Scottish Government
Riaghaltas na h-Alba

Scottish Social Attitudes Survey 2021/22: Public Views of Telephone and Video Appointments in General Practice

HEALTH AND SOCIAL CARE

social research

Contents

1. Summary

1.1 Summary of the context

This report will present findings from the Scottish Social Attitudes (SSA) Survey 2021/22 about public attitudes towards remote appointments in general practices, specifically in relation to doctors (GPs) and nurses.

Prior to the COVID-19 pandemic, Scotland aimed to increase accessibility to health and social care via remote services including phone and video appointments. Both phone and video appointments were primarily used in secondary care settings and telephone appointments were commonly used in general practices, although were not the default mode. The 2019/2020 Health and Care Experience Survey reported that 87% of respondents had a face-to-face appointment in comparison to 11% having a phone appointment and less than 1% for video or e-mail. In response to the COVID-19 pandemic, the use of remote services accelerated across Scottish health care settings. This was primarily to reduce the risk of infection that was increased through face-to-face contact. General practices across Scotland offered patients remote appointments, with face-to-face appointments when necessary. As restrictions eased, phone and some face-to-face consultations generally remained the two main appointment methods in general practices. Due to the public's exposure to digital services, sped up by the pandemic, work was commissioned to understand general attitudes to and impacts of remote appointments.

Questions were commissioned by the Scottish Government and developed in partnership with The Scottish Centre for Social Research (ScotCen) to be included in the 2021/2022 Scottish Social Attitudes Survey (SSA). The research took place between October 2021 and March 2022. Respondents were selected through a probability sampling technique using the Postcode Address File (PAF) and stratified to represent rural areas and the most deprived areas more fairly. Overall, 1,130 people took part via telephone interview. ScotCen shared the results along with statistically significant findings of the survey with the Scottish Government Healthcare and Workforce Analytical Unit. Further information can be found in the Methodology section of this report.

People in Scotland were asked questions based on the four general themes (see Figure 1).

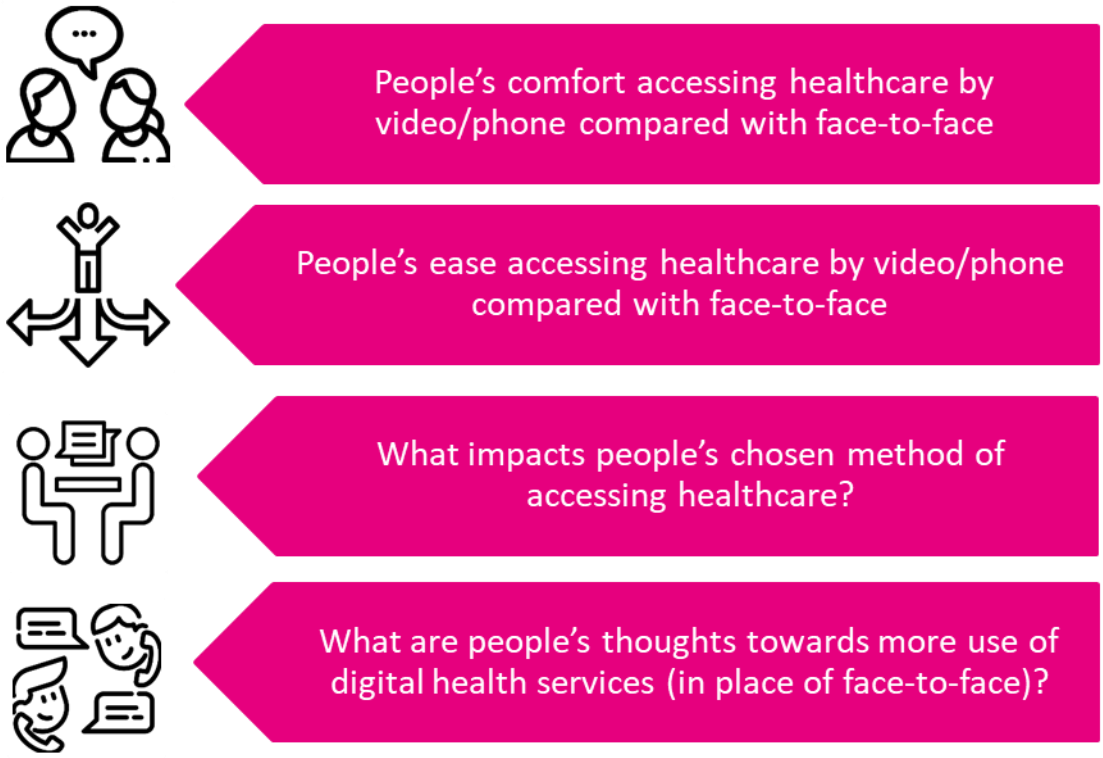


Figure 1: Survey themes[1]

1.2 Summary of results

Results are presented under the four research themes (Figure 1). All results below are based on the significant differences found in the survey results.

1.2.1 How comfortable are people with accessing healthcare by video/phone compared with face-to-face?

- A higher percentage of people thought that they would be more comfortable with a face-to-face (94% very or fairly comfortable)

[1] This figure has been designed using resources from Flaticon.com

appointment than a remote appointment (71% for phone and 67% for video).

- Those aged over 65 were more likely be very comfortable with face-to-face appointments (86%) in comparison to other age groups.
- Males (73%) were more likely to say they would be ‘very/fairly’ comfortable with video appointments than females (62%).
- Those with higher satisfaction with the NHS were ‘very/fairly’ comfortable with remote appointments (84% for phone and 79% for video). Lower levels of satisfaction with the NHS were linked with feeling uncomfortable with remote appointments.
- Those who reported using the internet several times a day were the most likely to be ‘very/fairly’ comfortable talking to their doctor or nurse via remote appointments (75% for phone and 71% for video).
- People with self-reported very good or good general health were more likely to be very comfortable with phone (40% vs 27% fair health vs 28% bad/very bad health) and video (40% vs 26% fair vs 13% bad/very bad) appointments than those with poorer health.

1.2.2 How easy are different types of appointments for patients?

- A higher percentage of the public thought that talking to a doctor or nurse via phone (81%) was easier than face-to-face (73%) and/or video (58%).
- People with self-reported very good or good general health were more likely to say attending face-to-face (53%), phone (53%), or video (36%)

appointments would be very easy compared to those with bad/very bad general health (21% face to face, 36% phone, 16% video).

- Those without long term illnesses, health problems or disabilities were more likely to say that it would be very easy attending an in-person (51%) appointment and very/fairly easy attending a video (63%) appointment in comparison to those with long-term illnesses. No significant differences were found for ease of phone appointment preference across different health states.
- Higher satisfaction with the NHS was also linked to finding both in-person (88%) and remote appointments (92% for phone and 70% for video) 'very/fairly' easy. Lower levels of satisfaction with the NHS were linked with finding all three consultation modes difficult.
- Those who used the internet several times a day were the most likely to say that it would be 'very/fairly' easy to talk to their doctor or nurse via phone (84%) or video (61%) about a medical problem.

