Optimising Access Through Human fit

Guide to Using the OATH Resource Set

Introduction

For both staff and patients, experiences around accessing general practice can be challenging. Patients may feel frustrated when rules around appointments change, and access to the care they need becomes more difficult. Staff can feel overwhelmed by the demand on general practice, as though they have more work to do than there are hours in the day.

This is where the OATH Resource Set can help.

OATH stands for Optimising Access Through Human fit. Researchers from The University of Manchester and University of Kent worked with patients and general practice staff to create resources that can help people think about access in a different way. We define access as 'human fit'. This describes the fit between the needs, capacity, and abilities of patients and those of general practice staff.

All of us—patients and general practice staff—are people with different feelings, experiences and expectations. We have developed the OATH Resource Set to support patients and general practice staff to work together, understand each other's needs, and find ways to improve the fit between them.

Our vision is patients and staff working together to make general practice more collaborative, compassionate, and accessible to all.

In our research on access to general practice, we found that holding 'collaborative meetings'—where general practice and/or Primary Care Network staff get together with patients and other local stakeholders to talk about access—was a helpful way to try and improve the 'fit' of access locally.

This guide is not intended as a rulebook. Our aim is to provide you with suggestions, ideas and materials. We hope these will help those organising and participating in collaborative meetings about access to decide on the approach that will work best for them.

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The guide is divided into sections. Sections 1 and 2 describe how we've been thinking about general practice access in our research. The infographics and animations within this Resource Set can help people think about access in a different way, understand the range of issues people face and develop solutions that improve the experience for everyone. They provide a foundation for the collaborative meetings, and can be watched and read outside of the meetings. Sections 3 and 4 offer some practical suggestions about arranging and carrying out collaborative meetings using the materials in the OATH Resource Set. The latest version of this guide and other materials in the OATH Resource Set, can be found here:

https://www.oath-access.com/resource-set

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1) The problems of access

In both the media and in research, there is often a focus on demand in general practice. Staff are caring for more patients than ever before, and due to staff shortages and funding challenges, the demand can feel overwhelming.

Our research has found that this focus on demand is actually part of the problem because it can both cause and hide unmet health needs.

Over time, practices and policymakers have introduced rules to help manage demand. But these rules can act as barriers to reaching care for patients, particularly patients who struggle to navigate their way through the healthcare system. Additional barriers can leave patients feeling frustrated and may stop them from trying to access care they need.

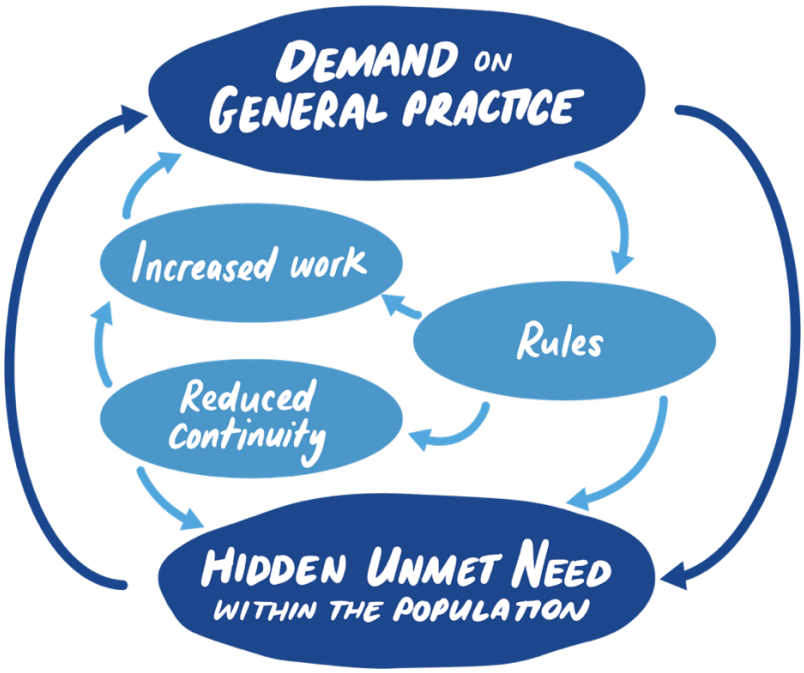
Rules also tend to focus on speed of access, or how quickly a person can access an appointment, and, as a result, reduce continuity. Continuity exists when patients are able to speak with staff who they know, and who know them.

