: 18-44 and 45+; and between socio-economic groupings ABC1 and C2DE. The Gwynedd fieldwork was convened in the medium of Welsh. Fieldwork took place 28 January to 18 February 2019.

Factors influencing positive and less positive experiences

1.4 The most prominent factors that influenced participants' positive and negative experiences of the process centred on **getting through to the surgery** to make an appointment and being able to **make an appointment** at a time and within a timeframe that suited their needs.

1.5 Key themes facilitating a positive experience were, broadly in the order of the patient journey:

- Getting through by phone without too much delay and speaking with a member of staff to make an appointment. Phone was used partly because it felt like an immediate, convenient way of organising an appointment, once through;
- Securing a convenient same-day appointment with a GP or within a day or two. The ability to walk in to make a same-day appointment added to a positive experience for some;

[1] See Statistics and Research Series: GP access
[2] See National Survey for Wales

- Seeing a GP face-to-face and, for some, seeing their preferred GP if it concerned an ongoing health issue or because it felt more reassuring. Face-to-face appointments tended to be preferred because it felt like a more comfortable way to explain or show what an issue might be;
- Having a satisfactory outcome in getting the care they needed including with another health professional such as a physiotherapist or nurse;
- Generally positive interactions with staff including: a same-day call-back from a GP normally resulting in a same-day appointment; and polite, helpful staff.

1.6 Key themes that contributed to a negative access experience, broadly in the order of the patient journey, were:

- Difficulty getting through to the surgery by phone in the morning with lengthy delays spent redialling or waiting for the phone to be answered;
- No same-day appointments being left because of the time spent attempting to get through to the surgery by phone in the morning;
- Having to explain to a receptionist the reason for the contact. Some felt uncomfortable disclosing sensitive information, some did not think a receptionist was qualified to ask such questions and some felt the receptionist was trying to prevent the patient from seeing a GP that day or unless they were ‘really ill’;
- Not seeing a GP on the same day or within one or two days. This impacted some participants who were working and some who had to take the children to school. There was no indication that those working might be prioritised although some thought that surgeries tried to prioritise appointments for young children. Participants believed they knew when they needed to see a GP;
- Having to wait a week or more for an appointment. Participants tended to be prepared to wait up to a week for what they felt was a non-urgent appointment. The distinction between ‘emergency’ and ‘non-emergency’ did not seem very clear.

The Welsh language and accessing primary care services in a general practice setting

1.7 Fieldwork in Gwynedd took place in the medium of Welsh and findings on the Welsh language relate to feedback from this location. Views and experiences may be different elsewhere in Wales. Overall, Welsh-speaking participants stated it was important to them to be able to access primary care services at their GP surgery in the language of their choice. Reception staff and, more often than not, health professionals spoke Welsh which enhanced participants' experiences. It helped them to feel comfortable and made it easier to express themselves.

1.8 Although some were content accessing services in either language (especially if it meant a quicker appointment), they still stressed that it was important to have the choice.

Awareness and perceptions of the Choose Well campaign

1.9 Choose Well is a tool that helps people decide if they need medical attention if they are unwell. It explains what each NHS service does and when it should be used. There was limited awareness of the campaign overall or of seeing a similar message. Participants on the whole believed that it seemed logical to encourage people to take responsibility in choosing the appropriate care for treatment. They anticipated that more people taking this approach would help to free up GPs' and other health professionals' time although they stated that they already followed these guidelines. There was thought to be an issue with patients making a GP appointment who probably did not need one.

1.10 Some wondered whether this approach to care could be risky in certain situations where a symptom might not receive the attention it required and might be misread. Seeing a GP was still more reassuring for those who did not want to take a chance with their health.

Reactions to the primary care model and triage approach

1.11 The approach uses telephone call-handling and online methods as the first step in receiving primary care, with a suitably trained health professional dealing with the first contact and finding out more about the patient's needs. This person may then give advice or may direct the patient to the most appropriate health professional / service. This model was well received on the whole. The main potential benefits

according to participants centred on: accessing the appropriate care more quickly; and how the model could reduce the pressure on GPs.

1.12 Less positively, concerns about **continuity of care** were an issue from time to time: a small number of older participants instantly disliked the primary care / triage model and did not want to deal by phone with an individual they did not know, preferring the comfort and reassurance of a familiar face or voice. They also wanted to be certain of seeing a GP.

1.13 There was uncertainty over how **qualified the trained professional** handling the initial contact would be. Participants on occasion felt that this new model might be an attempt to make it harder for them to see a GP.

The role of technology in the primary care model

1.14 Participants tended to be unaware of any online options that might be available at their surgery. As a result, they tended not to have used online technology to make appointments and access the care they needed. The handful of examples of current use were for **making an appointment** and for **repeat prescriptions**. Online technology had not been used for any other interactions with a health professional via the practice.

1.15 Across age groups, views were mixed on making (more) use of technology although older participants were less likely to be interested in a shift in this direction. Even so, the limited examples given of current use of online technology were from older and younger participants.

1.16 From a positive perspective, online **appointment booking** was considered by some to be convenient for non-urgent appointments, resulting in minimal disruption to the patient's day and no lengthy telephone wait. Appointments could also be booked any time of day or night.

1.17 Participants tended to be uncertain about using online technology for a consultation with a health professional whereas a **face-to-face appointment** remained important as an option. Some older participants reiterated that they would be more confident about the outcome and find the process more reassuring if face-to-face.

1.18 Some envisaged being more likely to use an online consultation for routine needs (e.g. a repeat prescription) which would be convenient and quick.

1.19 A key concern voiced was **how effectively the technology would work** and how it might adversely affect the experience. A further reservation was how effectively patients would be able to **describe the detail of their symptoms** if writing online.

What good access looks like to participants

1.20 The diagram overleaf highlights the key good access factors from the research. The darker the colour, the greater the overall preference for the factor. The main themes were: a continued preference for phone contact initially but with no long wait for the call to be answered; a reported openness to doing more online (more so for booking appointments); an interest in a triage approach with a suitably trained health professional; a desire for a prompt appointment (same day or within one to two days); extended surgery opening hours; an openness to seeing the most appropriate health professional although some older participants still wanted to see a GP.

Figure 1.1: Summary of what good access looks like for primary care services in a GP setting

2. Background

Policy background

2.1 Primary care services play a vital role within the wider system of health and care in Wales and access to local health services is essential for healthy communities. The demands placed on primary care and GPs in particular continue to grow and to become more complex owing to a number of factors including an ageing population and increases in chronic health conditions. At the time this study was commissioned, much of the demand experienced in primary care is managed by GPs who in turn are required to play a filtering role.

2.2 A good deal of ongoing work is taking place in Wales in relation to investigating how to improve the effectiveness and efficiency of primary care services, with patients' needs and a holistic approach to health placed at the heart of developments. These developments need to be delivered against the Ministerial priorities of primary care stability, more services delivered in the community and improved access to quality care.

2.3 In September 2017 Welsh Government published the national strategy *Prosperity for All*[3] which sets out commitments on access more generally. *A Healthier Wales: our Plan for Health and Social Care*[4] (June 2018) is Welsh Government's response to the *Parliamentary Review of the Long Term Future of Health and Social Care*[5]. It re-emphasises that when people need support, care or treatment, they will be able to access a range of services which are made seamless and delivered as close to home as possible. Services will be designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes.

2.4 Several new models and approaches have emerged in Wales in recent years, including examples which are sponsored by Welsh Government. Innovative work by primary care clusters, for example, through the national primary care pacesetter programme[6], has been the basis of much emerging good practice. Access to primary care may no longer only mean access to an appointment in a GP setting. It could also involve advice by phone, email or a home visit.

[3] See Prosperity for All: Annual Report 2018
[4] See A Healthier Wales: Our Plan for Health and Social Care
[5] See Review of Health and Social Care in Wales: Final Report
[6] See Primary Care One: Developing Primary Care in Wales: Pacesetters

2.5 The Primary Care Model for Wales, which has emerged from the national primary care pacesetter programme, is now the strategy for achieving accessible and sustainable care. Its focus is on informed citizens who are supported to self-care and the prudent use of the multi-professional team, such as pharmacists, therapists, dentists, audiologists, optometrists, social workers and people providing non-clinical care and support, working alongside GPs.

2.6 A core component of the model is the telephone first/clinical triage system. This system invites people to call first and to be directed to the right source of help. Many requests for help and advice can be responded to promptly over the telephone.

2.7 Better access to GP services has been a goal in Wales for many years. Statistics published in Wales in March 2018[7] showed an improving trend over the last six years in relation to the availability of GP surgery appointments during core opening hours, especially after 5.30pm. (Core hours in Wales are 8.00am to 6.30pm, Monday to Friday.)

2.8 However, results from the 2017-18 National Survey for Wales[8] do not show a corresponding increase in people's satisfaction with accessing GP services, with 42 per cent reporting finding it difficult to make a convenient appointment to see their GP (up from 33 per cent in 2012-13).

2.9 The Welsh Government therefore commissioned Beaufort Research to explore the concerns raised by National Survey for Wales data by carrying out research with members of the public. In particular, there was a need to better understand the barriers (and facilitators) people face in accessing GP services, as well as providing further insight into what 'good access' would look like for the people of Wales. The findings will help with the ongoing development of in-hours GP services, including the full range of services provided within general practice by different healthcare professionals delivering patient care.

Aims and objectives

2.10 The aim of the research was to gain views from the general public in Wales on access to primary care services delivered in a general practice setting during normal hours.

[7] See Statistics and Research Series: GP access
[8] See National Survey for Wales

2.11 The objectives of the research were:

- To explore views on access to primary care services in a general practice setting including:
  - Communication by GPs or other healthcare professionals, reception staff or other call handlers around clinical triage and signposting;
  - Timeliness;
  - Responsiveness;
  - Continuity;
  - Convenience of appointments;
  - Importance (or otherwise) of face-to-face contact;
  - Factors regarding the Welsh language;
  - Whether seen by a GP or wider multi-disciplinary team.
- To identify key barriers and facilitators to access GPs and wider primary care staff as appropriate;
- To make recommendations for future practice.

3. Methodology

A qualitative approach

3.1 Given the nature of the objectives, the research used a qualitative approach which consisted of a mix of focus groups and in-depth face-to-face interviews. The benefits to this project of a qualitative method included:

- The ability to shed light on the areas of concern from the National Survey for Wales and to explore the diversity around the topics of interest in more depth than would be possible via a quantitative approach;
- The time to probe on specific examples of experiences and their context. These in turn have been used in the report to illustrate and support the findings. The in-depth interviews in particular proved an appropriate means of exploring examples of service users' experiences;
- The opportunity to explore in depth with participants what good access to GP services looks like.

3.2 The potential drawback of this qualitative approach centred on the limited ability to draw decisive inferences from the feedback obtained that can be applied to a population, as the sample would be not be representative. Qualitative investigation is not designed to be statistically representative. It is intended to provide in-depth understanding which was required for exploring the research objectives. Its strengths lie in the ability to identify themes across diverse groups and experiences and indicate the prevalence of certain issues. A further limitation is that the wide range of needs that exist in the population with regard to primary care services and the breadth of demographic variables, which could affect experiences or views, cannot be fully reflected.

3.3 Where lists of points made by participants are provided in the report, they are organised in alphabetical order unless otherwise stated, indicating that the points were not dominant themes. Bold text is used in the report to identify themes and change of topic.

3.4 Anonymous verbatim comments made by participants are included throughout this report. These comments should not be interpreted as defining the views of all. Instead they give insight into individual views on the points identified. Comments are provided bilingually where the conversations were in the medium of Welsh.

Each comment has an attribution which indicates the participant's characteristics. Where more than one individual is contributing to a comment they are marked as 'F' for female and 'M' for male. The report also contains short, boxed case studies to provide examples of experiences. A pseudonym is used for each case study.

Research sample

3.5 The sample included a broad cross-section of the general public in Wales. The main sample criteria were: all participants had made an appointment at the GP surgery within the last six months; appointment convenience (mix of finding it convenient and inconvenient for their last visit); age (mix of 18-44 and 45+); language (some focus groups and interviews took place in Welsh and some in English); location (mix of urban and more rural); socio-economic grouping[9] (mix of ABC1 and C2DE); and gender (mix of women and men).

