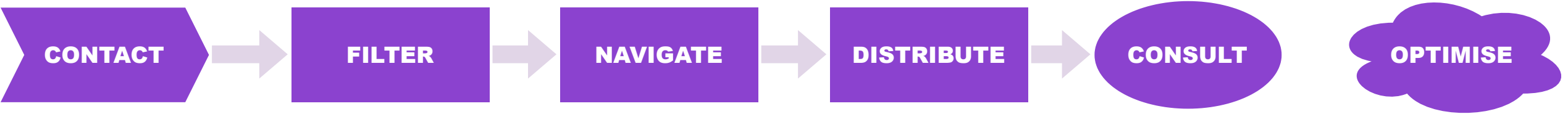
Increasing use of online contacts - Designing your pathway

Click a step for detailed prompts



Choices to consider

- Hope for online
- Recommend online
- Urge online

Initial filter?

Do you want to use preliminary filtering to direct admin queries to the right person first time?

What model?

Are you going to have a triage model that is clerical-first or clinical-first? Or a blend?

Who do contacts go to?

Will online contacts be sent to one 'duty' GP, shared out among several / all GPs, or handled differently depending on the situation?

End to one-size-fits-all?

How will you make the most appropriate use of clinical time and skills, now that you have the right information first time?

Continuous learning and improvement

No system is perfect. How can you further improve what you have now, so your access system serves patients and the practice as well as it could?

CONTACT

Choices to consider

- Hope for online
- Recommend online
- Urge online

In creating a new 'front door' for patients, you need to decide how assertively the online route will be recommended. Broadly speaking, the three main approaches practices take are:

- **Hope for online.** Some practices make online routes available but do not actively promote them.
- **Recommend online.** Some practices promote online routes through information to patients and optimising the front of the website.
- **Urge online.** A growing number of practices use every opportunity to redirect patients who can use online routes to do so.

Which option will you choose?

If you are going to 'recommend' or 'urge' online routes, **what do you need to plan**, to:

- inform and prepare patients
- make online routes as easy and attractive as possible
- give patients confidence that this is a good way to contact the practice (better than waiting on the phone)
- encourage patients to try it
- support patients who can't use online routes

FILTER

Initial filter?

Do you want to use preliminary filtering to direct admin queries to the right person first time?

How to handle admin queries?

Do you want to use a preliminary filtering step such as:

- having a different form or pathway for admin queries, sending them straight to clerical staff
- using 'patient group directives' for reception to manage specified clinically related contacts, for example:
- fit note request
- housing letter request

NAVIGATE

What model?

Are you going to have a triage model that is clerical-first or clinical-first? Or a blend?

Who does navigation?

Broadly speaking, there are three main options:

1. Clinical first. After filtering, the contact form is reviewed by a GP (usually with at least 5 years' experience).
2. Clerical first. Contact forms go first to a member of clerical staff. They make signposting decisions, supported by training and guides or protocols.
3. Blended approach. Contacts go first to the clerical team, who have easy access to.an experienced GP to address queries about the most appropriate signposting options.

Important considerations

When making your design choices, the following considerations can help you achieve a safe and effective system:

1. Medical urgencies. How to ensure contacts are assessed promptly for potentially urgent presentations? How to ensure this is done well? If you use a clerical-first model, do staff have the right training, guidance and support?
2. Signposting options. Does everyone making signposting decisions have access to comprehensive information about the options available and how to make best use of all the people and services available?
3. Avoidable appointments. How many avoidable appointments are booked by clerical vs clinical triage?
4. Clinical efficiency. How many contacts can be dealt with quickly by a GP doing triage, rather than being booked into an appointment slot?
5. Clinical time cost? How much GP time is taken up by trialing compared to the time saved? Can you.afford to put in that much time? Would a blended model help balance the time savings and costs?

DISTRIBUTE

Who do contacts go to?

Will online contacts be sent to one 'duty' GP, shared out among several / all GPs, or handled differently depending on the situation?

Which GPs deal with online contacts?