1.2.3 What impacts a person's decision to accept a remote appointment?

- The two biggest concerns for choosing to accept a remote appointment over face-to-face were how worried someone was about their condition (46%) and how quickly someone could get an appointment (36%).
- How easily someone could get to an appointment (7%) or how well someone knew the doctor they would be speaking to (7%) were lower priorities.

1.2.4 Thoughts towards more use in general practice of remote consultations in place of face-to-face?

- When asked about thoughts towards the use of remote consultations in place of face-to-face, over half of people strongly agreed/agreed that replacing face-to-face appointments with remote appointments would
    - result in their doctor knowing their patients less well (66%)
    - ensure that those who needed a face-to-face appointment could get one quickly (63%)
    - be more convenient for most patients (52%).
- There were mixed views as to whether remote appointments reduced the risk that serious medical conditions would be missed (40% for agree strongly/agree and 36% for disagree strongly/disagree).
- People with self-reported bad or very bad general health were more likely to agree that increasing remote appointments would result in their doctor knowing them less well (49%).
- Those with children under 16 viewed remote appointments comparatively more positively than those without children under 16, 26% (compared 14% of those without children under 16) found remote appointments more convenient than face to face appointments.

Significant differences in attitude were not found between individuals with different education (measured by Highest Level of Educational Qualification)

or deprivation (measured by Scottish Index of Multiple Deprivation (SIMD)[2]) levels, although may potentially be influential in patients' *experiences* of general practice appointments. There may also be evidence in existing research to suggest links between appointment type and respondent characteristics or demographics (e.g. general health and age linked to phone appointments), however this was not explored in this report.

1.3 Summary conclusion

This survey highlights the diverse attitudes towards accessing general practice appointments remotely. Attitudes towards appointment type were influenced by whether the person would find different appointment types 'easy' or not and whether they would be comfortable with different appointment types. Video appointments in general practices seemed to be the least favoured option for the people of this survey. This has also been found in other surveys conducted with clinical staff in general practices. Equally variations in demographics or other factors may influence people's preferences and concerns. For example, good general health, frequent internet use, and high satisfaction with the NHS were linked to a more positive response across all three modes of appointments. Therefore, the needs of the patient, clinical judgement, and service efficiency/effectiveness should be

[2] See Scottish Index of Multiple Deprivation 2020 - gov.scot (www.gov.scot) for further details.

central to ensuring that digital and remote appointments are enhancing patient care and safety.

Further research would be required to:

- understand the experiences people had with appointments, perhaps with a focus on capturing qualitative evidence
- widen the scope to include appointments with other members of the multidisciplinary team or other health and social care settings
- understand if the patient's *reason* for needing a health care appointment impacts the type of appointment preferred
- encourage wider participation from harder to reach groups that may not have been well represented in this research (for example, those whose first language is not English and LGBTQI+ individuals)
- examine intersectionality between certain characteristics and/or demographics (for example, the link between gender and ethnicity impacting on appointment choice).

1.4 Additional Notes

This survey is based on the attitudes of the general public rather than their actual experience of each consultation method. This survey was primarily quantitative as it is a module of the wider Social Attitudes Survey, thus no

follow up questions could be asked about *why* a particular answer was chosen.

Finally, this research may have missed a key group in understanding uptake of digital and/or remote appointments as the questionnaire was conducted over the phone, potentially missing those who do not have access to this technology or do not have portable devices. However, this was due to restrictions in place from the COVID-19 pandemic and usually the SSA interviews would be conducted face-to-face.

2. Introduction

This introduction will outline the context in which the questions for the SSA 2021/22 were developed and the justification for analysing the results against respondent demographics or characteristics.

2.1 Remote Appointments

Prior to the COVID-19 pandemic in 2020, digital appointments were largely used in secondary care to overcome rurality and only used in specific health boards across Scotland to increase accessibility, reduce carbon footprint of travel to appointments, and ensure healthcare services were delivered more efficiently. In response to the COVID-19 pandemic, the NHS video consulting platform Near Me was quickly rolled out across Scottish health care services and telephone appointments were increased to reduce infection rates among patients and health and social care staff.

During the pandemic, within primary and secondary care, there was a substantial rise in the use of Near Me across Scotland. Guidance for Scotland on 'Improving the use of Near Me Video Consulting in GP Practices' outlines key reasons to use Near Me: to enable physical distancing while still delivering person centered and convenient care. One study also highlighted that some GPs found that video appointments would "sometimes provide[-] clinically crucial information" that could not be captured over the phone. However, as

post-pandemic restrictions eased, general practices have since become one of the lowest users of Near Me, opting instead to continue with telephone consultations and offer face-to-face appointments where possible.

The Health and Care Experience Survey 2021/22 reported that only 1% of respondents had a video appointment with their general practice in 2021/22 (compared to less than 1% in 2019/20). In 2021/22, 37% of respondents to the survey reported having a face-to-face appointment and 57% had a phone appointment (compared to 87% and 11% respectively in 2019/20). The 'Public Understanding and Expectations of Primary Care in Scotland: Survey Analysis Report' undertook research on public understanding of primary care. This report examined themes of awareness of accessing primary care services, trust and confidence, and barriers to access. In this report, 36% of respondents who had contacted a health professional in the last 12 months were seen in-person at a general practice. Comparatively, 23% were seen by telephone and only 3% by video. According to a literature review on the use of remote consultations in the UK, clinicians preferred using telephone or face-to-face as it was easier because there was no need to send links/set up video calls. Even during the pandemic, a mixed methods case study found that GPs believed that telephone appointments were often sufficient, and that a physical examination would not be required.

Arguably, the experiences of the health care worker influences their preference to use remote consultations as their primary appointment method. However, this is also largely influenced by digital infrastructure, experience and skills with technology, deciding what is best for the patient, and time efficiency. This report will explore the patient's attitudes towards remote consultation and face-to-face appointments.

2.2 Inequalities and Patient Characteristics

Health and digital inequalities[3] have been explored in the context of remote appointments and these may impact public attitudes. Self-selected characteristics and demographics have been captured from respondents of this research and will be further explored in the results and discussion chapters[4].

In 2020, the first National Equality Impact Assessment of the use of Near Me (EQIA 2020) was published. This report highlighted that a move to video consultations as default would disproportionality impact 'protected characteristic groups' (such as women and LGBT people who may not have

[3]Health inequalities are defined as 'unjust and avoidable differences in people's health across the population and between specific population groups'. A digital inequality can be defined as "differential access to healthcare depending on digital access, digital literacy or both".

[4] ScotCen cross examined particular demographics, such as Satisfaction with the NHS, taken from the core module. Not all demographics from the core module were cross examined with the data from this module.

access to safe and confidential spaces at home), as well as people who experience intersections between characteristics which make them more at risk of inequalities (such as older people from ethnic minority backgrounds). In some cases, certain patients were not offered a video consultation at all. A mixed methods case study reflected on pre- and post-pandemic found that older patients or those who were also assumed to have little digital literacy were offered telephone appointments rather than video. A report based on the experiences of GPs in Glasgow and Edinburgh working in areas of high deprivation in the early months of the pandemic, highlighted the difficulties that remote consultations brought for their patients as many did not have the technology to support telephone or video appointments, some did not have translators, and patients were struggling to describe their condition properly. The patient's choice and skills, their environment, and the clinician's own work set up are influential on the decision making process about which appointment is the most appropriate.