3.6 The total minimum target sample for the study was 54+ participants. Sixty six people took part across three locations. The approach for each location is in the table below:

Table 3.1: Qualitative sample

Research location	Number who took part	Methods
Cardiff	22	2 focus groups (1 x 18-44, ABC1; 1 x 45+, C2DE) and 6 depth interviews (mix of age, gender and SEG)
Carmarthenshire	21	2 focus groups (1 x 18-44, ABC1; 1 x 45+, C2DE) and 6 depth interviews (mix of age, gender and SEG) Adverse weather conditions disrupted the scheduled fieldwork; so the final format consisted of 3 mini-groups, 3 paired depth interviews, 5 depth interviews
Gwynedd – convened in the medium of Welsh	23	2 focus groups (1 x 18-44, C2DE); 1 x 45+, ABC1) and 6 depth interviews (mix of age, gender and SEG)

[9] Socio-economic grouping is based on the occupation of the head of the household, with each group defined as follows:
AB: Higher and intermediate managerial, administrative and professional occupations
C1: Supervisory, clerical and junior managerial, administrative and professional occupations
C2: Skilled manual workers
DE: Semi-skilled and unskilled manual workers, state pensioners, casual and lowest grade workers, unemployed with state benefits only

3.7 Thirty participants were aged 18-44 and 36 were aged 45+. Thirty six participants were female and 30 were male. Seven Black and Minority Ethnic people took part in total. Focus groups lasted up to 1.5 hours and interviews up to 50 minutes.

Recruiting participants

3.8 Before recruitment started, Beaufort agreed a participant recruitment questionnaire with Welsh Government. Two methods were then used to recruit participants. The first involved using participants from the National Survey for Wales who had consented to be re-contacted for research purposes. Beaufort contacted potential participants from its offices from a database provided by Welsh Government. The second method used Beaufort's qualitative recruiter resource. Using the questionnaire, the regionally based recruiters found participants by knocking on doors, stopping people in the street and through networks.

3.9 Each participant was given a financial incentive for taking part to contribute towards any costs and as a thank-you for their time. Fieldwork took place from 28 January to 18 February 2019.

The discussions and analysis

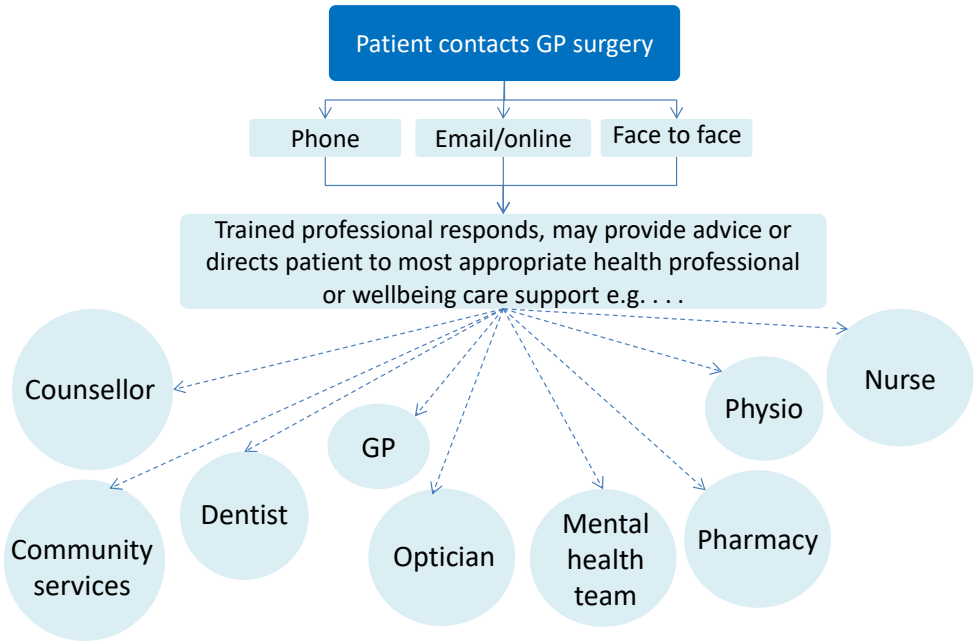
3.10 Beaufort drafted a topic guide (see annex) to use in the discussions which was revised based on feedback from Welsh Government. The first day of fieldwork was used as a pilot to check that the topic guide worked. No significant changes were made.

3.11 The discussions began with asking participants for their top-of-mind associations with their experiences of getting the care they need at their local GP surgery during normal hours for any kind of service.

3.12 The discussions then explored participants' positive and less positive examples of experiences of accessing primary care services in a GP setting from making contact through to seeing a health professional. The role of the Welsh language was also explored in the Gwynedd focus groups and interviews.

3.13 Participants were also asked for their views on the primary care model (which was accompanied by a short introduction) and were given the diagram overleaf to help them understand the concept. Their views on making greater use of technology were explored as well. In addition, awareness of and reactions to the Choose Well[10] campaign were covered.

Figure 3.1: Primary care model summary



GPs continue to be the first port of call for most urgent care

3.14 Finally, participants were asked to describe what good access to primary care services in a GP setting would look like for them.

3.15 The focus groups and interviews were audio-recorded with participants' permission. They were transcribed verbatim. An inductive approach to the analysis was used whereby the researchers, through descriptive analysis, categorised the data to develop themes that emerged from the content of the focus groups and interviews. The categories and themes were broadly framed within the key research objectives.

[10] See Choose Well

4. Accessing primary care services delivered in a general practice setting – perceptions of the current patient experience

4.1 This chapter explores participants' perceptions of the key stages of recent experiences accessing primary care services via a GP setting. It covers making contact with the surgery, making an appointment, the time between making contact and seeing a health professional and getting the care needed. The section includes examples of positive and less positive experiences which highlight the factors that influenced participants' perceptions of the experience.

Overall perceptions

4.2 Key factors that influenced participants' positive and negative experiences of the process centred on **getting through to the surgery** to make an appointment and being able to **make an appointment** at a time and within a timeframe that suited their needs.

Making contact

4.3 Recalling GP surgery appointments in the last six months, participants in the main had **contacted the surgery by phone** and were more likely to have called in the morning. They tended to assume that there was no other way of making an appointment, other than face-to-face in some cases. Awareness and use of an online appointment booking option was quite low across the different locations.

4.4 In a couple of cases, participants did not think the surgery kept them up to date with any new ways of accessing primary care, for example only finding out about online repeat prescriptions by word of mouth.

4.5 Phone contact was chosen through a combination of not knowing of any other methods, habit and the view that it was an immediate way of confirming an appointment, once the patient had got through to a member of staff.

> *I can usually phone up and get an appointment. You've got to phone in the mornings for an appointment and it's like ten past eight, so I'm sat there if I need a doctor's appointment or [my wife] needs one. I am there: ringing, ringing, and I can usually get in to see a doctor. (Male, 45+, ABC1, Cardiff)*

4.6 **Difficulty getting through by phone** to make an appointment was a key frustration overall. There were regular references to having to call at 8.00am / 8.30am and then the phone being engaged or waiting for it to be answered. It tended to take participants several calls before they managed to speak with a member of staff, usually a receptionist. 'I would say at least forty tries before you get put in the queue', according to one participant while another reported that it had taken an hour to get through last time. This difficulty was often considered the norm. For a couple of older participants it had reached the point where they now visited the surgery to make an appointment because it was quicker, even though one individual did not think the surgery encouraged this method. It was also easier than navigating the automated phone system, according to one older participant.

> *Mae hi'n ofnadwy o anodd cael unrhyw math o ateb. Dwi 'di byw yna ers pedwar blynedd ar ddeg, ac unwaith, unwaith dwi wedi cael ateb yn syth bin. (It's awfully hard trying to get any sort of answer. I've lived here for 14 years and I've only once had someone answer straight away.) (Female, 45+, ABC1, Gwynedd)*

> *That process is a nightmare, because they say phone at eight o'clock, I think, and I start phoning at around five to eight, and the phones are already engaged. (Male, 18-44, C2DE, Carmarthenshire)*

4.7 This impacted some participants who were working and some who had to take the children to school. In one example, a parent explained that when she did get through, there was an automated message encouraging patients to visit other primary care providers if appropriate, for example the pharmacist for a cough. Once this message was complete, the phone was engaged so she had to redial and listen to the message again.

> *I think I rang, like, 20 times, which was ridiculous, because I was trying before taking her to school. Then it was just line engaged, line engaged, constantly. Then I got through, and then I had the appointment. It was about quarter to eleven. (Female, 18-44, ABC1, Carmarthenshire)*

4.8 It should be noted that some participants describing *positive* experiences of accessing the care they needed still referred to this difficulty getting through by phone. Other factors, however, such as being able to see a GP the same day as

calling had more influence on these participants' overall perceptions of the experience.

4.9 From time to time, participants accepted having to wait a while to get through to the surgery by phone because GPs were known to be busy with heavy workloads.

4.10 For one rurally based older participant with limited mobility and without a landline, contacting the surgery sometimes meant going into her garden to obtain a signal for her mobile because mobile network coverage was unreliable.

4.11 Infrequently, some participants in rural and urban locations reported no problems getting through in the morning to the surgery by phone on a recent occasion. It was considered a fairly typical experience for these participants. In addition, when ringing outside peak hours for contact, participants in general did not report issues with getting through overall.

> *I rang up on a Monday morning as I had [an illness]. I had to see a doctor. They said 'Yes, come in at half past two and you'll be seen'. That was an appointment. I've not had any issue whatsoever with getting appointments or getting seen by a doctor. (Female, 45+, Cardiff, C2DE)*

4.12 The example outlined below provides further evidence of a positive experience shaped by the ease of getting through and being seen on the same day:

4.13 *Rhys (18-44) lives in a semi-rural location. He was feeling ill for three days and was not getting better. He contacted the surgery by phone which was easy to do. Rhys is unaware of any other options for making contact. He phoned 'dead on half eight'. He normally gets through quickly and did so on this occasion. The receptionist asked if it was an emergency and, if not, to make a longer wait appointment. He felt he needed to be seen that day because it had been three days of illness. The receptionist offered him an appointment between 10.00am and 11.00am which was convenient because his shift work started at 12.00pm. On arrival, he did not wait more than 15 minutes to be seen which is the norm. The key positive element was getting an appointment promptly and seeing a GP 'who wants to help'.*

4.14 Some mainly older participants across the locations described how they **walked in** in the morning to queue to see a GP or to make an appointment on the same day. Reasons included: mornings being for walk-in surgery only and emergency appointments for the afternoon; ensuring they saw a GP that day and being prepared to wait (staff were reportedly 'more cooperative' face-to-face); the surgery being nearby (to home or work); not working so having time to wait; finding it easier than attempting to navigate an automated phone system; and part of a routine for

making advance appointments for an ongoing condition and enjoying chatting to staff. It was worth the 30 minute walk in order to secure an appointment that day for one 80+ year old even though the walk was quite a challenge for her. As another participant summed up, 'at least then I know that I'm going to get [an appointment] that way'.

> *Dwi'n gweld fod genna chi fwy o siawns cael un os ewch chi yna de. (I think you're more likely to get an appointment if you go there) (Male, 45+, C2DE, Gwynedd)*

> *It's so much more difficult over the phone. I've found if you go in and speak to them face-to-face they're far more cooperative. If they can see you they're less likely to say no. (Female, 45+, C2DE, Carmarthenshire)*

4.15 However, the experience was sometimes frustrating with a long wait, uncertainty over when a patient will be seen and having to share a waiting room with other ill people.

Getting an appointment

4.16 The time it sometimes took participants to get through to a receptionist at the surgery by phone meant that there was **not always an appointment available that day**, which they felt they needed. In a few cases, participants reported that the surgery only allowed them to make a same-day appointment and that they would have to try again the following morning; urgent and non-urgent appointments could not reportedly be made at a later date. Others commented that they were offered an appointment in several days' time instead, which was deemed unsatisfactory (see also the next section on 'The convenience of appointments'). Some emphasised the need to phone immediately from the opening time onwards otherwise they stood even less of a chance of getting through and getting the appointment they wanted. This outcome therefore added to the frustration felt.

> *I think probably started ringing about eight o'clock in the morning, to get through. . . . I would say at least forty tries before you get put in the queue. . . . If you haven't spoken to someone before maybe half past nine in the morning, you're unlikely to get an appointment that day. (Female, 18-44, ABC1, Cardiff)*

4.17 The case study overleaf illustrates the difficulties of getting through to make an appointment and securing a same-day appointment, among other factors.