Broadly speaking, there are three main options:

1. Online GP. One GP is responsible for dealing with all online contacts in each morning / afternoon session. In most practices they can also act as the 'duty GP', answering queries from other members of the team and providing supervision to registrars and ARRS staff. In afternoon sessions, most practices find there is also time for the duty GP to undertake clinical admin tasks as well.
2. Share out. Contact forms are distributed among a group or all GPs working that day. The initial information from the patient is easily viewable, to enable each GP to make their own decisions about urgency and any alternative signposting to request back to reception.
3. Share & schedule. The person navigating contacts can choose whether to share out forms equally to all GPs working today, or if appropriate to direct the form to a specific colleague, for them to deal with when they.are next in the practice. This makes it a lot easier to provide continuity of care for patients, and to avoid too many situations where GPs are having to make decisions about patients they don't know. This model requires the triage person to have information about when colleagues are rota'd, as well as agreed approaches in the practice for how to make these decisions and how to keep the patient informed. At least a third of patients value continuity above speed of access, so this model can be very effective, although it also requires the greatest degree of forward planning and workload measurement.

End to one-size-fits-all?

How will you make the most appropriate use of clinical time and skills, now that you have the right information first time?

Right access - right consutation type?

Getting information first time about the patient's needs allows the practice to match them with the most appropriate type of consultation. There is no one type of need, and there doesn't have to be one type of consultation.

As part of your planning, it is worth considering which of the following to include in your rota:

- Remote / phone / face-to-face consultations
- Short / medium / long slot lengths
- Urgent / ordinary needs
- Medical urgencies / non-urgent needs
- Specific date requested / next available appointment
- Single / group consultations (eg COPD, type 2 diabetes, moderate-severe heart failure, affective disorders, weight management, cardiovascular risk management, etc).

Continuous learning and improvement

No system is perfect. How can you further improve what you have now, so your access system serves patients and the practice as well as it could?

From good to great - what could you do next?

Once you have an access system that is working satisfactorily there are often further changes you can make to improve safety, quality, appropriateness, timeliness, efficiency or experience. Why not start by asking patients and staff what improvement opportunities they see?

There are often both 'tweaks' and 'additions' worth considering. Commonly used additions to the access pathway are:

- GIFT loops. List the scenarios where care navigation / triage could be more safe or effective if more information was available about the patient's needs. For the most common scenarios, create a message template to send to the patient, requesting this information. If you have a clerical-first triage model, it will also be important to provide staff with a protocol to guide the selection and use of these templates. Examples could include:
    - Rash / skin lesion: ask for photos (with link to tips for quality images)
    - Sore throat in adults: ask for photos (with link to tips for quality images)
    - Headache: diagnostic server questions
    - LUTS: symptom score
    - Respiratory infection: request for observations (temp, pulse, RR, skin changes, PEFR)

- Work the wait. Where a patient has been booked for an appointment, it is often possible to enhance the quality of the consultation by helping them prepare for it. Common scenarios include:
    - Completing a symptom diary or scoring inventory to bring to the appointment.
    - Getting a series of home monitoring results in advance.
    - Reviewing the test results in their online patient record, to prepare their questions in advance.
    - Considering what their priorities are for managing their condition ('what matters to you?').
- Productive follow-up. How could planning ahead help make better use of patients' and clinicians' time? Options could include:
    - Scheduling a text message with a follow-up question (eg 'is the new treatment helping enough?', 'has the rash settled completely yet?', 'have you been managing to take the treatment regularly?', etc). Many of these can be dealt with by the requesting clinician very quickly without forcing the patient to take time out of other commitments.
    - Sending a message to the patient with links to information about the issues discussed in the consultation.
    - Sending a link to book directly with the right person for their next appointment, bypassing reception and triage.
    - Putting management instructions and self management prompts in the notes, for the patient to read in their online record.

Practices usually find they need detailed information about demand and activity to inform decisions about potential enhancements to an already effective system. This involves gathering new metrics, beyond those already extracted for GPAD. This kind of data collection costs time, so it is worth considering which questions to address by a periodic collection rather than adding a new routine data collection. This particularly applies where data collection is going to be manual.