In response to the research around digital health inequalities and accessibility issues, a number of case studies and consulting guidance documents have been made. The NHS England guidelines outlines how to approach appointments for children and young people, older people, and those with long-term conditions. Guidance notes for the use of Near Me in appointments for long term conditions, acute conditions and care homes for NHS Scotland has been made available, as well as general guidance for using remote

appointments during the COVID-19 pandemic. However, it is not always easy or appropriate to categorise individuals into groups or labels due to the changing characteristics and health concerns of primary care users, intersections between characteristics and experiences, and an individual's own self-identity.

2.3 Aims and Objectives

There have been a number of studies that examine how individuals feel about video, phone, and a return to face-to-face appointments, many of which include viewpoints from clinical staff, health boards, and other organisations. This report will contribute to the existing research by presenting findings about current attitudes of the Scottish public about remote healthcare appointments specifically in general practices. The aim of this research is to understand degrees of ease and comfort, acceptability, and public attitudes towards general practice appointments as we move out of the pandemic and adopt a more hybrid method of consulting across primary care. This report also aims to identify potential inequalities based on respondent characteristics. Finally, this report hopes to highlight gaps in understanding and make recommendations for future research/policy.

3. Study Design & Methodology

In 2021, the Scottish Government identified consultation methods as a priority theme to contribute to recent publications about public understanding and expectations of general practice services. Questions about 'attitudes towards accessing healthcare services digitally' were developed in partnership with ScotCen[5] (see Annex 8.1 for list of questions). The Scottish Government commissioned these questions to be included as a module in the Scottish Social Attitudes Survey (SSA) 2021/22.

An initial pilot study, which included seven questions on views of remote health care, was conducted with 14 people to trial the wording of the questions and raise any issues. After adaptions were made, ScotCen undertook their annual research into the Scottish Social Attitudes Survey in 2021/22. Fieldwork for this research took place between October 2021 and March 2022. Relevant demographics and characteristics were agreed for cross examination. ScotCen sent anonymised raw data and data tables with indications of significant findings in Excel format to the Scottish Government in July 2022 for analysis and reporting.

3.1 Impact of COVID-19

[5] For more information on ScotCen please see: NatCen Social Research (scotcen.org.uk)

Prior to the pandemic SSA interviews were conducted face-to-face, however due to restrictions in place this survey was conducted over the phone. The fieldwork was to take place over two months, however with the impact of COVID-19 on methodology and response rates, the fieldwork was extended by three months in order to capture the minimum response rate. This survey is referred to as SSA 2021/22.

The impact of COVID-19 on the research methodology means that this data cannot be straightforwardly compared with other years in the series.

3.2 Sample and Weighting

Respondents were selected using the Postcode Address File (PAF). In previous years the postcode samples would be clustered to accommodate the interviewer conducting face-to-face interviews. As this was not required, the list of postcodes, selected through probability sampling, was stratified to over-sample rural areas and the most deprived SIMD 2020 quintile (as underrepresented groups). Invitations to take part were issued to 21,775 addresses. Overall, 1,130 people took part in the telephone survey.

The weighting applied to the data in this report are to account for potential bias in the sample, non-response, and the over-sampling of rural areas and the most deprived SIMD quintile. Further information about weighting can be found in the SSA Technical Information Report. A summary of respondent demographics and characteristics can be found in Annex 8.2.

3.3 Statistical Information

All percentages used in the results below are based on weighted data. All figures were rounded up to the nearest percentage which explains some discrepancies within graph figures that may be found in this report. Any figures that note a ‘0%’ indicate that less than 0.5% of respondents selected this answer. Significant differences were tested using a logistic regression analysis and any significant difference noted is at the 95% confidence level or above, unless otherwise stated.

4. Results

This section will summarise the results of the survey in relation to the themes explored for this survey. Each theme will discuss the general overview of the results and any significant differences between respondent demographics or characteristics. Due to the limited number of questions that could be asked, this survey did not capture if respondents had experience of all three (face-to-face, phone, and video) consultations. Thus, the results below are assumed to be the **attitudes and perceptions** of the Scottish public rather than reporting on personal experience.

In addition, existing evidence outwith this survey may suggest correlations between respondent characteristics and response, for example poor general health and age may be influential in a respondent's answer about which consultation method they prefer. The results below will only explore the significant differences found in this survey data as well as where there were no links to respondent characteristics/demographics.

4.1 Comfort accessing healthcare by video/phone compared with face-to-face

4.1.1 General Overview

In the first theme of 'Comfort accessing healthcare by video/phone compared with face-to-face', people were asked if they would be comfortable talking to their doctor or nurse via a face-to-face, phone, and video appointment

separately. In this research analysis, comfort was associated with feelings and attitudes.

Figure 1: People's comfort level with face-to-face, phone, and video appointments.