Both rules and reduced continuity can create extra work for patients and staff. This extra work can include staff having to explain rules of why a certain request cannot be met in the way the patient is asking, to multiple patients, and efforts of patients and carers making multiple attempts to request care. The time costs of this extra work can make it more difficult for general practices to be flexible or reach out to patients, and harder for patients to access care.

Instead of focusing on demand, we believe it is important focus on the hidden unmet need in the population. Those with hidden unmet need include carers who don't have time to seek care for themselves due to their caring responsibilities. They include some of the frail older patients who do not want to bother the doctor. They include those with mental health problems that make it hard to engage through certain lines of communication. They include those with poor written English literacy, who might not seek care if it starts with writing in online form. It includes those who do not know who their doctor is, and hence feel they don't want to seek care about a sensitive or scary issue because they do not have trust in how the interaction will be.

If we restore continuity, reduce rules, and decrease unnecessary work, we could free up capacity in general practice to better reach those with the most health needs.

This is illustrated in the diagram below.



There is an animated version of this explanation on the OATH website: What's the problem with access to general practice? (https://www.oath-access.com/resource-set). This animation can be watched by those interested to learn more about the concepts, either as preparatory work before a collaborative meeting (as we will detail further in Section 3), or separately to gain general understanding.

2) Access as human fit

Access as human fit means the fit between the needs, capacity, and abilities of people seeking healthcare, and the people working in health care.

People's needs, capacity, and abilities are shaped by their health, society, and the healthcare system.

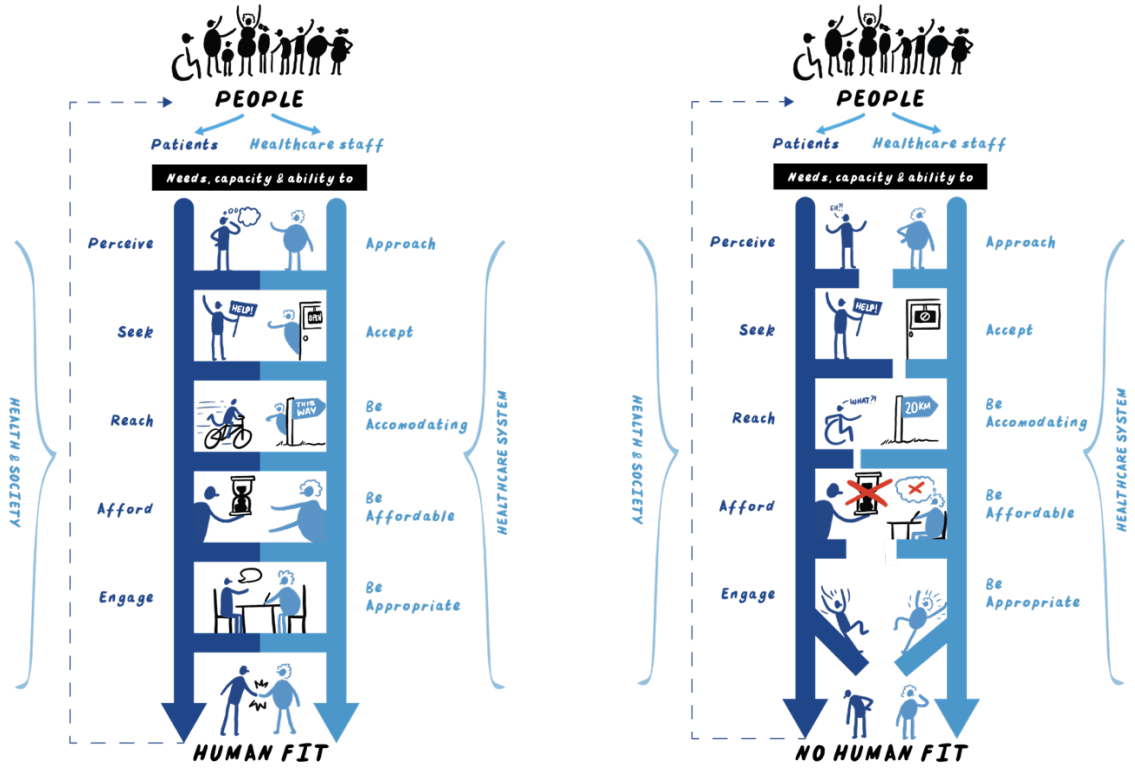
Things like gender, knowledge, and beliefs, can impact whether a person seeks healthcare, and how they engage with their general practice.

On the other side, aspects of the healthcare system, like funding, and policies, affect the ability of general practice staff to meet patients' needs.