4.18 *Jackie was concerned about her daughter's health. She started phoning the surgery at 8.00am on a Monday. It took 48 calls to get through which was not unusual. She chose to phone as it is the only method she is aware of. Also 'I'm quite old-fashioned. I like to ring'. When she did get through there were no appointments left. She gave the receptionist 'a piece of my mind' and challenged her on her medical qualifications. Jackie felt compelled to reveal the reason for the call which was difficult in a rural community where 'everybody knows everybody's business, especially in the surgery'. She insisted she would see a GP that day and an appointment was offered later that morning with a GP. It was an inconvenient time because Jackie had to obtain permission to take her child out of school. She would have preferred after 3.00pm to fit around school. The quality of the care, however, was 'absolutely astounding'. A hospital referral followed.*

4.19 **First contact was normally with a receptionist**. In some cases in Cardiff and Carmarthenshire, participants' surgeries were using a '**telephone first**' approach. This was thought to involve the receptionist asking why they needed to see a GP and these notes were passed on to the GP who then called the participant back. With a few exceptions, participants tended to be fairly positive about this method and felt that the GP had been responsive. An appointment might occasionally be made with the practice nurse or physiotherapist instead which was not an issue for the few who had experienced it. The call-back could be very quick or within two to three hours which was considered acceptable. The process was convenient to some as it saved time and sometimes a trip to the surgery which suited work commitments, for example if seeking advice about a virus or a change in prescription.

> *They'll say, 'right is there any specific doctor you'd like to see and if he's not there will you accept somebody else?', you say 'yes' and they say, 'right the doctor will get back to you soon'. It's normally maybe about two or three hours later, you're expecting that anyway because he's got surgery as well and from there then your appointment will be made. I've got no problem, nothing bad to say about it. (Male, 45+, C2DE, Carmarthenshire)*

4.20 Participants with these experiences tended to feel that they were receiving an appropriate level of care, for example mostly never having been in a situation where they thought they should see a GP face-to-face and not having the opportunity to do so. There were mixed views, however, on explaining the reason for their call to a receptionist when recalling recent experiences. In the following example, the ability

to be seen on the same-day contributed to the overall positive experience, with no issues discussing the need for care.

4.21 *Owen (18-44) phoned the surgery on a Monday morning at 9.00am for his primary school aged daughter. There was no problem getting through which began with an automated Welsh or English option. He then spoke with the receptionist who asked about the reason for the call. He had no issue with this although he thought it would be different if it was a sensitive health matter. As the receptionist had explained, an 'on-call' GP phoned back within 20 minutes. They discussed the symptoms and Owen made an appointment for that afternoon with the GP. His daughter was prescribed antibiotics.*

4.22 There were cases where a participant had felt uncomfortable and 'embarrassed' telling the receptionist over the phone why they wanted an appointment because it was a sensitive issue. Some also did not think the receptionist was suitably qualified to be able to ask about the reason for the appointment. (Communication is discussed later in this section.) In addition, the waiting involved with a telephone first approach in one case proved inconvenient because the participant was rurally based and several miles from the surgery. A number of further issues meant this participant (below) felt the overall experience was not very positive.

4.23 *Having experienced symptoms over the weekend, Tom (18-44) phoned his surgery on Monday morning at 8.00am, hoping for a same-day appointment. It took him 20 minutes to get through to reception which disrupted getting his son ready for school. He then felt he had to justify the need for the appointment to the receptionist which annoyed him: 'she takes on the role of doctor'. This left him feeling a little 'embarrassed and [the experience] degrading'. Tom had had to reveal more sensitive information for a previous issue which had been very embarrassing. He had wanted to see a male GP on that occasion but had to justify why.*

4.24 *The receptionist on the latest occasion informed him the GP would then phone back between 9.00am and 12.00pm. It had to be on the landline because Tom's mobile reception was poor. This meant being 'confined' at home after he had dropped his son off at school (he is unemployed). The GP phoned back at about 10.30am, asking Tom to 'come down now' which involved a drive of several miles. He would have preferred a consultation by phone as he felt he recognised the symptoms. On arrival, Tom saw a GP he knew which was helpful but it still involved a referral to external primary care.*

4.25 In another less positive example, the surgery had been unable to say what time of the day the participant would be phoned back which meant being 'stuck in the house' until called. In addition, there was an example among older participants of being advised to visit a pharmacy when called back by a GP with the telephone first approach. In their minds, they contacted the surgery because they wanted to see a

GP rather than be referred to another health professional who was not as well qualified.

> *The reason why you've gone to the doctor's in the first place is because you feel bad enough that you have to see a professional. (Female, 45+, C2DE, Cardiff)*

4.26 Further occasional concerns with the telephone first approach included:

- The GP calling back at an inconvenient time when the patient was at work;
- The patient might miss the call-back because of a poor signal in their rural area although this had not happened to date.

The convenience of appointments

4.27 Participants concluded that it depended on the nature of the care required as to when was convenient for an appointment. If they or a child were feeling ill and decided they needed care (which was normally the case when they phoned), a **same-day appointment** was often desired and a key influence on a positive experience. In a few instances, parents of young children believed that the surgery had prioritised their children when there had been an issue with their health, resulting in a positive experience overall.

> *Do, hefo bychan fi. Nes i ffonio'n bora a ges i appointment tua 10:00. Es i'n syth i mewn. Do'n i'm yn gorfod disgwyl. Syth i weld y doctor, syth allan. . . . Ond that's very rare 'de. (Yes with my little one. I called in the morning and I had an appointment around 10:00am. I went straight in. I didn't have to wait. Straight to see the doctor, straight out . . . but that's very rare.) (Female, 18-44, C2DE, Gwynedd)*

4.28 In some cases, the distinction between '**emergency' and 'non-emergency'** did not seem especially clear to participants ('a loose phrase' as one person put it). It was down to their own judgement on when they felt they should be seen. However, participants tended to believe that if they felt ill, they needed to be seen that day. A concern was expressed that an illness could worsen if the patient had to wait longer than this. The alternative, according to some, was a much longer wait, up to two weeks or possibly more which was deemed unsatisfactory.

> *If you're ill, it's today you need to be treated. Especially if you're working. (Male, 45+, ABC1, Carmarthenshire)*

4.29 A small number of participants acknowledged that 'emergency' was a somewhat 'grey area' when asked by the receptionist. They admitted saying that it was an emergency and that they probably took advantage of the system to be seen on the same day.

> *You have to say [yes it's an emergency] otherwise you'll be bumped to a routine [appointment]. . . . Probably like a two week wait. (Male, 18-44, ABC1, Cardiff)*

4.30 Less positively, obtaining a same-day appointment meant that the participant did not necessarily see the GP who knew their history. On occasion, this resulted in the GP taking longer to deal with the patient (continuity of care is discussed later in this section).

4.31 It was not always possible to get an emergency appointment and in some cases participants were only ever offered an appointment for a number of days' time, in contrast to those who were only offered a same-day appointment. According to one participant, their partner had eventually required treatment in hospital because the receptionist at the GP surgery had reportedly refused him a same-day emergency appointment.

4.32 As described below, another participant had what he deemed a negative experience because he could not get a same-day appointment.

4.33 *Having suffered the symptoms over a weekend, Dan, a young participant living in an urban area, phoned the surgery early Monday morning. He had tried unsuccessfully to self-care via NHS online guidance. He managed to speak with the receptionist quickly, after an automated message. The earliest appointment was in four days' time. Dan was unhappy because he was in pain and had explained how he was feeling. However, by the time the appointment came round the issue was clearing up so he decided not to attend. Dan admitted that he did not contact the surgery to cancel.*

4.34 Some participants who were **working** stated that it was sometimes **difficult to fit an appointment around their schedules**. In one example, the participant explained how the surgery was closed on a Wednesday afternoon which had been inconvenient when attempting to make an appointment for that time. Even so, when asked, some did not know the exact hours their surgery was open for appointments.

4.35 Those working shifts, however, found it easier to make appointments because they had days off during the week to see a GP. Booking in advance (for minor care

needs) also meant that early appointments were available which suited one or two who worked regular office hours. Also, among those who were **not working**, the opening hours of their surgery were acceptable overall.

4.36 When some participants were recalling appointments for more **routine care needs**, they did not mind a longer wait too much, for example within a week or sometimes longer if they had to make appointments on a regular basis over time.

The wait on arrival at the surgery

4.37 A delay in seeing a GP at the given time of an appointment tended not to be raised spontaneously as an issue unless the wait had been unusually long. Where participants had made a same-day appointment, the wait on arrival at the surgery varied from a few minutes to two hours (this latter example was for a Monday morning appointment). It might also vary depending on which health professional a patient saw: a longer wait for a GP appointment but a shorter one for a practice nurse. The wait was therefore another factor that could have a negative impact on the overall experience. Some surmised that there were too many patients and not enough GPs.

> *Os ti'n gweld doctor, ti'n son am ryw hannar awr. Nyrs, ti'n gwbod, ti'n syth i mewn more or less really….Ia, mae hynna just oherwydd bod hi'n absolutely rammed yna o hyd. Ti'n gwbod, does 'na'm really byd maen nhw'n gallu neud am hynna. (If you're seeing the doctor, you're talking about half an hour wait. With a nurse, you're straight in more or less really…yeah that's because it's absolutely rammed there all the time. You know there's nothing they can really do about that.) (Male, 18-44, ABC1, Gwynedd)*

4.38 Under different circumstances, however, a long wait was bearable on occasion, such as walking in late morning, having no schedule commitments and queuing to see a GP (overleaf):

4.39 *Angharad is retired and became concerned about a health issue over the weekend. The surgery had recently moved to a 'drop-in' only system in the mornings, between 8.00am and 10.00am. She was keen to see a GP and arrived at 8.20am on a Tuesday. The receptionists were on first-name terms with her which put her at ease. She joined the queue to be seen that morning and then informed the receptionist which GP she wanted to see. Angharad admitted that it was very boring waiting for about an hour but the reason for the visit encouraged her to be patient and wait. The GP saw her for 20 minutes and was concerned about her health which led to a hospital referral. She was relieved that she had sought care and that treatment was offered quickly. Under the previous system Angharad thought she would have waited a couple of weeks for an appointment.*

Contact with the health professional at the surgery and continuity

4.40 In general, participants across age groups and locations had had **face-to-face contact** with a health professional when recalling recent experiences, including those using the telephone first system. It was also their preferred method of contact overall. Face-to-face was considered reassuring and critical by some. It felt like a more comfortable way to explain or show what an issue might be, for example a child's rash and other external symptoms. The patient could gain more from the health professional's expression as well. It was also what they were used to, and some found it difficult to articulate why they preferred this method. Also, for one participant, face-to-face was important because she had a hearing impairment and liked to be able to see the GP's face.

> *It's the one-to-one, it's the face-to-face, isn't it? That people . . . we're human. We need that. We're not robots. (Male, 45+, C2DE, Carmarthenshire)*

4.41 As other possible options for health professional interactions emerged during the discussions, however, some participants showed an interest in alternatives, depending on the type of care needed. Examples included by phone or online, discussed later in this report.

4.42 Views varied on how important it was to have **continuity of care** and see the same GP or health professional. Given participants' recent experiences were mostly with GPs, they focused on GP continuity rather than continuity and seeing different health professionals (discussed below and in reactions to the primary care model).

4.43 Some older participants, particularly female, were more likely to stress its importance to them, being able to trust in a GP and feeling more comfortable. **Developing the relationship** helped to put the patient at ease as well as the GP

being familiar with their history. It felt like the GP genuinely knew the patient and their history – 'a family doctor'. Some therefore asked to see the same GP each time (not necessarily successfully) but others did not have this opportunity. Some rurally located participants noted that they knew their GPs anyway as part of the community.

> *I think that's very important, because they've got to know you personally. And you tell them very intimate things about yourself, don't you? (Female, 45+, ABC1, Cardiff)*

4.44 Some believed it depended on the nature of the need, for example to see an issue through to its conclusion where relevant (e.g. discussing test results); or for ongoing or more sensitive conditions. To illustrate the point, one participant had preferred the care received for a mental health issue from one GP over another. Another participant had found it frustrating seeing different GPs about an ongoing condition, with each GP advising different treatment. With recent surgery appointments, some participants had therefore been prepared to wait a couple of weeks and in one case a month to see a specific doctor. A negative experience with one GP meant that participants on occasion were keen to see the same GP to avoid those they disliked.