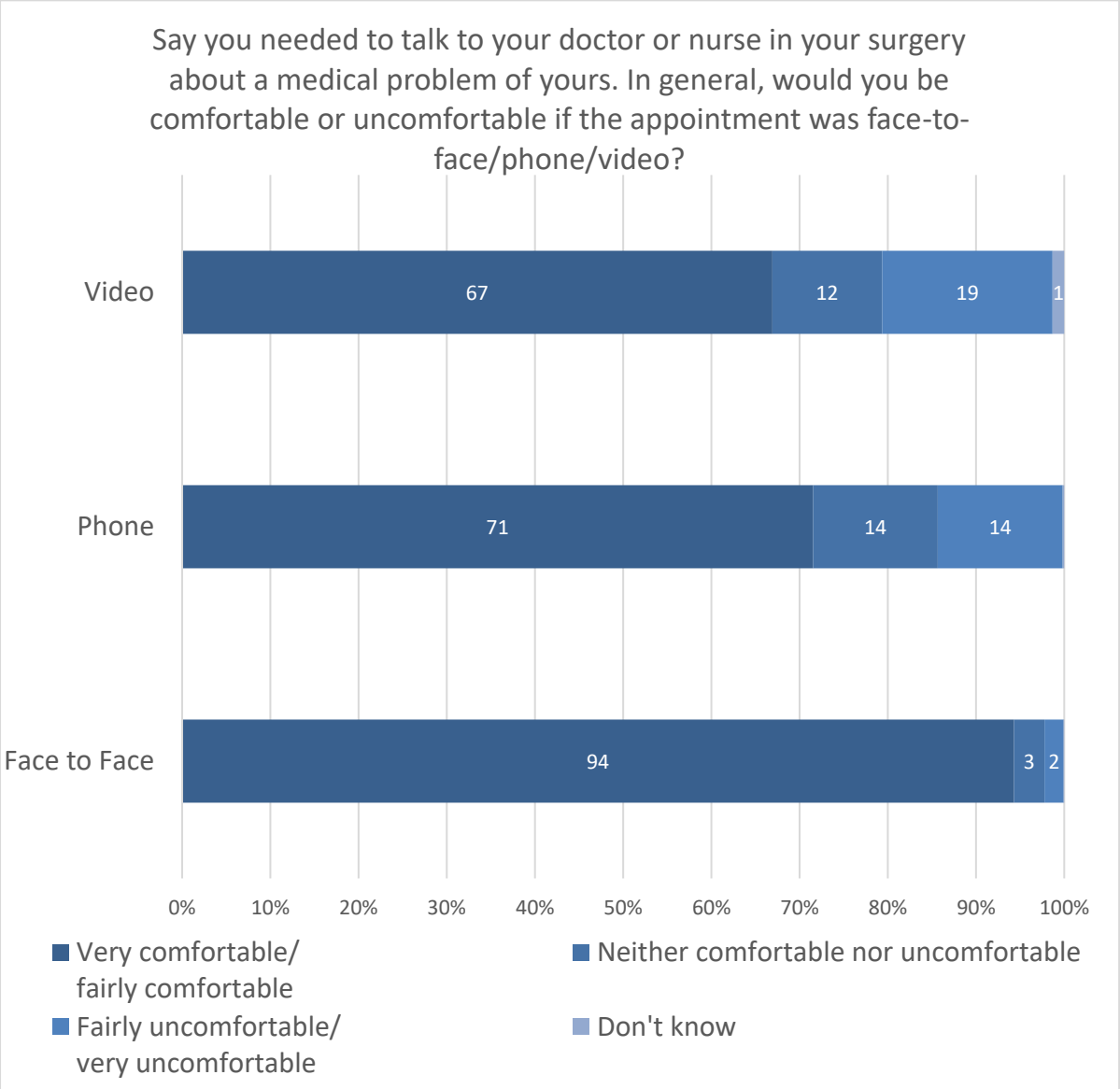


Figure 2 shows that 94% (n=1130) of people thought they would be very/fairly comfortable with face-to-face appointments, compared to phone appointments (71%) and video appointments (67%). This trend reversed for 'fairly/very

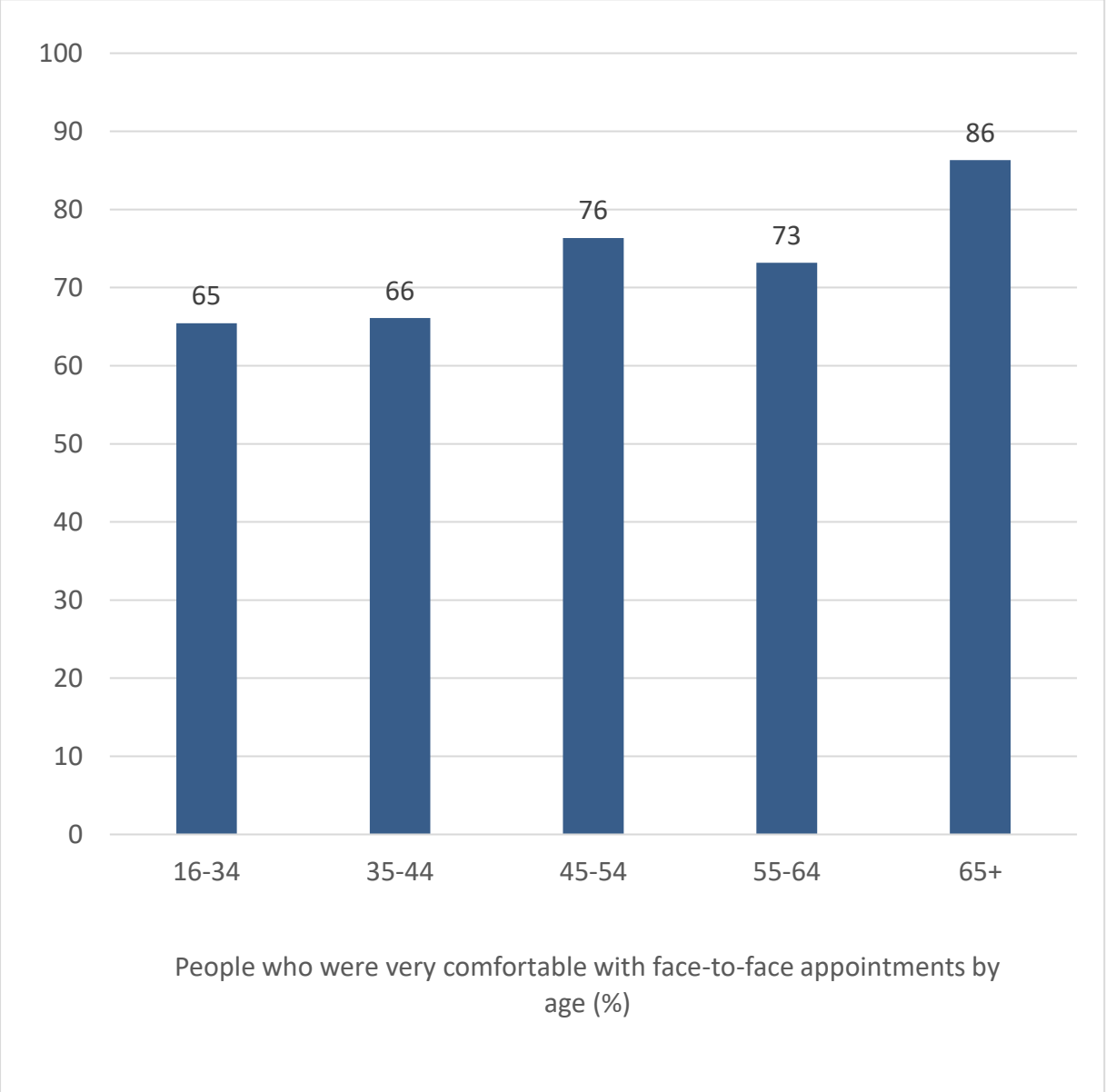
uncomfortable’ where only 2% people thought this was the case for face-to-face appointments, 14% for video, and 19% for video.

4.1.2 Respondents’ Characteristics – Significant Differences

There were no significant differences with comfort levels and long-term illness, health problems or disability; Educational qualification; SIMD; and Participants with or without children under 16.