Patients and general practice staff 'meet' several times on every healthcare journey - from the start of the journey when a health need is recognised, to the end point when that need is addressed. If there is a good fit between patients and staff, it is easier to complete the journey.

It might be helpful to imagine this process as a little like climbing down a ladder. If there is a wobbly rung – caused by a lack of 'fit' between the person who needs care and the people providing that care – then getting safely and successfully to the bottom of the ladder, or the end of a healthcare journey, is harder.

Thinking about access as human fit can help us consider the problems faced by both patients and staff, and look at ways to bridge any gaps. The ultimate goal is to improve fit, leading to better access for patients and more job satisfaction for staff.



An amination explaining the content of the Access as Human Fit infographic can be found on the OATH Website (https://www.oath-access.com/resource-set).

Soon there will also be a second animation which goes into more detail about the abilities of the people on both sides and the society and health care system factors that affect those abilities. There will also be an interactive version of the Access as Human Fit infographic, which will allow for people to explore certain terms in more depth.

3) Preparing and organising collaborative meetings

Our experiences developing the OATH Resource Set included facilitating multiple collaborative meetings with patients and staff from practices and primary care networks (PCN). Our learning from that research has informed the suggestions below, including around early decision-making and organisation.

There is no perfect or 'one-size fits all' approach to organising collaborative meetings. Each practice or PCN will be starting in a unique place, with historical differences in what has been tried before, what the current system is, how the relationship is with the patient participation group (PPG) and other patients within the area. The ethos and atmosphere of the meetings are important. We suggest you aim to create a place where everyone can:

- Be treated with respect and kindness
- Have an opportunity to share their experiences and be heard in a non-judgemental way
- Have empathy for fellow meeting attendees and try to understand what things are like from their perspective.

You might want to create some ground rules. The following are the rules we used in our meetings:

- Treat each other well within the group
- Respect each other's point of view, whilst feeling free to disagree
- Speak one at a time and allow others to finish their point so everybody's contributions can be heard
- Speak openly and honestly
- Discuss any issues or concerns about the meeting with one of the facilitators
- Keep the personal details or aspects of stories shared by any and all attendees confidential - what is said here stays here.

We recommend that you give it a go, see how it works, and then reflect on how future meetings might be improved.

Who to invite?

We suggest the best learning would come from a mixed group of staff and patients. However, we recognise that this might not feel like a possible starting for all situations. Another option is to have initial meetings of staff and patients separately and then come together for subsequent meetings.

Regardless of whether it is a mixed meeting of patients and staff, the aim should be for a diverse mix of roles and perspectives of the attendees. For the staff, include a range of admin and reception staff, management, and different clinical staff. For the patients, consider the patient population at large and invite a mix of patients in terms of characteristics and needs. It is probably useful to invite PPG members, but it may not be adequate to only invite PPG members. We found that around 12 people is he ideal for everyone in attendance to have an opportunity to contribute. We do not recommend having more than 20 people.

How to invite people?

It can be useful to take a person-centred approach to inviting people, particularly patients. Some patients might not have access to email, for example, and it might be more helpful to be invited by text, letter, or a phone call. Participants can be directed to the OATH website—https://www.oath-access.com/resource-set—and invited to watch the videos ahead of the session, but this should be framed as an optional choice.

Where and when to hold a meeting?

It is important to recognise that the location and time that a collaborative meeting takes place will affect who is able to attend. It can be useful to ask potential participants about their availability and then arrange a meeting at a time that takes account of this. A local community building, within easy reach by public transport, can be a good venue choice. The majority of collaborative meetings that we held during the project took place in general practice premises, which were accessible and familiar to most, but it is important to recognise that this setting is not neutral.

Holding meetings online, using Zoom or a similar video-conferencing platform, is also an option, but it is important to consider whether this would be accessible for attendees.

How long should a meeting last?

We have found that two hours, with a short break halfway through, is a useful length of time.

Who should lead the meetings?

The answer to this question depends upon the local context and the availability of support, in particular. If a collaborative meeting involves a general practice, or Primary Care Network, and its patients, then it could be led by a member of healthcare staff or a patient representative. It is important to recognise that this will have implications for the dynamic of the meeting and potentially create a power imbalance. Another option is to seek someone from another organisation, such as a voluntary and community sector organisation or a local NHS Trust, or someone from another local general practice to facilitate that meeting and conduct the meeting in an independent role. Whatever arrangements are feasible for you, it is important to try and make sure that the arrangement for leading the meeting help to make attendees feel comfortable, valued and heard.