> *Dwi wedi aros yn y gorffennol pythefnos i weld y doctor o'n i isio. (I've waited for a fortnight, in the past, to see the doctor I wanted.) (Female, 45+, ABC1, Gwynedd)*

4.45 If on the other hand a health issue was **more straightforward**, like an ear infection or obtaining a repeat prescription, it was **not so important** for some who they saw at the GP surgery, particularly among younger participants. More generally, some were **unconcerned** who they saw and were more focused on being seen as soon as possible. They trusted that the health professionals (normally the GP) were suitably trained to deal with them: 'A doctor is a doctor, to be honest' summarised one participant.

> *It's not critically important. . . . It's more that I just want to be seen sooner rather than later. (Male, 18-44, ABC1, Carmarthenshire)*

Experiences of seeing other health professionals

4.46 There were a small number of participants who had experienced a triage approach to getting the care they needed and been referred to a different health professional,

normally to a practice nurse or occasionally a physiotherapist. These participants were mainly satisfied with the access experience overall even though they were not necessarily expecting to see an alternative health professional when they decided to contact the surgery. The choice of health professional seemed appropriate for their needs which were considered reasonably routine (e.g. a vitamin B12 injection, an asthma check-up or monitoring a healing wound).

> *Fel o'n i'n deud cynt, nes i ffonio a deud fod o dal… ac mae rhywun o'r feddygfa yn deud, 'O, gyna ni physio ar gael yn y feddygfa.' Mae hwnna 'di gweithio felly i fi. Deintydd, mae hynna 'di digwydd unwaith hefyd. Yn ystod blwyddyn dwytha, nes i ffonio'r feddygfa am bod rhywbeth yn bod ar y daint, a ddaru nhw ddeud, 'Dos i weld y deintydd gynta'.' (As I said earlier, I phoned and said it was still hurting…and someone from the surgery said 'Oh we have a physio available at the surgery'. So that has worked for me. Dentist, that's happened once too. In the last year, I called the surgery because there was something wrong with my tooth and they said 'Go to see the dentist first'.) (Male, 45+, C2DE, Gwynedd)*

4.47 The process had felt easier and quicker on occasion as well, especially if it meant seeing a health professional at the surgery rather than having to travel elsewhere. For one participant, it involved being initially offered (via an automated message) the options of a GP or nurse appointment or a repeat prescription. This individual felt that the system helped him to 'make the right choice'. In another positive example the participant phoned and a prompt appointment was made with the practice nurse, as described below:

4.48 *Cara (18-44) doesn't contact the GP surgery very often. She normally makes appointments for herself and her partner who she has to persuade to see a GP. She wanted to check her partner's wounds were healing properly and phoned mid-week around 9.00am. She got through after a few rings, assuming this was the only way to contact the surgery. She was happy to explain the situation to the receptionist who offered an appointment with the practice nurse which was 'absolutely fine'. The initial appointment time the next day was inconvenient so Cara was offered a later time which was convenient. Overall, Cara was 'pleasantly surprised' with the efficiency of access and content with the care received. 'I was really happy that they offered us something when I wanted it to be*.'

4.49 The quality of the care received helped to reinforce the perception for some that triage was a positive and convenient method of accessing care. The benefit to the GP in freeing up time was also noted on occasion. In one example, a practice nurse

had been very thorough and reassuring, resulting in a 'brilliant' outcome according to the participant. It concluded with making a follow-up appointment for further care which added to the reassurance. In another case, a participant had not been expecting to be offered an appointment with a physiotherapist when he called but 'it made sense' given his issue and the access experience was positive. The appointment two days later resulted in a hospital referral.

4.50 The positive outcome in the example below also influenced the participant's perceptions of the experience, even though it did not follow the path she expected.

4.51 *Sue (45+) contacted her surgery first thing in the morning, wanting to see a GP. It took her about 15 minutes to get through, calling from 8.00am which was a little frustrating. The receptionist asked what the problem was so that a GP could call her back later. The participant requested a specific GP for a face-to-face appointment but he was not available. The receptionist offered an appointment with the practice nurse instead, which the participant took up. During the appointment, the practice nurse called in a locum for their opinion. The locum gave Sue a referral to the hospital which left her feeling satisfied with the process overall, even though 'I would have rather seen my doctor. The one that I'm under'.*

4.52 Triage was also used in another example where the participant phoned to make an appointment for his annual 'asthma review'. Unfortunately the review could only take place on a certain day of the week and the participant was unable to attend because of work. The receptionist arranged for the practice nurse to phone the patient back later that day. The nurse went through the appropriate information which meant that the participant did not have to attend in person.

4.53 Isolated, less positive examples centred on concerns about the quality of care and a more protracted process. A perceived shift was occasionally noted towards: using more locums which meant a lack of continuity in seeing the same GP; and making more use of other health professionals who might be unable to make a decision on treatment. A retired participant opted for a non-emergency appointment because she associated 'emergency' with life-threatening conditions. She did not want to wait two weeks to see her GP so took up the offer of seeing a physiotherapist the next day. She was given exercises to do which did not help: 'Why should I go to see a physio when I want a doctor?' she demanded.

Ond mae 'na lai o ddoctoriaid, mwy dwi'n amau o locums. Dwi'n ffeindio'n reit od. Gormod o staff eraill sydd yn helpu'r doctoriaid yma ond na fedran nhw neud dim byd pwysig ar eu pennau eu hunain. (But there are fewer doctors, more locums I suspect. I find it quite odd. Too many staff are there to help the doctors but they can't do anything important by themselves.) (Female, 45+, ABC1, Gwynedd)

4.54 Finally, an older participant in a more rural location described a recent development at her surgery where the receptionist would recommend seeing the practice nurse on the same day as a first step. This could then result in having to make an appointment to see the GP which felt frustrating and more protracted. It was considered an attempt to prioritise the calls to the surgery.

Communication with GPs, reception staff and other health professionals

4.55 Participants tended **not to highlight communication** with surgery staff as a key problem affecting their experience of accessing care. Some, especially in more rural locations, commented on how pleasant and polite staff were: 'this is what we keep on saying, everybody is nice here'. They also showed concern and provided useful advice. Some spoke very positively about the GPs they saw and how they interacted with them. Examples included the GP contacting a participant about some test results; and the surgery contacting a participant to let them know there had been a cancellation on the day they had unsuccessfully tried to make an appointment.

4.56 *Cerys was concerned about her 15 month old baby as her child had been ill when he was born. When she called her local surgery the receptionist told her to keep an eye on her son and that they would make an appointment for him the next day if the symptoms grew worse. The receptionist also suggested that Cerys could go to one of the local hospitals if she felt her son needed more urgent attention. She found this guidance reassuring and she felt the receptionists in the local surgery generally gave good advice to parents who were concerned about young children. Like other participants, Cerys was pleased that the local surgery seemed to prioritise children who were very young*.

4.57 As described above, however, there were instances where some participants had experienced negative or difficult communications, mostly with **reception staff**, regarding accessing care. Examples of communication issues included:

- Feeling embarrassed having to talk about the health issue with the receptionist when asked, or when walking in to see a GP – others in the waiting room could

potentially overhear the conversation; similarly in a rural location, 'everybody knows everybody's business' so having to explain the reason for a call could be sensitive;

F: Dim yn neis iawn. Mae lot o bobl yn cwyno am hynna, gofyn am personal… ti'n gwybod. Cos mae 'na bobl yn ciwio tu ôl i chdi'n disgwl. A os 'di o'n rwbath ti'm eisiau trafod. . . .M: Mae'n hollol wrong bod nhw'n gofyn wrtha chdi i ddisgrifio be sy'n matar hefo chdi. (F: It's not very nice. A lot of people are complaining about that, asking for personal…you know. Because a lot of people are queueing behind you waiting. And if it's something you don't want to discuss… M: It's completely wrong that they are asking you to describe what's wrong with you.) (18-44, C2DE, Gwynedd)

- Having to explain to a receptionist who was not clinically trained the reason for needing to see a GP: 'they're not doctors' complained one participant;

  The receptionists ask you questions. What are their qualifications? Are they doctors? How do they know if you're desperately ill? (Male, 45+, C2DE, Cardiff)

- Recalling a receptionist's refusal to offer an emergency appointment when it transpired one was needed. It was mentioned in one group that ensuring a child saw a GP could mean exaggerating the symptoms so they were seen promptly;

- Sensing that having to explain to a receptionist the reason for the appointment was a means to prevent patients from seeing a GP unless they were 'really ill'. Also, more generally, encountering receptionists who were quite 'rude'.

  I do find they can be very unhelpful. . . . They were dismissive. . . . I don't ring the doctor's unless I need a doctor, you know? (Female, 45+, C2DE, Carmarthenshire)

4.58 The complaints about receptionist experiences were sometimes countered with recognition that it must be quite a stressful role at times.

4.59 Despite taking exception to having to reveal to a receptionist the reason for a call, the overall access experience could still be deemed positive, as demonstrated by the example overleaf.

4.60 *Avril, who is retired, wanted to see a GP that day because of the pain she was in. She began phoning the surgery at 8.00am when it opened. It took about one hour to get through to the receptionist who asked her why she needed to see a GP. Avril did not think that the receptionist was qualified to ask this question; and it was a private matter. She believed that she was asked as a way of deterring patients from covering more than one issue with the GP. Avril was told the GP would call back that day and did so within one hour, followed by an appointment 'within an hour or two' which was convenient. There was no delay in seeing the GP on arrival at the surgery. The GP called in a physiotherapist during the appointment which Avril thought was 'a very good idea' because of their expert knowledge*.

The Welsh language and accessing primary care services in a general practice setting

4.61 Fieldwork in Gwynedd took place in the medium of Welsh and the findings in this section relate to feedback from this location. Views and experiences may be different elsewhere in Wales. Overall, younger and older participants were able to access primary care services in a GP setting in their chosen language. They explained that they felt more comfortable speaking to a health professional in Welsh as they were able to express themselves more effectively and therefore felt less anxious and self-conscious. Indeed some reported that they checked they could see a Welsh-speaking GP when making an appointment. Speaking Welsh when accessing services contributed to participants' more positive experiences. All agreed it was **important** to be able to do so, especially if patients were more vulnerable, such as older people and children.

> *Mae o yn eithriadol o bwysig yndi, y peth pwysicaf un. 'Dan ni'n meddwl yn Gymraeg a bob dim dydan, wedyn pam na fedran ni gael o yn Gymraeg de? (It's exceptionally important, the most important thing. We think in Welsh and everything don't we, so why can't we have it in Welsh?) (Male, 45+, C2DE, Gwynedd)*

> *Bysa plant fi'n deall, ond fysa nhw ddim yn gallu cyfathrebu'n ôl 'de. So 'san well ganddyn nhw Cymraeg. 'San nhw'n atab yn well yn Gymraeg. (My children would understand [English], but they wouldn't be able to answer back. So they would prefer Welsh. They would answer better in Welsh.) (Female, 18-44, C2DE, Gwynedd)*

4.62 An appointment with a non-Welsh speaking health professional, combined with not seeing a GP, led to a negative experience overall for one participant (overleaf):

4.63 *Rhodri, an older Welsh-speaker from a rural area, was slightly taken aback when he had to see the nurse rather than his GP. Furthermore, the nurse did not speak Welsh which meant he became flustered during the appointment and felt self-conscious having to use English. He did not understand why he had to see the nurse rather than the GP when the surgery did not seem busy at all. Rhodri understood that the nurse was more appropriate for some illnesses. However, he would still have preferred to see the GP on this occasion.*

4.64 Some who stated they were just as comfortable speaking English still felt a Welsh language service was important for Welsh speaking communities. It was occasionally thought to contrast favourably with secondary care experiences at hospital where it was considered unusual to be dealt with in Welsh.

4.65 Recalling a merger of two surgeries, one participant reported that there had been numerous complaints about the lack of Welsh-speaking GPs attached to the new practice. As a result, the surgery had since ensured that there had always been Welsh-speaking locums available.

4.66 Non-Welsh speaking staff who were making the effort to learn the language were appreciated. It showed respect for the local community.

4.67 However, when discussing the importance of factors that influence perceptions of access to services, some younger participants concluded that they would be happy to speak English in an appointment if it meant they were seen more promptly.

> *F: Dwi'm yn really bothered. F: Dwi ddim chwaith i fod yn onest. . . . F: Mae'n neis, ond wedyn 'di o'm yn dealbreaker. So fyswn i'n hapus neud yn Saesneg, ond fydda fo'n neis cael siarad Cymraeg. (F: I'm not really bothered. F: I'm not either to be honest… F: It's nice, but then it's not a deal breaker. I would be happy to do it in English but it would be nice to have it in Welsh.) (18-44, C2DE, Gwynedd)*

5. Awareness and perceptions of the Choose Well campaign

5.1 This chapter explores participants' awareness and perceptions of the Choose Well campaign[11]. Choose Well is a tool that helps people decide if they need medical attention if they are unwell. It explains what each NHS service does and when it should be used. The aim is to encourage people to take more responsibility for choosing appropriate care or treatments and managing their health, using online tools and other information available.