Age

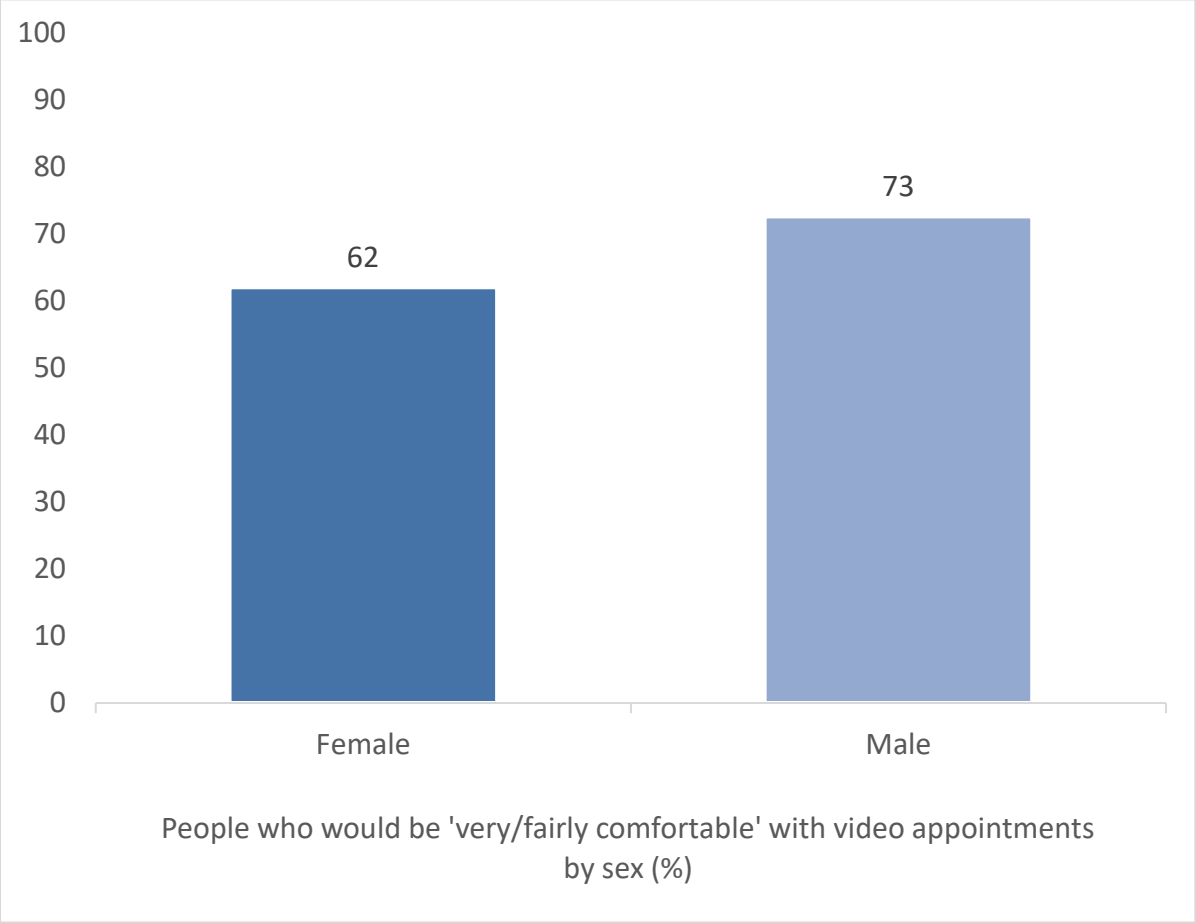
Figure 2: People's comfort level with face-to-face appointments, by age.



As seen in Figure 3, over half of all age groups selected ‘very comfortable’ as their response to face-to-face appointments. A significantly higher percentage of those aged 65 and over (86%) were more likely to say that they were ‘very comfortable’ with a face-to-face appointment than any other age group (n= 267). There were no significant differences found for age in relation to phone or video appointments.

Sex

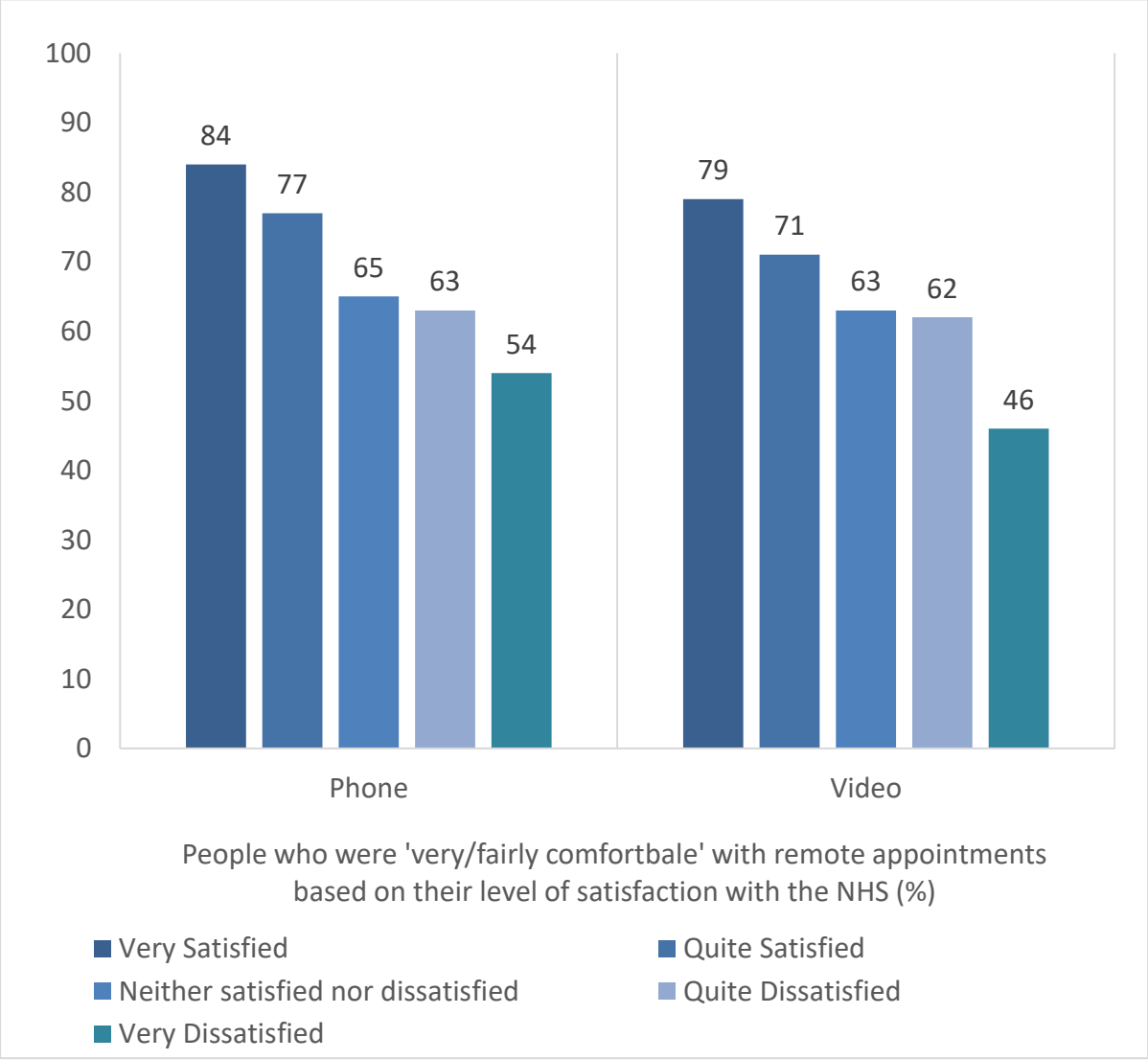
Figure 3: People who were 'very/fairly comfortable' with video appointments, by sex.