4) Meeting content and activities

Suggested meeting structure

Agenda 1 (leads with the access concepts)

1. Welcome and introductions
    a. Plan for the meeting and ground rules
    b. Introductions
2. Access to primary care
    a. The problem of access
    b. Thinking about access differently: access as human fit
    c. The experience of access
        i. Access vignette activity
    d. Discussion and reflection
3. Improving the experience of access
    a. Next steps
    b. Discussion and action plan
4. Reflections on the meeting

Agenda 2 (leads with the access vignette activities)

1. Welcome and introductions
    a. Plan for the meeting and ground rules
    b. Introductions
2. Access to primary care
    a. The experience of access
        i. Access vignette activity
    b. Thinking about access differently: access as human fit
    c. The problem of access
    d. Discussion and reflection
3. Improving the experience of access
    a. Next steps
    b. Discussion and action plan
4. Reflections on the meeting

Using OATH Resources

The OATH Resources include the infographics and videos (discussed and linked to in Sections 1 and 2 above), the access vignette activities, and the action plan templates (explored below). In the suggested meeting structure above, 'The problem of access' might include attendees watching the What's the problem with access to general practice? (https://www.oath-access.com/resource-set) animation and discussing the details of this. Similarly, 'Thinking about access differently: access as human fit' relates to the Access as Human Fit infographic and animation (https://www.oath-access.com/resource-set).

Access vignette activities

We have developed several 'access vignette activities', which are included in this section. The scenarios and interactions and are inspired by the results of our research – things we observed, and things people told us about. They are not descriptions of specific situations, but they do reflect people's experiences and have been drawn together to highlight a range of access issues. They are designed to be balanced and non-judgemental. They highlight the experiences of both patients and staff without blaming anyone for what did or did not happen. They include observable facts and strive to consider everyone's feelings and needs in the scenarios. Although our vignettes are numbered 1-3, they do not need to be used in that order. Those who are facilitating or planning the meetings might want to read through and select one or possibly two to use in each meeting that most resonate with their own experiences.

We also realise that people might want to create their own vignettes, based on their experiences within their contexts. We encourage this, but suggest, as we did, to write them in a balanced and non-judgemental way. Perhaps groups could start with using one of our vignettes in initial meetings, and then reflect on their experiences going forward to develop their own after further consideration. It may be best to work as a team and include different view points in the creation of the vignette. We do not advise using a single, specific, real-life exchange, but to create a typical example of a type of exchange that arises and would benefit from discussing in this way. Try to avoid any blaming within the vignette content, as the purpose is to increase understanding of the people in the two sides. A template for creating your own vignette activity is included after the 3 existing access vignette activities.

During meetings, we suggest that attendees work through the vignette activities together. The facilitator can lead ask attendees for volunteers to read out the different parts so that it becomes a role-play. It can be powerful for healthcare staff to read out the role of the patient and vice versa. The facilitator can then lead a discussion about how the vignette relates to different dimensions on the access as human fit ladder diagram and encourage attendees to reflect on this. It can be helpful to read through the first page and have a discussion, before then turning to the second page. The second page is designed to help you see how the idea of access as human fit can increase empathy and understanding between patients and staff.

Optimising Access Through Human fit

Access vignette activity #1

Prescription request

Fred is a patient, and Lizzie is a care navigator. Fred arrives at the reception desk at 10:20 on a Tuesday.

L: Good morning, how can I help?
F: I'm here to drop off a prescription request.
L: You can just pop it in the box over there.
F: I've added a note, because I'm going on holiday on…
L: That's fine.
F: I'm going on holiday on Saturday. That's why I'm putting the request in early.
L: Okay.
F: I will need that this week so I don't run out while I'm away.
L: Okay, I can take that for you.
F: I wouldn't ask for more than I need.
L: I'll pass that on to the doctor for you.
F: Okay.
L: Thank you
F: Okay.
L: Goodbye.