Awareness of the campaign

5.2 Participants were shown a screenshot of the Choose Well website and the moderator read out a short description of the tool.

5.3 There was some awareness of the campaign overall or of seeing a similar message. Some stated that they had seen it at their GP surgery or at hospital as a poster or on a TV monitor, or on Facebook. Recall of its content was not widespread. One person remembered a headline saying 'If you've got a cough or a sore throat there is no need to phone the GP,' followed by a list of what care to use based on the type of condition. Another had seen a message about how the starting point should be to call a helpline rather than seeing a GP as the default action.

Views on the Choose Well campaign

5.4 Participants concurred that it made sense to help members of the public choose appropriate care for treatment which in turn would **help to free up GPs' and other health professionals' time**. Most felt that there were a proportion of patients at GP surgeries who probably did not need to see a GP and wondered how much of an impact the campaign would have on this group. Only one or two participants admitted that they might fall into this bracket, for example asking for an emergency appointment when it was not an emergency; and not attending an appointment.

> *That would free up a lot of time for general practices, to be able to make appointments. Hospitals, as well. Certainly, there's people complaining about the waiting times in them. Often they don't need to be there. (Male, 18-44, ABC1, Carmarthenshire)*

[11] See Choose Well

5.5 On looking down the list of care needs, participants often reported that **they already knew** where to go for different types of care need and that they used a self-care approach where possible. Some commented how they were reluctant to attend the GP surgery unless they were very ill so as not to feel as though they were wasting GPs' time; and to avoid catching anything worse. However, the point was raised in one group that a GP appointment might result in a free prescription whereas a visit to the pharmacy would incur a cost.

5.6 Some older participants found the information a useful confirmation of what the pharmacist could help with as they had never been entirely sure.

5.7 A **reservation** emerged from time to time over how a symptom might be misread by an individual where it would have been appropriate to see a GP or visit the hospital. Among older participants, seeing a GP was still more reassuring for those who did not want to take a chance on their health. Similarly, a concern was voiced that the initiative might affect more vulnerable and / or older people who may be reluctant to seek help when needed.

> *I did notice at the doctors, like 'Go to the pharmacy if you've got a cough or backache'. Now, I thought that was really out of order because it could be a serious injury. (Female, 45-64, C2DE, Carmarthenshire)*

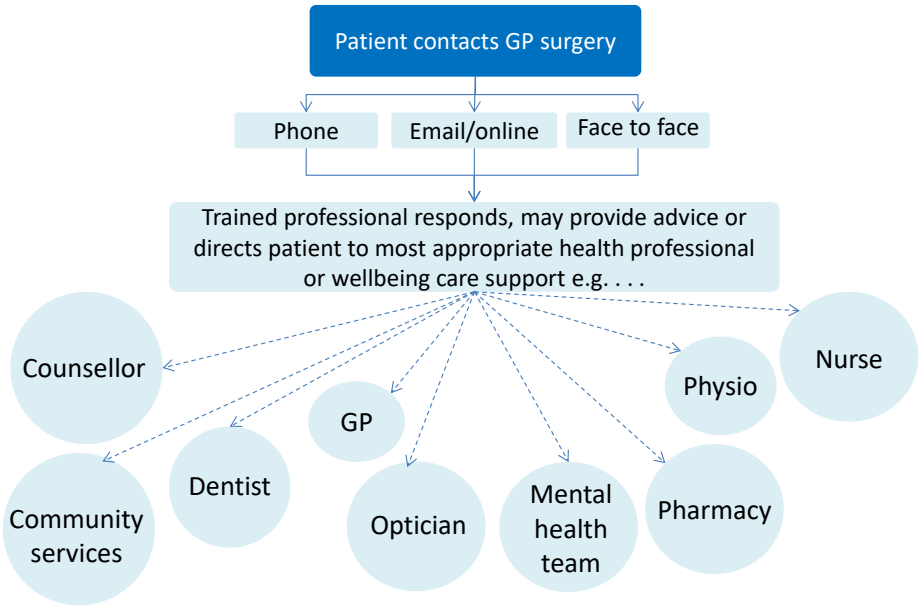
5.8 The point was also made on occasion that an exception should be made for young children who 'should always be seen' by a GP.

5.9 Summing up, some thought the campaign could be **publicised more widely** and placed in more community based settings, as well as via social media and outdoors. There was also a suggestion that the campaign could include information on where to find sources of support in each local community (e.g. contact numbers and addresses).

6. Reactions to the primary care model and triage approach

6.1 Participants were shown the following primary care model as a simple example of how it can work. It was accompanied by a short explanation of how it functions. This chapter covers their opinions on the model, including views on making more use of technology for accessing primary care in a GP setting.

Figure 6.1: Primary care model summary



Overall awareness of and reactions to the model

6.2 Participants tended not to have encountered this model where first contact was with a health professional. Those with experience of a telephone first approach or with a referral to another health professional via the surgery assumed that they had dealt with a receptionist rather than a suitably trained professional. Having heard the explanation, some felt that it sounded similar to 'NHS Direct' or the '101' service in that a health professional was believed to answer initial queries by phone: 'having the NHS helpline in front of going on to having an appointment'.

Advantages of the primary care model

6.3 On the whole participants were quick to identify possible advantages with this method.

Accessing the appropriate care more quickly

6.4 A prominent theme from participants' reactions to the primary care model was that it could mean accessing the appropriate care more quickly. The health professional responding to the first contact would be able to give informed advice on who to see or what to do next. This in turn could remove the need to see a GP first before receiving the specialist care needed – a 'fast-track' process or 'cutting out the middle man', according to some. The care received might be more specialist than a GP was able to provide.

> *Sa hynna'n lot gwell system dwi'n meddwl. Especially hefo pethau fatha cwnsela a thîm iechyd meddwl. Really, 'di GP chdi methu neud dim byd am hynna nadi, so bod y person yn gallu referrio chdi i'r bobl ti actually angan mynd i weld. So mae hynna'n sortio problemau nhw yn gynt hefyd. (That would be a much better system I think. Especially with things like counselling and a mental health team. Really your GP can't do anything about that can they, so that person could actually refer you to people you actually need to see. That would sort their problems out sooner as well.) (Male, 18-44, ABC1, Gwynedd)*

> *If a nurse could tell me straight away that, 'Yes, you need to go to physio', then you don't have to wait for that GP then, if he's fully booked up or you can't get that appointment with him. . . . You've missed all that out, because she's already fast-tracked you. (Male, 18-44, C2DE, Carmarthenshire)*

6.5 Illustrating this positive aspect of convenience, the participant below had not expected a referral to a physiotherapist.

6.6 *Mike, an older male participant, was pleasantly surprised when he phoned his local surgery and they offered him an appointment with a physiotherapist at the surgery, rather than going to see his GP again. He felt it worked well and he was glad to have such facilities on his 'doorstep'. He found it easier and more convenient - it saved him time as he thought the GP would only have referred him to the local hospital, which would probably have taken weeks.*

6.7 It might also mean, for example, a patient who was feeling unwell did not need to leave home to attend the surgery if the advice was received by phone. Where a participant's surgery used the telephone first system it might, as one participant suggested, mean that they did not then have to wait for a GP to call them back later that day. Speaking with a health professional by phone would therefore save time.

6.8 This primary care model, a small number felt, would also remove any doubts over where to go with a health issue. One participant recalled being uncertain over who to call with an eye problem and therefore liked the idea of speaking with a health professional first to obtain appropriate advice and signposting. Furthermore, the patient would not feel any guilt over potentially wasting a GP's precious time.

6.9 Thinking of how the approach could have affected a previous experience, one participant gave an example of having received different advice from different GPs on mental health. The prospect of a direct referral to a mental health team sounded attractive because the individual would be seen by a suitably trained professional more quickly. Similarly on mental health, another participant thought that this model would help to reduce the anxiety she sometimes felt going to see a GP; there would be one less step in the process to act as a barrier to seeking help.

> *With anxiety and things like that, it builds . . . it takes a lot to even go to the GP. And once you go the GP you have to do it all again to go and sit with someone else. Like I've literally had to build up the courage to go to the doctors, and then they refer me and then I've got to walk to another place – like, the mental health team's only around the corner. (Female, 18-44, C2DE, Cardiff)*

6.10 Furthermore, those who had issues in their dealings with reception staff were attracted by the idea of speaking with a trained professional first, rather than a receptionist deciding when an appointment was needed. In addition, it was anticipated that the patient would feel more comfortable discussing a health issue with a trained professional than with a receptionist as some currently did.

> *I totally agree with it. The key word you've said there is 'a trained professional'. When you try to see somebody at the moment, unless you go to the pharmacy, you're hitting a brick wall because they're not trained, but they're playing God. (Female, 45+, C2DE, Carmarthenshire)*

A means of reducing the pressure on GPs

6.11 Some participants considered the move towards this model as a reaction to a perceived increasing strain on GP resources. The current situation was thought by some to be exacerbated by people who probably did not need to see a GP for their care. The model would help to ensure that those with more urgent needs received the appropriate care in a more timely way. It might also result in a patient being able

to spend more time with the GP and could reduce waiting times for appointments. Gradually over time, according to one participant, patients would become used to seeing other health professionals and less concerned about always seeing a GP.

> *Mae'n mynd i dynnu pressure off doctoriaid dydi, lle maen nhw'n mynd i gael canolbwyntio ar y pethau mwya' serious 'de. (It's going to take the pressure off doctors, so they can concentrate on more serious stuff.) (Female, 18-44, ABC1, Gwynedd)*

6.12 A further, less prevalent advantage identified with this model was the convenience of three different ways to contact the surgery.

Disadvantages of the primary care model

6.13 In Cardiff and Carmarthenshire, participants aged 45+ were slightly more likely than younger participants to voice reservations with the primary care model. In Gwynedd there was no discernible difference by age group.

6.14 Concerns about **continuity of care** were an issue from time to time. Some older participants, especially in Gwynedd, instantly disliked the primary care / triage model. They did not want to deal by phone with an individual they did not know, preferring the comfort and reassurance of a familiar face or voice: 'dwi rhy hên i hyn (I'm too old for this)' summed up one older participant. They contacted the surgery because they wanted to see a GP who they trusted, along with the receptionist they had grown to know. Also, some participants were uncomfortable with the idea of disclosing their reason for calling by phone to someone who was not their GP.

6.15 More broadly, there was uncertainty over how **qualified the trained professional** would be and sometimes a concern that this individual (e.g. 'a glorified receptionist') might miss a serious illness. Some wanted to know that they could insist on seeing a GP if they wished. They found it difficult to see past this issue with the model, particularly some older participants. As with certain existing experiences with a telephone first approach, some on occasion felt that this new model might be an attempt to make it harder for them to see a GP.

> *I wouldn't want somebody on the end of the phone saying to me 'Well, really you don't need to see the GP today, just go to the pharmacist and get this or get that'. I'd think 'you're just pie-ing me off'. It's as if this way, they don't want people to go to their surgery. (Female, 45+, C2DE, Carmarthenshire)*

6.16 From a practical point of view, some were concerned that the experience might **take even longer**: call handlers would have to deal with patients describing their reason for calling; and a referral to a practice nurse might then result in having to make an appointment with the GP.

6.17 On occasion, older participants wondered how easy it would be to **express themselves adequately by phone** when discussing their issue. One individual, for example, doubted she would be able to talk about her mental health on the first contact.

6.18 Further occasional disadvantages and queries raised included:

- Will reassurance be provided that a GP would still review the case when appropriate?
- Will the human element eventually be superseded by automation?
- With triage, will the patient be connected to the other sources of care in the same call rather than having to start the process again with another number?

The role of technology in the primary care model

Current use of technology for accessing primary care services in a GP setting

6.19 Participants tended not to have used online technology to make appointments and access the care they needed because of a lack of awareness. Even so, it was remarked that technology was prevalent in people's lives and in how they interacted with some organisations. Surgeries, a few felt, would have to move with the times.

6.20 Infrequent examples of current use were for **making an appointment** and for **repeat prescriptions**. There was also an example of receiving a text message reminder from the surgery which was useful when the appointment was a number of weeks in advance. It also acted as a reminder to cancel an appointment if the individual no longer needed care.