In response, 73% of males (n=544) to this question were more likely to say that they would be ‘very/fairly comfortable’ with video appointments than females (62%, n=581). The sample size was too small to include a representative sample in ‘other/prefer not to say’. There were no significant differences found for face-to-face or phone.

Level of Satisfaction

Figure 4: Percentage of people who were very/fairly comfortable’ with remote (phone and video) appointments by level of satisfaction with the NHS.

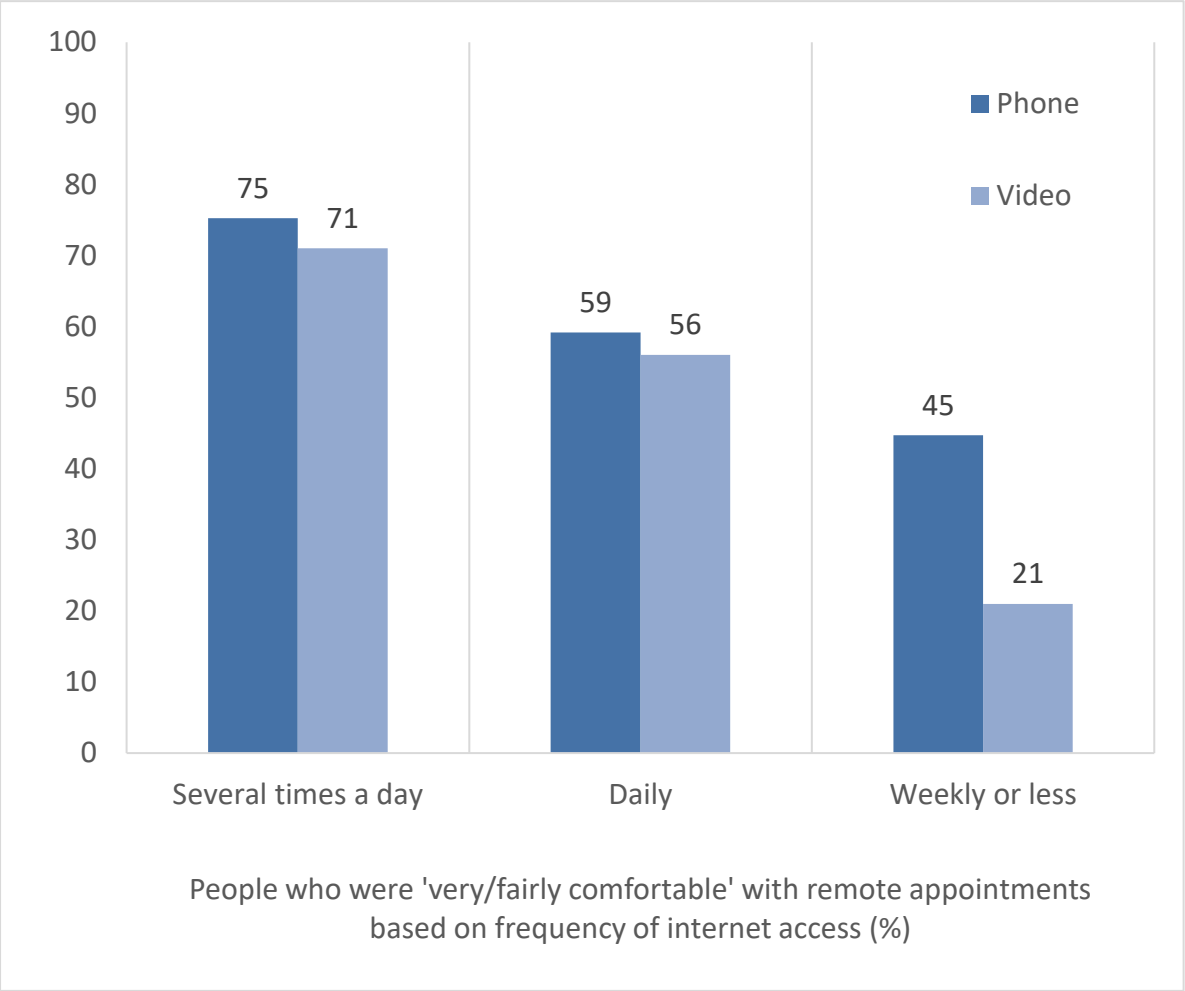


Higher satisfaction with the NHS also emerged as a correlating factor with those were ‘very/fairly comfortable’ with remote appointments. Those who said they were very (n=131) or quite satisfied with the NHS (n=484) were also more likely to report being ‘very/fairly comfortable’ with medical appointments over the phone and through video.

The proportion of people who said that they would be ‘very/fairly comfortable’ for both phone and video appointments decreased as satisfaction with the NHS decreased.

Frequency of Internet Access

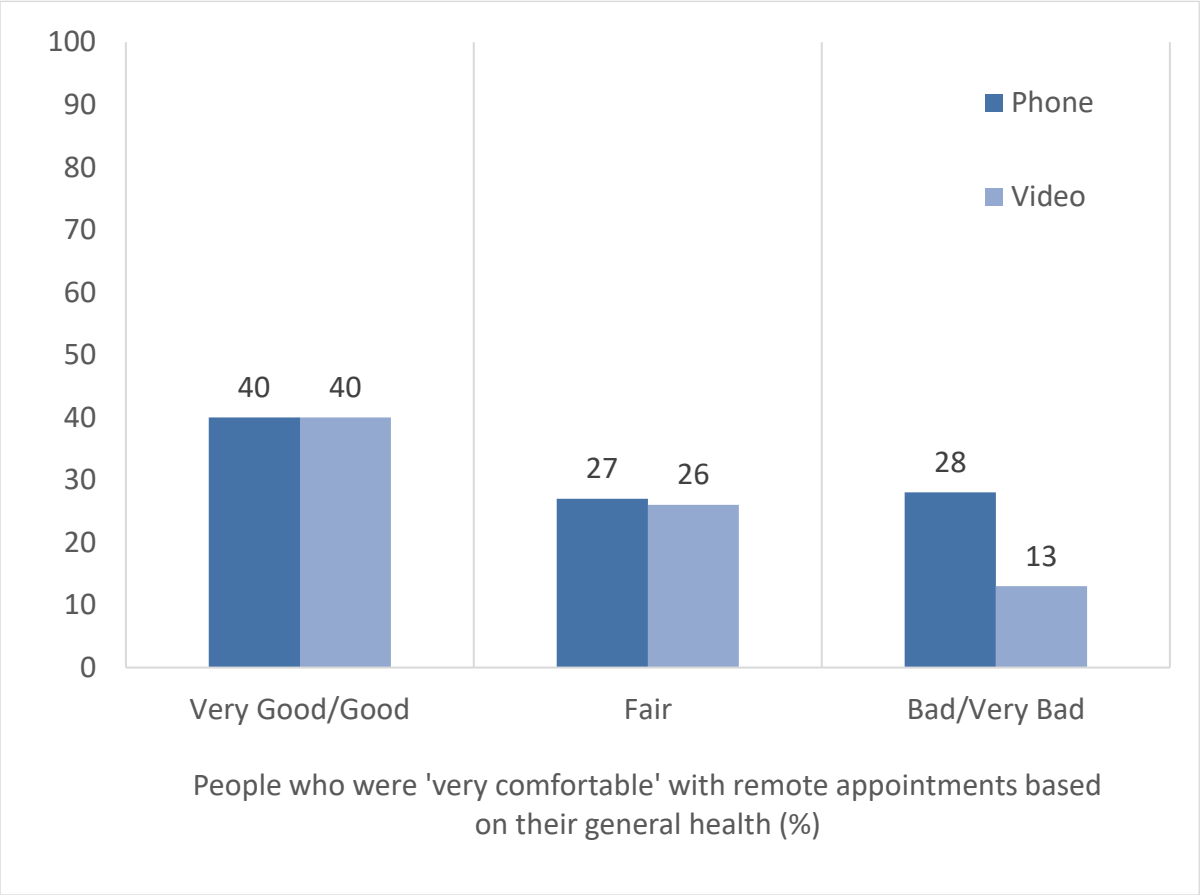
Figure 5: Percentage of people who selected being 'very/fairly comfortable' with remote appointments by frequency of access to the internet.