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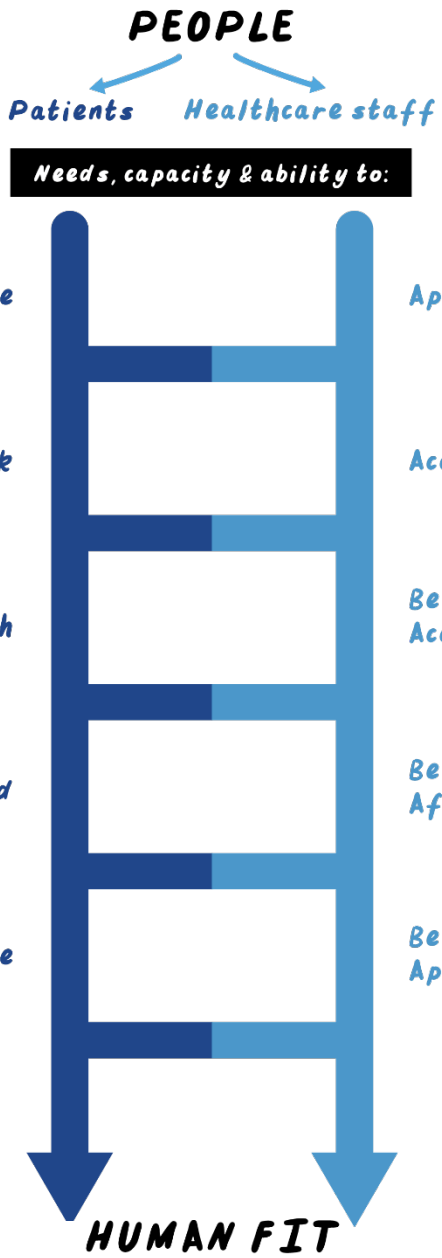
Access vignette activity #1



Fred: On Saturday, I realised I would run out of medication while on holiday. The last time I put a prescription request in early, it was questioned and got held up. I was worried that would happen again. I wanted to hand it in as soon as possible but I look after my grandchildren on Mondays.

Lizzie: I'd just got off the phone when Fred arrived. The caller was upset her son hadn't been seen in person. She shouted at me. I felt distracted when talking to Fred. I wondered if he knew he could request his prescription online.

Given his age, I assumed he wouldn't feel comfortable doing that. Even if he was, it could take a while to explain how to do it. There were other people waiting.

Optimising Access Through Human fit

Access vignette activity #2

Online consultation form referral

Belinda is a receptionist, and Fatima is a patient. Fatima phones the practice at 08:00 on a Wednesday morning.

B: Good morning, Belinda speaking, can I take your date of birth please?
F: Hello. It's the 20th of June 1976.
B: And your name.
F: Fatima Begum.
B: Thank you, Fatima. How can I help you today?
F: I want to see a doctor.
B: I'm afraid all the GP appointments have gone for today. What's the problem?
F: I rang yesterday and was told the same thing.
B: You could try again tomorrow.
F: It's not easy for me to phone at 8 o'clock. I should be on my way to work.
B: Could you go online and complete one of our consultation forms after 5 o'clock?
F: Consultation forms?
B: Have you filled one in before? If not, you'll need to sign up. I can send you the link via text.
F: Okay.
B: The form has a few questions. If you fill all those in it will help reduce the consultation time.
F: Okay.
B: Great. I've sent you the link.
F: Thank you.
B: Goodbye.
F: Oh. Err. Goodbye.

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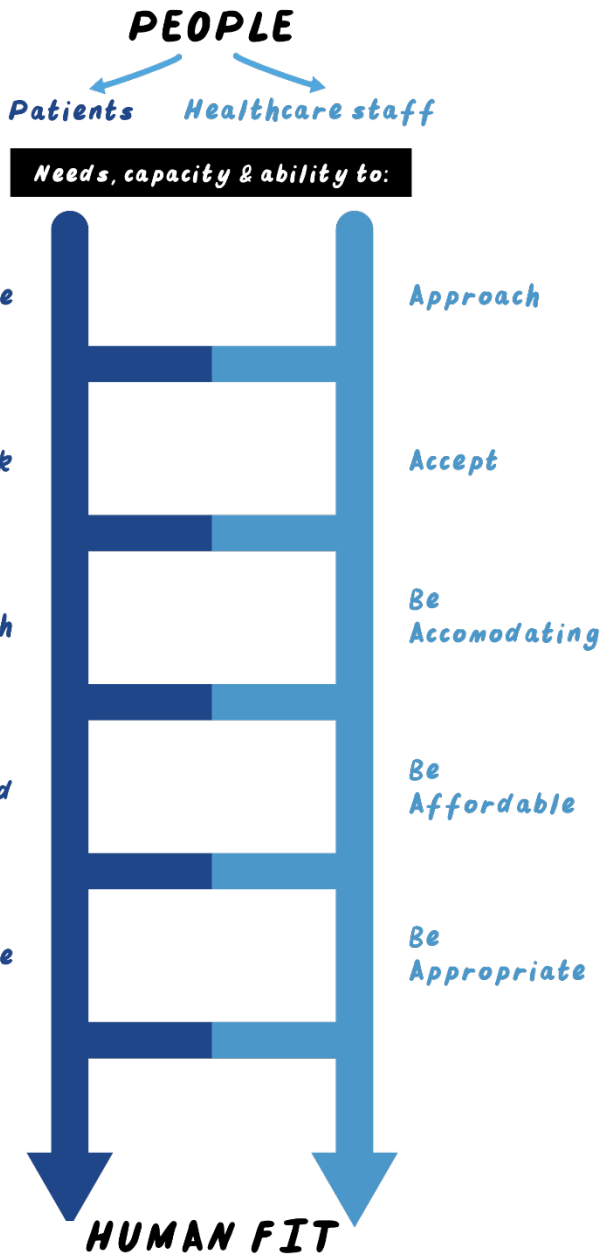
Access vignette activity #2