Opinions on making more use of technology for accessing primary care services in a GP setting

6.21 Views were mixed on making more use of technology for accessing primary care services via the GP surgery. Although a range of views were expressed across the two age groups, some older participants across the sample and some younger participants in Gwynedd were less likely to be interested in a shift to making more

use of technology. However, the limited examples of current use of online technology were from older and younger age groups.

Benefits of technology

6.22 From a positive perspective, online **appointment booking** was considered by some to be convenient for non-urgent needs, resulting in minimal disruption to the patient's day and no lengthy wait on the phone. There was therefore some interest in being able to do more online in this respect although reassurances would be needed that the appointment had been registered. The small number of participants who had made appointments online or gone online for repeat prescriptions were mostly positive about the process, for example being able to choose which GP they saw for a non-urgent appointment a week or so later; and saving time with repeat prescriptions.

> *I just fill it out and send on My Healthcare and it tells me when it's ready in the chemist. . . . It saves time, there's no messing about with it. (Female, 45+, ABC1, Carmarthenshire)*

6.23 Some also thought that technology could be used where the health professional did not think the situation warranted face-to-face care, such as 'recurring sick notes', a repeat prescription or something else non-urgent. Online methods could therefore result in a **quicker outcome**.

6.24 There was also some spontaneous interest among younger and some older participants in using **live chat** (as long as it was with a human rather than artificial intelligence) or **Skype** / **FaceTime** for certain consultations. They could be used for minor issues, save time visiting the surgery, or might help busy parents with children to look after or those with mobility issues.

> *[Skype] is ideal because you've still got the face-to-face, but you're where you want to be, home. . . . It's live, it's face-to-face . . . . You can show them the problems. (Male, 45+, C2DE, Cardiff)*

6.25 A further benefit occasionally highlighted was that online could provide a more discreet option for a patient who was uncomfortable discussing an issue by phone or face-to-face.

Drawbacks and reservations with technology

6.26 A key concern among participants was **how effectively the technology would work**: would an online appointment definitely be registered? Would an email definitely be received? Could there be confidentiality issues over who saw online messages or video? Could it be susceptible to hacking? Would phone call handling take precedence over online contact? How long might a patient have to wait for a response to online contact? Expectations of the latter ranged from within a day to 'a reply the next day'. Some also wondered how a surgery would be able to manage and filter what could be large volumes of online contact / emails. Speaking to surgery staff by phone, on the other hand, provided this assurance and immediacy.

> *I wouldn't really trust that because you don't know how often someone is checking the email, when they're going to pick it up. Are they going to pick it up at 8:30 in the morning or do they get around to doing it once they've got the phone calls out of the way? (Female, 18-44, ABC1, Cardiff)*

6.27 Reinforcing this concern, one participant had booked appointments online but had attended on the given day to find that his appointment had not registered. It was 'not a user-friendly system at the moment'. Another older individual had given up attempting to book online because there never seemed to be GP availability, only nurses. The interface felt difficult to use as well.

6.28 A further reservation voiced with technology concerned the quality of the patient / health professional interaction at the triage and appointment stage: how effectively would patients be able to **describe the detail of their symptoms** if writing online. It could involve further questions online, 'crossed wires', taking up more time and creating uncertainty about the process (e.g. missing a call-back or further email exchanges). It would also feel quite cold and impersonal versus a face-to-face appointment. When participants raised possibilities like Skype or live chat for a consultation, some thought that it might be risky to attempt to diagnose online in this way instead of seeing the patient in person.

> *Achos pan mae rhywun yn fatha messagio, chi'n cymryd o ffordd wrong. Ti'm yn gwybod be mae'n feddwl. (Because when someone messages you, you take it the wrong way. You don't know what it means.) (Female, 18-44, ABC1, Gwynedd)*

6.29 Some across different age groups, therefore, still felt that it was **important to have the face-to-face option** for consultations, especially 'if it's something serious'. Some older participants reiterated that they would be more confident about the outcome and find the process more reassuring if face-to-face. They could not envisage how an online method could provide the same experience and sense of care as seeing a GP face-to-face. More generally, some mainly older participants emphasised that they felt more comfortable phoning a surgery and then seeing a GP. They appeared reluctant to consider alternatives.

> *F: I would prefer to see the doctor, yes. M: You feel more confident then, than going online. (45+, C2DE, Cardiff)*

6.30 Further occasional reservations with using more technology included:

- Booking an appointment online with a GP might mean that triage was not used to help the patient choose the most appropriate health professional or wellbeing care support for their needs. The convenience of online appointment booking might also make it too easy to book a GP appointment they did not really need;
- Not being computer literate and doubting they would be able to use the technology;
- The inconvenient prospect of having to visit the surgery to collect and complete an application form to register for My Health Online[12].

[12] See NHS Wales Informatics Service: My Health Online

7. Perceptions of good access to primary care in a GP setting

7.1 This chapter highlights what participants believed good access to primary care would look like in a GP setting. It traces the key steps and interactions of the experience. In addition to their own preferences, participants were encouraged to consider what good access would look like for others where appropriate: younger people who worked, those with young children and older people. The main distinctions to emerge during discussions were broadly based on younger people, people who worked, parents and older people.

Overview of key factors associated with good access

7.2 Overall, there was a good deal of commonality with what good access looked like across age groups. In the main, participants opted for a triage approach for accessing primary care services in a GP setting. Some participants of different ages were **concerned about wasting GPs'** time with what was probably a minor issue. Triage and online methods would therefore make them feel more comfortable contacting the surgery. **Better initial access by phone** without the frustrating delays was also requested. There was a suggestion that some surgeries could do more to promote the different ways of accessing primary care services they might have at the practice, in particular the **online** appointment booking option.

7.3 A **prompt appointment** within one or two days was also desired with a **GP or suitably qualified health professional**.

7.4 Key differences to emerge by age group, working and family situation were:

- Preferences for **appointment availability** with those working and those with children requiring more flexibility for appointment times than older, retired participants;
- Preferences for **technology** as participants tended to assume younger patients would be more open to using it whereas older participants would want to use more traditional methods of access;
- Some mainly older participants wanting to **keep to a similar system** they currently used, with a receptionist (phone contact) and GP (face-to-face) as the main access components;

7.5 The diagram overleaf summarises the key attributes for good access that emerged from the research. The darker colours denote greater preference.

Figure 7.1 Summary of what good access looks like for primary care services in a GP setting

Methods of making contact and an appointment

7.6 **The flexibility** to make contact with a surgery via different channels – phone, online, face-to-face – would represent good access overall, according to most participants in different age groups. Being able to make an appointment 'twenty four seven' was also regularly suggested. However, **phone was still the main preferred** option across all age groups – and deemed essential for those aged 75+. It would, in some participants' minds, probably be just as quick and potentially more direct than attempting online contact. Some felt offering phone contact would also help with reassuring any patients who preferred to see a GP that they were being given good advice or a suitable referral to another health professional for their needs.

> *We came to the conclusion that flexibility is one of the main important aspects. Some of the most convenient methods would be either electronically, by phone or by app or by coming in and talking to somebody. (Male, 18-44, ABC1, Cardiff)*

7.7 Parents of young children were likely to want quick access for their children's health issues which phone contact to make an appointment could provide, assuming no delays in getting through (discussed below). Speaking with a health professional would also be more reassuring than online, for example, if the parent was especially worried about the child, according to some.

> *[As a parent], being able to speak to somebody is crucial. . . .They might be nervous and worried that their child is ill, but just having a reassuring voice might make things a little bit easier just to calm down the parents . . . I've used NHS Direct plenty of times. Talking to doctors or nurses there they've reassured us. (Male, 18-44, ABC1, Carmarthenshire)*

7.8 There would need to be enough **resource in place** to handle the volume of calls normally received in the morning. They could operate out of a call centre, suggested a few participants.

7.9 A **walk-in** option to make appointments and see a GP on the same day was thought by some to represent good access for older patients including those aged 75+. It was not so important to some who were younger and also in rural areas where they had to drive several miles to a surgery. Building on this point, a suggestion was made among participants aged 45+ for a walk-in surgery open from 7.00am with a

large number of GPs. The patient would be seen shortly after entering with no appointment necessary. It would be convenient and result in minimal disruption to the day.

> *I could pop in to my surgery, say, 'I've got to see the Doctor', they say 'okay wait, it's open access between eight and ten'; you can just sit there and wait until you see a doctor. I think that's good. (Female, 45+, ABC1, Cardiff)*

7.10 When walking in to ask to see a health professional, some requested **improved reception layout** where the patient had to discuss their health with the first member of staff they speak with. This would avoid the embarrassment of being overheard by other patients.

7.11 As part of good access, some expected that **online** would be available with its convenience for booking appointments. It would be especially helpful for those normally travelling to work or taking children to school at the time they would usually have to phone the surgery. However, participants who were open to the idea of using online for health advice felt that they would only use online contact for more minor issues.

7.12 For all age groups, good access would mean **not having to redial several times to make the first contact** by phone with the surgery. Some of those who worked and / or had young children also wanted to be able to contact the surgery by phone at an earlier time of day, for example from 7.30am onwards. This would fit more conveniently with work and childcare commitments. There was a suggestion that a queuing system on the phone would at least give the caller an indication of how long they would have to wait rather than continuous redialling.

First contact with a member of staff – a triage approach

7.13 In keeping with reactions to the triage model, participants of different ages generally suggested that having first contact with a health professional such as a nurse, a 'trainee doctor', a paramedic or someone with a **medical background** would represent good access to GP surgery services. The patient would feel reassured talking about their health issue, the advice they received and the professional's ability to 'at least . . . categorise how important [the issue] is'. Some wanted to be able to easily find out what the call handler's background was in health. Older participants sometimes stressed how important it would be to them that the individual was 'highly trained', friendly and helpful on the phone, rather than

seemingly creating barriers to seeing a GP. Those with negative experiences of interactions with receptionists liked this approach.

> *If I knew some of the symptoms I had, I could speak to them over the phone or online and they could relay some advice back to me, point me in the direction. (Male, 18-44, C2DE, Cardiff)*

> *Dylai nhw ddeud be 'di cefndir nhw a ballu. Ti'n teimlo'n fwy hyderus wedyn yn gwbod bod y person ochr arall i'r lein yn gwbod be maen nhw'n siarad am. Ac wedyn ti'n teimlo'n fyw hyderus yn gwbod ti'n mynd i gael dy referrio i'r person iawn. (They should say what their background is and stuff. You would feel more confident then that the person on the other end of the line knew what they were talking about. Then you feel more confident that you're going to be referred to the right person.) (Male, 45+, C2DE, Gwynedd)*

7.14 Where relevant, the first contact would result in the patient being informed of what type of health professional or wellbeing care support professional they would be seeing, their name and the appointment details. The point was made that it would be helpful to be put through directly to the appropriate professional rather than having to start the contact process again.

7.15 In contrast, for some older participants, good access would largely reflect their current experience: first contact with a receptionist and 'if you want to see a GP you see one. If you want to see a nurse you see one'. Having more GPs available would also help with creating good access and patients getting the care they need, according to some. More Welsh speaking GPs were also requested by a few participants to improve the overall experience.

A focus on technology

7.16 When considering what good access would look like, participants aged 18-44 were slightly more likely than participants aged 45+ to suggest making greater use of technology. The main suggestion across age groups was the ability to **make an appointment online** which would include immediate written confirmation for a prompt appointment. Text messages could be used as subsequent reminders. The benefit would be greater convenience for the individual to make the appointment at any time and without the possible delays getting through by phone. This could be via an app, as several participants proposed. More use could also be made of online access for repeat prescriptions or booking a smear test, for example.

F: It would be an app, done online. M: Maybe text updates saying, 'your appointment is at this time with this doctor. (18-44, ABC1, Carmarthenshire)

I'm always up there with the technology so I'd definitely use . . . if there was an app for my local GP . . . where you could have a look at what available space they'd got to be seen and have an appointment, I'd most definitely use it. It'd make life so much easier. (Male, 18-44, C2DE, Cardiff)

7.17 While some participants considered how technology could aid good access, others contemplated complications and uncertainty as described earlier in the report. Issues with broadband reliability were raised on occasion in rural areas. Good access using online methods would therefore mean **robust and reliable platforms** and networks to deliver it.