Those who said they were ‘very/fairly comfortable’ with phone and video appointments were more likely to use the internet ‘several times a day’ (n=882). A higher percentage of people who used the internet weekly or less said they would be ‘very/fairly comfortable’ with phone appointments but a lower percentage said the same for video appointments.

General Health

Figure 6: Percentage of people who were ‘very comfortable’ with remote appointments by general health level.



In repsonse to this question, those who reported ‘very good/good’ general health (n=770) were also more likely to say they would be ‘very comfortable’ having an appointment over the phone or via video than those with ‘fair’ or ‘bad/very bad’ health.

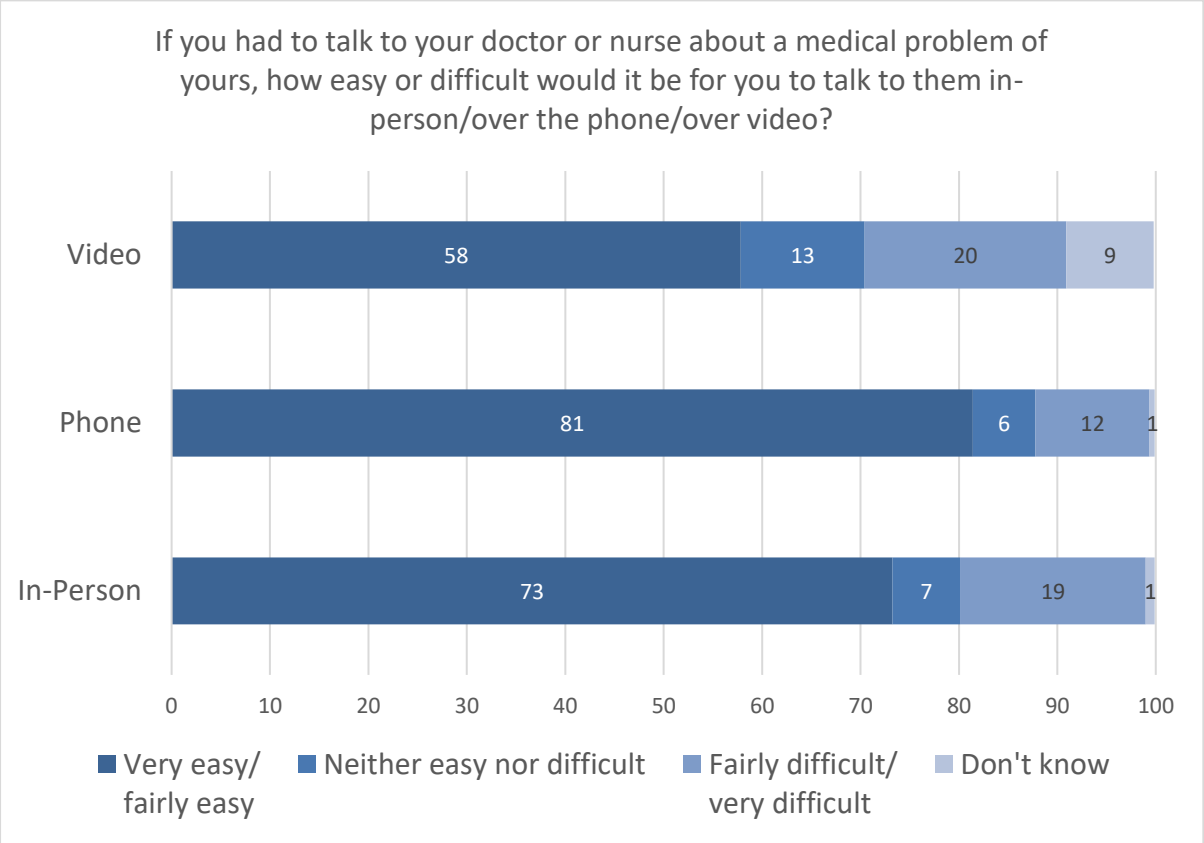
A higher percentage of people with bad/very bad general health said they would be ‘very comfortable’ with phone appointments, than those who said the same for video appointments.

4.2 Ease of accessing healthcare by video/phone/in-person

4.2.1 General Overview

In the theme of general ease of access to appointments, people were asked if they would find it easy talking to their doctor or nurse via a face-to-face, phone, and video appointment separately. In this research analysis, ease was associated with practicalities of attending an appointment. As shown in the graph below, more people selected that phone appointments were easier than those who selected face-to-face or video (n=1130). Those who reported that they 'did not know' for video appointments could suggest that these people do not have experience with this method of consultation.

Figure 7: People's level of ease with face-to-face, phone, and video appointments.



4.2.2 Respondents' Characteristics - Significant Differences

There were no significant differences with educational qualification; Gender; Age; SIMD; and Participants with or without children under 16.

General Health

Figure 8: Percentage of people who found appointments 'very easy' according to their general health.