Fatima: I was late for work for the second day in a row. I'd stayed home to phone the practice so I could have some privacy when explaining what was wrong, but I needn't have bothered. I felt frustrated and upset when I learned there were no appointments left again.

Belinda: I've worked at the practice for a while and am confident I can direct people to the care they need. I felt frustrated and concerned when Fatima didn't tell me what the problem was. I know some people don't like to share this with reception staff. If Fatima had, I may have been able to help. If it had been serious, I could have used one of the GPs' emergency slots. If not, I may have been able to get her an appointment with someone other than a GP.

Optimising Access Through Human fit

Access vignette activity #3

Background

Fran knew she needed to call her general practice. She'd been putting it off but things weren't improving. Eventually she picks up the phone and dials.

Greg was quite new to the practice and had only recently started taking calls on his own. He was grateful Sophie was working in reception today. She seems to know everything. The phone rings. Greg answers.

The Interaction

Greg: Good morning. Gold Street Practice, Greg speaking. Can I take your name and date of birth, please?

Fran: It's er Frances Hall. 6th September '89.

Greg: How can I help you?

Fran: I'm er, I've been. I'm feeling very down. I have been for ages and I'm not getting better.

Greg: Ok, Frances. Is there…

Fran: I'm just… I'm struggling to even get out of bed and can't make it out of the house. I've got no energy at all.

Greg: Let me see…. Can you just hold for a minute please?

Fran: Er yeah. Okay.

[Greg puts the phone on hold and looks over at Sophie]

Greg: I've got a patient who sounds depressed and can't get out of bed. What do you think I should do?

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Optimising Access Through Human fit

Access vignette activity #3

Scenario A

Sophie: Just get her on the telephone triage list and put an urgent flag on the system.

[Greg takes the phone off hold]

Greg: Hi Frances. I've put you on the telephone list. A doctor will call you back at some point today.

Fran: Oh. Okay. Thanks.

Greg: Goodbye.

[Later that day… Fran's phone rings]

Fran: Hello?

Dr Shaw: Hello, this is Dr Shaw, is this Frances Hall?

Fran: Er. Yes, it is.

Dr Shaw: How can I help, Frances?

Fran: It's… Well. I'm… I don't know where to start. I've been depressed for a really long time. It comes in these waves, and I'm not doing so good at the moment.

[There's a pause – Fran hears clicking]

Dr Shaw: I'm just having a look through your record. Has anything helped you in the past?

Scenario B

Sophie: Let me have a look. Oh, Fran. She's seen Dr Singh in the past. Add her on one of her black slots. I'll deal with any issues.

[Greg takes the phone off hold]

Greg: Hi Fran. I see you've seen Dr Singh in the past I've put you down for her to give you a call later this morning.

Fran: Okay. That's great. Thank you!

Greg: Goodbye.

[Later that day… Fran's phone rings]