Fi fy hun, lle dwi'n byw, dwi'n cael trafferth efo wifi, lot o hen bobl ella ddim yn gallu gwneud hynna, ac maen nhw'n licio weithia' gweld rhywun yn wyneb yn wyneb. ond o leia' gen ti y dair opsiwn does? Ac os ti'n methu neud o ar-lein, ella fedri di fynd yna. (Myself, where I live, I have trouble with the wifi, a lot of older people wouldn't be able to do it, they like to see people face-to-face but at least you have the three options don't you? And maybe if you can't do it online then you can go there.) (Female, 18-44, C2DE, Gwynedd)

7.18 Less often, some participants in different age groups also suggested using online technology for the first contact with a health professional or subsequently with a GP. **Skype** or **FaceTime** were raised as options to help patients express themselves more effectively than in written correspondence online. It would, some thought, be useful for busy parents with children to look after because they would not need to organise the children for a journey to the surgery.

7.19 **Live chat** with a health professional was a further idea put forward mainly among 18-44 year old participants as part of good access to primary care services in a GP setting. It was considered convenient and instant unlike submitting symptoms via an online form or email. An example was given by one participant of using live chat on health matters via the BUPA scheme at work which he had found very useful and convenient: 'I can do it at a time that suits me, and I book an appointment . . . and do it from the comfort of my own home'.

7.20 Further online options occasionally suggested as part of good practice included:

- Email correspondence with a preferred GP for an ongoing health issue: it would be ‘fantastic’ to be able to email a GP direct who ‘knows your history’;
- Submitting minor issue symptoms online and receiving a response within one hour. The example given where this option could work was a recurring problem with eczema. It would also result in the patient not feeling that they were ‘using up the time of these people that need to be seeing and dealing with more serious complaints’.

The convenience of appointments

7.21 Views varied on how long a patient should wait for an appointment and what would be a convenient time of day. Participants across age groups tended to believe that, if contacting the surgery early in the morning (for example between 7.30am and 9.00am), **same-day** appointments would represent good access or at least within around 24 hours or ‘a day or two’. This access would be for situations where the patient felt they needed to see a health professional urgently. With an unexpected care need, for example where a patient had delayed seeking help to see if the issue would clear up, or where pain was becoming worse, a same-day appointment was deemed good access. Some again argued that if they were taking the time to contact the surgery it was because they felt they needed care as soon as possible: ‘Dim mwy na diwrnod. Os dwi’n sâl, dwi’n sâl (*No more than a day. If I’m ill, I’m ill*)’.

7.22 Those with **young children** should certainly be seen on the same day, according to some, because of the possible risks of serious illness. The prospect of having initially had some advice when making the appointment via the trained professional sounded reassuring on occasion.

7.23 According to some, if the patient **did not consider the issue urgent**, it was acceptable to wait two to three days or up to a week. More broadly, greater control of the scheduling of an appointment was sometimes deemed good access.

7.24 A further individual suggestion for good access included knowing in advance that there may be a delay when they arrived for their appointment. Some commented that they would be prepared for a short delay to their appointment, for example 15 to 20 minutes.

7.25 Some thought that **lengthening opening hours** with more options before and after work and around school hours would offer greater flexibility and improve access. Suggestions included opening hours for appointments of 7.00am to 7.00pm or extending the day to 7.30pm / 8.00pm. A couple of extra hours could mean more availability and parents not having to take the children out of school, depending on the issue. It was suggested that with an evening appointment, those in more rural locations would not have to take so much time out of their working day if they had to travel a fair distance to their surgery.

> *I think for the surgeries to be open earlier in the morning would mean that I could go before work, without having to miss anything, if I could get an appointment for that day. (Female, 45+, ABC1, Cardiff)*

7.26 Good access would include a **weekend** option especially for those who worked and those with young children, according to some. It was pointed out that pharmacists and sometimes dentists opened at the weekend. A half day on a Saturday was given as a suitable possibility. Some anticipated that a surgery's caseload would consequently be more spread out, helping to free up more mid-week appointments.

> *It's a twenty-four-seven society. You've got shops open twenty-four hours a day. You can go to chemists twenty four hours a day. So, why – I'm not saying doctors twenty four hours a day – but why can't they be open longer and weekends? (Female, 45+, C2DE, Carmarthenshire)*

Post triage: contact with a health professional

7.27 Reflecting the overall reactions to the primary care model, participants were generally prepared to have contact with **the most appropriate health professional** based on the initial exchange with the surgery. Good access would mean being able to receive specialist care more quickly and potentially with a better outcome than with a GP, depending on the need. A physiotherapist, for example, may have more expertise than a GP.

7.28 For those with an ongoing health issue, **seeing the same GP** or 'your regular doctors' would represent good access to ensure continuity of care. This preference was more prevalent among older participants and those with longer term health problems. Similarly, a small number of older participants maintained their view that good access would mean continuing to see a GP over other health professionals.

If you see the same doctor, which I feel you should be able to do, then it becomes clearer and they'll understand what you're coming for. Especially when, you know, you're a pensioner. (Female, 45+, ABC1, Carmarthenshire)

7.29 **Seeing the health professional face-to-face** tended to be the preferred option across age groups for good access, especially where the patient considered it urgent or if the issue concerned a child. It was also suggested that face-to-face should be a priority for children to help with safeguarding. Participants in general felt that a **mix of other options** should still be available covering phone and, less often, online.

Wyneb yn wyneb, dros y ffôn - dibynnu eto be sy'n matar ond wyneb yn wyneb. Pobl hŷn, mae angen iddyn nhw gael gweld person a siarad hefo person yna. (Face-to-face, over the phone - depends what's wrong but face-to-face. Older people, they need to see a person and talk to them.) (Male, 45+, ABC1, Gwynedd)

A mix of options would be good depending on the circumstances of what you want to see the doctor for. Instead of making an appointment, maybe a phone conversation will do. (Male, 18-44, ABC1, Cardiff)

7.30 **Phone or online contact** with the GP or other health professional could be helpful where: a care issue was considered minor or concerned ongoing medication; it minimised disruption to the working day; a parent might find it inconvenient to take children to the surgery; a parent might worry about a child being exposed to illnesses in a waiting room; a patient would struggle to visit the surgery with their health / mobility; a patient felt they were infectious; a patient knew the GP and the GP was familiar with their history, according to some older participants; or if the care related to a particularly sensitive or 'embarrassing' issue.

7.31 The telephone first approach was identified as good access by some with experience of it, provided the patient was called back promptly, for example within the hour.

7.32 If the referral was to a health professional or to wellbeing staff who were based off site, those in rural locations would want to know the location of the referral from a travel point of view. One rurally based participant recalled being surprised at how far he had to travel (45 minute drive) for physiotherapy after a referral.

7.33 Also from a rurality perspective, access to a local surgery would be the ideal whereas, according to a small number of participants in rural areas, the local practice had merged with another further away – so it was now possible to be given an appointment at either surgery.

8. Conclusions

Overarching themes

8.1 The two main themes to emerge from the research that relate to the National Survey for Wales results on finding it difficult to make a convenient appointment to see their GP were: difficulty getting through to the surgery by phone to make an appointment; and not being able to see a GP promptly – that is, on the same day or within a day or two. These were key barriers (and facilitators when not present) for accessing GPs and wider primary care staff.

8.2 There was an expectation that an individual should be seen when the patient feels it is urgent. This highlights the uncertainty that can exist over what constitutes the need for an 'emergency' or same-day appointment and what does not.

8.3 There was some appetite for making greater use of technology, more so for appointment setting than with consultations with health professionals. It was often difficult to envisage what the consultation experience would be like and how it would compare with speaking with staff and a health professional face-to-face. Its potential advantages, therefore, were sometimes overshadowed by concerns about how online would work effectively. Explanation and reassurance would be needed for more complex use of technology for accessing services.

8.4 The primary care model with a triage approach involving a health professional was mainly positively received. Potential benefits of the system were often clear: getting the right care more quickly and reducing pressure on GPs. The caveat for some, especially among older participants, was that the call handler would need to have a credible medical background. In addition, some older participants disliked the prospect of not being able to see a GP when they felt they needed to.

8.5 The conclusions now provide key observations regarding the specific research objectives.

Objective: perceptions of communication by GPs or other healthcare professionals, reception staff or other call handlers around clinical triage and signposting

8.6 Overall, participants tended to report positive experiences of communications with staff. The one exception for some was with receptionists: the experience of having to explain the reason for the call and a sense that a receptionist was 'playing the role of doctor'. They assumed that they had been communicating with a receptionist

rather than a health professional in these instances. Participants with experience of triage reported that they had been clearly informed when making an appointment of the type of health professional they would have for the consultation (e.g. a physiotherapist or nurse).

Objective: perceptions of timeliness and responsiveness

8.7 Timeliness and responsiveness became an issue with getting through to the surgery by phone and where there was uncertainty over how long it would take for a GP to phone the patient back after first contact with the surgery. Even so, responsiveness of staff where a participant was expecting a call-back was positive in the main. There is the potential, however, for uncertainty over the timing of a call-back from the GP. It can affect the experience by disrupting the patient's schedule (e.g. with work or parent commitments).

8.8 Where used, online options (appointment booking and ordering repeat prescriptions) were generally found to be convenient and responsive.

Objective: perceptions of continuity

8.9 Participants' experiences tended to have been with GPs providing care. In those circumstances continuity became more important with ongoing health conditions and, for some older participants, where they were used to seeing the same GP(s) over time and felt at ease talking about health issues with them. Triage to other health professionals where it happened was mainly considered an appropriate choice of health professional and the care received had generally been satisfactory. There were isolated examples where a patient would have always wanted to see a GP for their perceived superior expertise, resulting in dissatisfaction with the experience.

Objective: perceptions of the convenience of appointments

8.10 Participants were satisfied when they managed to secure an appointment on the same day or within a day or two. A longer wait for more routine appointments also tended to be satisfactory (e.g. a repeat prescription or a regular injection). Overall, however, a wait of more than a week for an appointment for an unexpected condition prompted dissatisfaction among participants. In their minds they are sufficiently ill to require a prompt appointment. There were also requests for earlier and later appointments which would be more convenient for those who worked and those with children at school.

Objective: the importance (or otherwise) of face-to-face contact

8.11 Despite some interest in other channels, face-to-face contact with a health professional remained important to participants overall including when considering the primary care model and good access. It was associated with clarity describing symptoms, accuracy with treatment and generally feeling comfortable with the level of care received. It was also what participants were used to. Skype or similar as an alternative was of interest to some because it maintained the face-to-face element.

Objective: accessing primary care in a GP setting and the Welsh language

8.12 It should be borne in mind that the conclusions for this objective only relate to participants in Gwynedd. They may differ for other parts of Wales. Accessing care in Welsh was important to Welsh-speaking participants. In the main, they had been able to access services and receive the care they needed in the language of their choice. A seamless, proactive offer of Welsh was often a key factor contributing to a positive experience and was raised spontaneously. It meant participants could express themselves as they wished and felt at ease when discussing health issues. Care from a non-Welsh speaking health professional can result in difficult situations on occasion, such as feeling flustered.

8.13 Receiving care more promptly but in English was sometimes preferable, however, reflecting the overall importance of appointment wait times.

Objective: whether seen by a GP or wider multi-disciplinary team

8.14 Participants tended to have been seen by a GP when recalling recent experiences. Where they had instead been referred to another type of health professional, the experience was mainly positive. In these cases, they had been informed which health professional they would see and despite sometimes being surprised at the offer, they had found it a positive experience (e.g. seen promptly and receiving good care). The exceptions were where participants felt that they should have seen a GP and where the care (e.g. some stretches from a physiotherapist) were perceived to be inadequate. This suggests that some patients require reassurance about seeing other professionals and an explanation of how their expertise is appropriate for the condition.

9. Recommendations

9.1 Described below are recommendations from the research for future practice which would help to address issues regarding satisfaction with accessing GP services.

Making contact with the surgery

9.2 Patients would benefit from:

- A better phone queuing system which removed the need to constantly redial and gave patients an indication of how long they would have to wait to speak with staff;
- A system that reduces the wait to speak with the surgery by phone, given that phone contact is the preferred method overall. Several of the recommendations below may also contribute to this goal in terms of encouraging a shift to other contact channels;
- Exploring how the system can be developed to spread the time of day contact is made to make an appointment rather than patients focusing on calling when the surgery opens;
- Greater promotion of what alternative options are currently available at surgeries for accessing primary care services, particularly online and My Health Online. Promotion should incorporate strong rationales for using these channels with clear examples of how other patients are benefitting from using them;
- A range of channels for contacting the surgery, i.e. phone, face-to-face and online options;
- Allaying concerns about online options' robustness and immediacy of contact;
- A convenient, well publicised app for making and cancelling appointments;
- As painless a system as possible for registering for online services;
- The ability to walk in to make an appointment and / or receive same-day care which remained important for some older people;
- Continued promotion of the Choose Well campaign including an emphasis on how a patient can receive swift and credible care via other means, for example stressing how highly qualified pharmacists are.

A triage system

9.3 The primary care model with triage received positive feedback overall:

- Continue to encourage the adoption of a triage system with a trained professional handling the contact. Continue to explore supporting online options like Skype and live chat;
- Promote the medical qualifications and expertise the trained professional has in patient communications. A nursing background was widely suggested. This move may also resolve the issue some voiced about disclosing health issues to a receptionist during first contact. The resulting referral would likely be more credible and accepted;
- Proactively offer the Welsh language so that Welsh-speaking patients are comfortable expressing themselves which will mean they are directed to the most appropriate care;
- Reassure patients that GPs will still be accessible and emphasise the purpose is to help them get the appropriate care more quickly;
- Stress the message that triage with a trained health professional will ultimately benefit all as patients are directed to the right care, freeing up GPs to focus on care for those who need it most. Consider whether messaging on the benefits of triage could be framed in the context of the challenges of an ageing population and increases in chronic health conditions;
- Ensure those making face-to-face contact feel that they cannot be overheard by others when discussing their health;
- Promote more widely the range of primary care services available at the GP surgery and continue to refer to health professionals as locally as possible.

Appointment times and opening hours

9.4 Good access was associated with seeing a health professional as promptly as possible: same-day or within a day or two. There was sometimes a degree of acknowledgement that GPs are stretched and that some patients who make an appointment with a GP do not need one:

- Promote surgeries' current opening hours as some participants did not know what hours their practice operated;

- Consider how opening hours could be expanded further at the start and end of the day to support the needs of those who work and parents with school-age children, for example remaining open later on one day a week. A weekend option would also be welcome. Consideration could also be given to allocating earlier and later appointments to those restricted by work and school commitments;
- Improve patients' understanding and promotion of what would constitute urgent and less urgent reasons for an appointment via the GP surgery. Include guidance on when to choose different types of contact for the GP surgery and under what circumstances.

Annex – Topic guide used for the discussions

A. Introduction

1. *Thank participants for attending. Introduce self, Beaufort and client if present.*

2. *Explain aims of study:* Welsh Government has asked us to explore the general public's views and experiences of making an appointment and getting the care they need at the local GP surgery for any kind of primary care service during normal opening hours. (*Explain primary care so everyone is clear on the discussion focus*) Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice – your local GP surgery, community pharmacy, dental and optometry (eye health) services. In this discussion we're focusing on services provided at your local GP surgery. This can include seeing a GP, vaccinations, repeat prescriptions, seeing the practice nurse and so on. Other services are sometimes available at a surgery such as counselling and physiotherapy. With your help, we'll be able to tell Welsh Government about:
   - What currently works well with making appointments during normal hours of opening and getting the care you need at the surgery;
   - What issues people are experiencing with making an appointment and getting the care you need at the surgery;
   - What a good experience looks like and what you would do to improve things.

3. *Explain purpose of discussion is to allow them to express their own views, talk about own experiences – there are no right or wrong answers and they only need to mention views / information they're comfortable sharing. If there's anything they would prefer to feed back separately they can do so at the end or by noting it down for the moderator.*

4. *Explain MRS Code of Conduct / GDPR key points:*
   - *Reassure about confidentiality and obtain permission to record – purpose of digital recorder is to aid analysis. We may make a transcript of the recording but Beaufort will not pass it on to the client. The recording / transcript will be securely stored and then destroyed within 3 months of the project ending;*
   - *Participation is entirely voluntary;*
   - *Check they received a copy of the Privacy Notice and if they have any questions;*
   - *Housekeeping: mobile phones, fire safety.*

5. *Introduce group members:*
   - *First name;*
   - *Who's in the household at home including age of any children;*
   - *What they like most about the area they live in.*

B. Current GP access experiences

6. Tell me first of all, what single words immediately come to mind to sum up your experiences of getting the care you need at your local GP surgery during normal hours for any kind of service?
    - What other words come to mind?

7. Let's explore the more positive words / phrases first. Tell me what you mean by [*prompt and probe words / themes on flipchart*]
    - What examples can you give me to support your point?
    - How common is this experience?

8. Moving on to the less positive words / phrases, tell me what you mean by [*prompt and probe words / themes on flipchart*]
    - What examples can you give me to support your point?
    - How common is this experience?

For depth interviews, researcher to map out timeline of experiences

9. Let's focus now on any recent appointment you made at the GP surgery that was a positive experience in terms of making the appointment and getting the care you or a member of your family needed. Remember you only need to share information you're comfortable with (*ensure participants stay focused on a specific, recent occasion*). Who has a good example? *Aim to collect 3+ examples, allow others to contribute*
    - How did you contact the surgery?
        - What made you choose this method over others?
        - How efficient was it? *Probe*
        - What time of day did you contact the surgery?
        - (*As appropriate*) How would you sum up your interaction with the person you contacted?
    - How long did you have to wait between making the appointment and seeing the health professional?
        - What do you think is a reasonable amount of time to wait for an appointment? *Probe for variations depending on reason for the appointment*
        - How convenient was the appointment day and time?
            - *Probe for preferences*
    - (*If appropriate*) How timely was any response you received from the surgery, for example a call back or email response?
    - Did you see a GP or another health professional?
        - (*If another health professional*) How did you feel about this? *Probe any concerns e.g. continuity of care*
            - Was this your preference?

- (*If relevant*) Were you aware what kind of health professional you'd be seeing?

- How comfortable did you feel with the health professional who dealt with you?
  - How important is it to you to be able to build relationships with the health professionals you see?
  - What's your usual experience in this respect? *Probe for facilitators and barriers to building sense of continuity*
- Overall, what was the communication like with all the staff you had contact with? *Probe*
- How important to you was face to face contact with a health professional on this occasion? *Probe*

10. Summing up, what would you say were the key factors on this particular occasion that meant making an appointment at the GP surgery and getting the care needed was a positive experience?
    - How typical was this experience?

11. Let's turn now to any recent, less positive experiences you've had when making an appointment and getting the care needed at the GP surgery – either for yourself or a family member. Who has an example to share? *Aim to collect 3+ examples, allow others to contribute*
    - How did you contact the surgery on this occasion?
      - What made you choose this method over others?
      - How efficient was it? *Probe*
      - What time of day did you contact the surgery?
      - (*As appropriate*) How would you sum up your interaction with the person you contacted?
    - How long did you have to wait between making the appointment and seeing the health professional?
      - How convenient was the appointment day and time?
        - *Probe for preferences*
    - (*If appropriate*) How timely was any response you received from the surgery, for example a call back or email response?
    - Did you see a GP or another health professional?
      - (*If another health professional*) How did you feel about this? *Probe any concerns e.g. continuity of care*
        - Was this your preference?
      - (*If relevant*) Were you aware what kind of health professional you'd be seeing?
    - How comfortable did you feel with the health professional who dealt with you?
      - How important is it to you to be able to build relationships with the health professionals you see?

- What's your usual experience in this respect? *Probe for facilitators and barriers to building sense of continuity*

- Overall, what was the communication like with all the staff you had contact with? *Probe*
- How important to you was face to face contact with a health professional on this occasion? *Probe*

12. Summing up, what would you say were the key factors on this particular occasion that meant making an appointment at the GP surgery and getting the care needed was a more negative experience?
    - How typical was this experience?

Accessing care in language of choice (Gwynedd fieldwork)

13. Still thinking about your local GP surgery, which language do you normally use to access the care you need? *Probe*
    - Why this language? *Choice versus limitations with service*
    - How does it normally work? *Probe if proactive offer made or not*
    - How often are you able to use your preferred language, from making an appointment through to getting the care you need? *Probe for facilitators and barriers*
    - How important is it to you to be able to communicate in Welsh when making an appointment and getting the care you need?
        - What difference does this make to you?

Choose Well: Hand out home page screenshot

14. Have you ever come across any communications based on this campaign called Choose Well? *Probe for any recollections, views on Choose Well*

15. Choose Well is a tool that helps you decide if you need medical attention if you are unwell. It explains what each NHS service does and when it should be used. How do you feel about this idea of people taking more responsibility for choosing appropriate care or treatments, and managing their health, using online tools and other information available?
    - In what circumstances can you see it working?
    - What reservations do you have with this idea?

C. Primary care model (20 mins)

16. The way in which we access primary care services at the GP surgery is beginning to change. The current system normally involves having an appointment with the GP as the starting point, who then decides what care a patient needs and refers them to other services when required.

    The aim is to move to safe and effective system using telephone call-handling and online methods as the first step in receiving primary care, with a suitably trained health professional dealing with the first contact and finding out more about the patient's needs. This person may then give advice (phone or online) or may direct the patient to the most

appropriate health professional / service, which may or may not be the GP. This may involve seeing other health professionals at the surgery (e.g. a physiotherapist) or elsewhere in the community (e.g. optometrist) rather than the GP.

It is also possible that there may not be any need for an appointment. In some cases, telephone advice from a trained professional might be all that's needed and could reduce the number of face-to-face consultations.

Here's an example of what some surgeries are already doing along these lines. (*Hand out example basic triage model. Explain some contacts could result in a referral to another location e.g. dentist, optician etc.*)

17. Tell me your initial thoughts on this kind of approach for making appointments at your local GP surgery and getting the care you need? *Probe whatever emerges including:*

- What do you see as the main advantages of this kind of approach when you contact the surgery? *Probe including by method of contact and expectations*
- What reservations or concerns do you have about this approach? *Probe including by method of contact , expectations and any concerns about losing continuity of care if not seeing a GP*

Technology and methods of making appointments

18. (*If not already covered*) Are you aware of any online methods of accessing the care you need from your GP surgery – not just with making appointments? *Probe whatever emerges including*

- Tell me about any experiences you've had with online methods? *Probe*
- What do you all think about the idea of making more use of technology to access the care you need? *Probe positive / negative associations*
- How interested are you in making more use of technology / online methods?

D. What good access looks like

19. In this last part of the discussion, we're going to focus on improvements to making appointments for services at the GP surgery and getting the care people need. We'll start by dividing you into two groups. Each team will have one group of people to think about when coming up with ideas on what good access looks like for making an appointment and getting the care they need.

    It's up to you how you describe it, for example using a flowchart or map showing the different steps. Please think about it from the moment the patient feels they need help through to them receiving the help.

(Give each team a flipchart sheet and pens, a patient group and key steps to consider)

Patient groups 1 and 2 to be used in focus groups 1-3 (18-44s) and in corresponding depth interviews. Patient group 1 – How do we ensure good access for parents of young children (e.g. children up to 7 years old)? Patient group 2 – How do we ensure good access for young working professionals e.g. aged 18-30 or so?

Patient groups 3 and 4 to be used in focus groups 4-6 (45+) and in corresponding depth interviews. Patient group 3 – How do we ensure good access for people aged 45-74? Patient group 4 – How do we ensure good access for people aged 75+?

Steps to consider in your map / flowchart (to be handed out on a sheet)

A. What are the most convenient methods for this group to make an appointment at the GP surgery?
   - How does this work exactly?

B. What time of day would suit them for contacting the surgery?

C. Who do they have the first contact with?
   - What makes them feel reassured about this first contact?

D. What are they told about the health professional dealing with them?

E. What is the time gap between making the appointment and the appointment itself that this group are comfortable with?

F. Do they want face to face / phone / online contact with the health professional – or a mix of options?

G. What time of day / day of the week is the appointment (if face to face / phone)?

H. (*Gwynedd groups*) For patients who are fluent Welsh speakers: what does a good experience mean regarding the Welsh language?

20. Can this team talk through what you came up with? *Probe as appropriate*
    - What does the other team think?

21. The second team now, please can you tell us what you came up with? *Probe as appropriate*
    - What does the other team think of these ideas?

22. If we take into account everything we've discussed so far, including those examples you gave me where you had negative experiences making an appointment and getting the care needed, what do you want to add to the ideas you've just come up with, to make sure they meet your preferences and needs as well as those of your local community? *Probe*
    - *Cover off main areas listed on the 'Steps to consider' sheet above, A-H*
    - Thinking back to your last not so positive experience, imagine it had been a good experience making the appointment and for the service you needed – what's changed?

23. What single improvement to making an appointment and getting the care you need during normal hours at your local GP surgery would make the biggest difference to you?