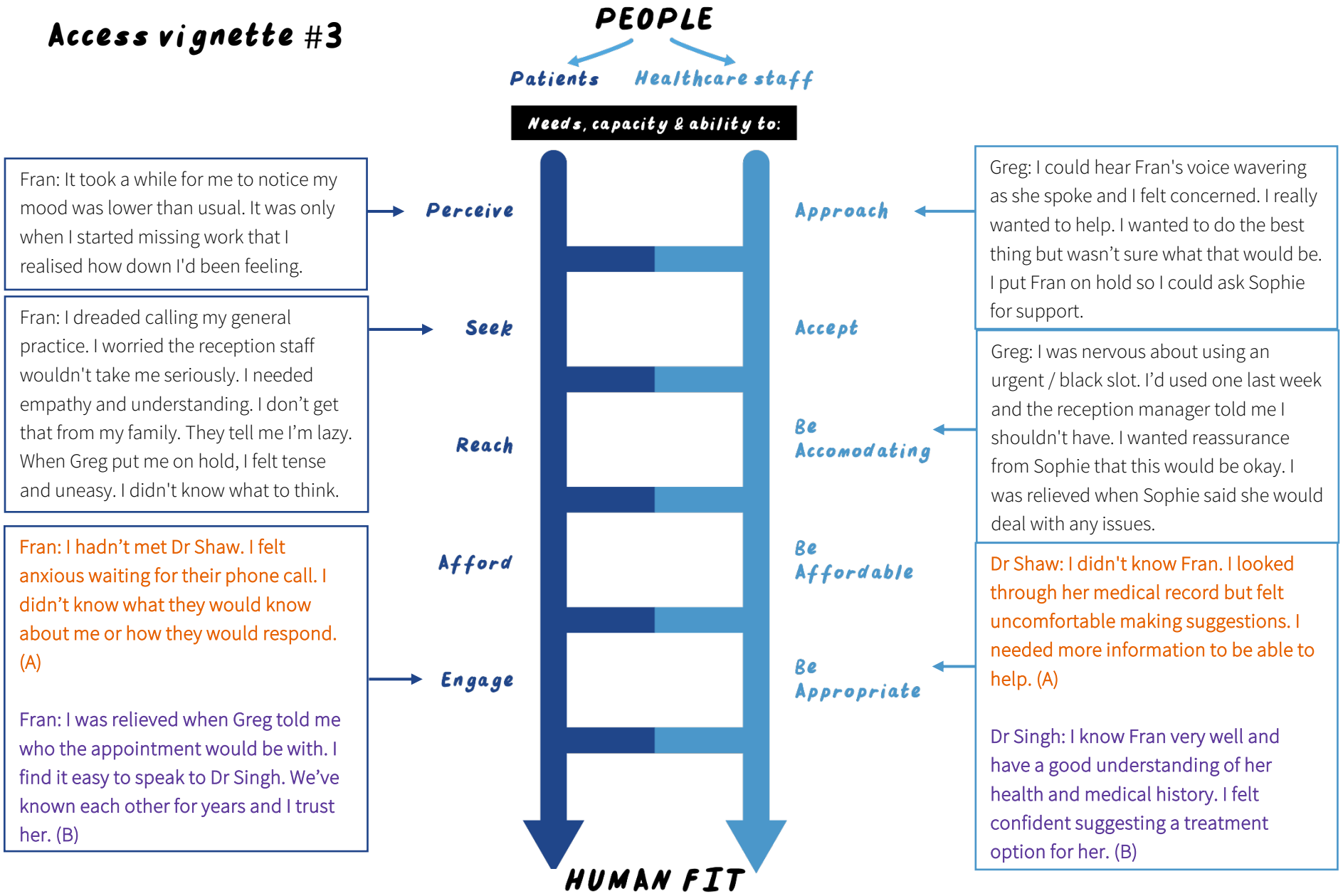
Fran: Hello?

Dr Singh: Hi Fran, it's Myra, GP from Gold Street Practice. You're having a tough time?

Fran: Yeah, as bad as last year. I just feel really down. I can hardly get out of bed.

Dr Singh: I'm sorry to hear that. I remember that adjusting your medication worked before. We could do that again. Is there anything else you'd like to try?

Access vignette #3



Fran: It took a while for me to notice my mood was lower than usual. It was only when I started missing work that I realised how down I'd been feeling.

Fran: I dreaded calling my general practice. I worried the reception staff wouldn't take me seriously. I needed empathy and understanding. I don't get that from my family. They tell me I'm lazy. When Greg put me on hold, I felt tense and uneasy. I didn't know what to think.

Fran: I hadn't met Dr Shaw. I felt anxious waiting for their phone call. I didn't know what they would know about me or how they would respond. (A)

Fran: I was relieved when Greg told me who the appointment would be with. I find it easy to speak to Dr Singh. We've known each other for years and I trust her. (B)

Greg: I could hear Fran's voice wavering as she spoke and I felt concerned. I really wanted to help. I wanted to do the best thing but wasn't sure what that would be. I put Fran on hold so I could ask Sophie for support.

Greg: I was nervous about using an urgent / black slot. I'd used one last week and the reception manager told me I shouldn't have. I wanted reassurance from Sophie that this would be okay. I was relieved when Sophie said she would deal with any issues.

Dr Shaw: I didn't know Fran. I looked through her medical record but felt uncomfortable making suggestions. I needed more information to be able to help. (A)

Dr Singh: I know Fran very well and have a good understanding of her health and medical history. I felt confident suggesting a treatment option for her. (B)

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Access vignette activity template

[scenario name]

[brief background information about people in vignette exchange to set context]

[Dialogue of exchange]

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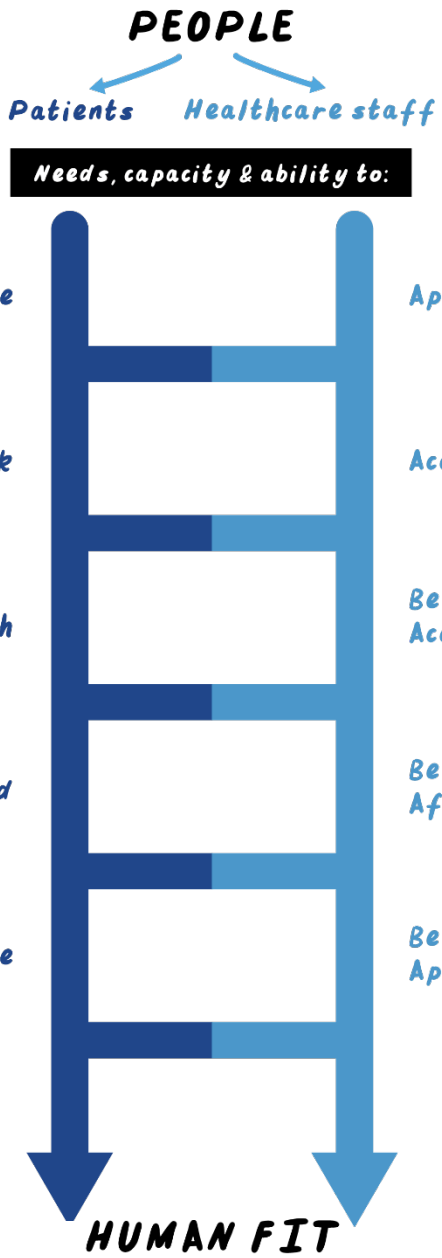
Access vignette activity template



[Further information about the feelings, thoughts, and needs of the person/people on the patient side of the exchange. Write in the first person using I/we statements.]
[Copy arrow and create boxes at each stage of the ladder that is relevant.]

[Further information about the feelings, thoughts, and needs of the person/people on the patient side of the exchange. Write in the first person using I/we statements.]
[Copy arrow and create boxes at each stage of the ladder that is relevant.]

Action plan activity

After the learning and discussions that have taken place during the meetings, attendees can be encouraged to set some individual actions. An action plan template is on the next page. This template is an example and users of the resources may want to change the wording to suit their goals for the meeting. The actions provide a way for people to keep thinking about the discussions after the meetings.

During the meetings, attendees can be encouraged to discuss their actions points with others. It is helpful to give space and time for people to write their own so they have the opportunity to take individual responsibility for some of the next steps. Everyone can have a role to play in improving the fit of access.

Optimising Access Through Human fit

Action Plan template

Date: _ _ _ _ _ _ _ _ _

How could the OATH resource set help with issues of access locally?

_____

_____

_____

_____

_____

What is needed to improve the fit and experience of access for all?

_____

_____

_____

_____

_____

What can I do about it?

_____

_____

_____

_____

_____

What barriers might I face? How can I overcome them? Who else should I ask?

_____

_____

_____

_____

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After the meetings

The facilitators/planners should communicate with attendees, thanking them and sending out a summary of the meeting. They could also request feedback on the meetings and allow space for further discussion of the content of the meeting. Attendees can be encouraged to review their actions plans and act on them following the meeting.

Further meetings

You may want to organise meetings in cycles or blocks, with two or three over a period of several months, followed by a further short series of meetings organised later.

It might be helpful to reconsider who to invite to future meetings. There are pros and cons of keeping the meeting attendees consistent vs widening the invitation list. If you include the same people, they may more comfortable with each other, which can be helpful for discussions. However, it may become clear during discussions that other people were identified to be included in future meetings.

Content of the future meetings may change based on the initial meeting. It may be helpful to review the summary of the previous meeting and/or ask attendees about their actions plans if they made one in the first meeting.