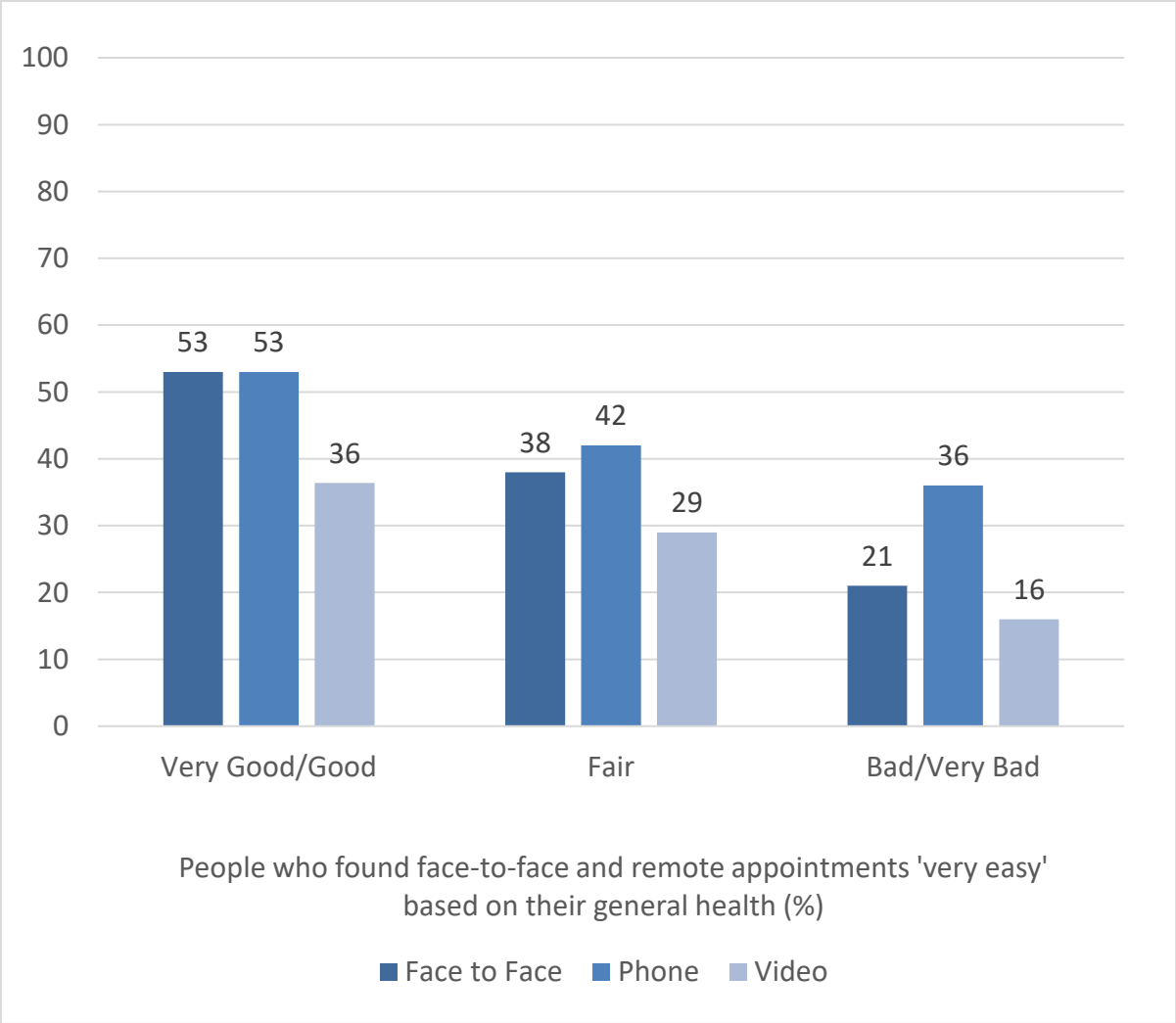
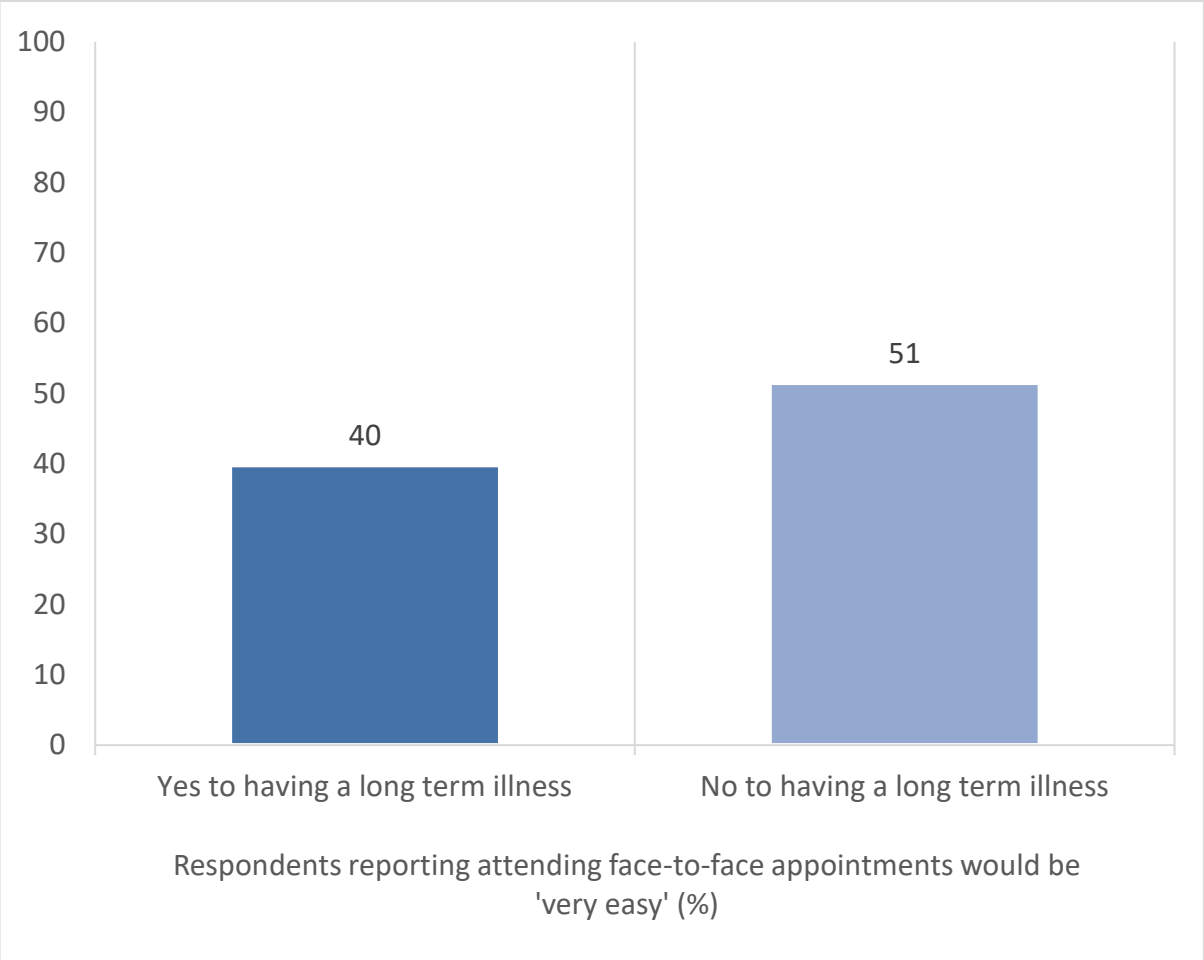


Figure 9 shows that peoples' health could potentially be seen as an influencing factor on ease of attending appointments. In this question, those who reported 'very good/good' general health (n=770) were more likely to say

that attending a face-to-face appointment would be ‘very easy’ (53%). Those who said their health was ‘very good/good’ were also more likely to say that talking to a doctor or nurse would be ‘very easy’ than those with ‘fair’, ‘bad/very bad’ general health. In addition, those who reported ‘very good/good’ general health (n=770) were more likely to say that video appointments were ‘very easy’’ (36%).

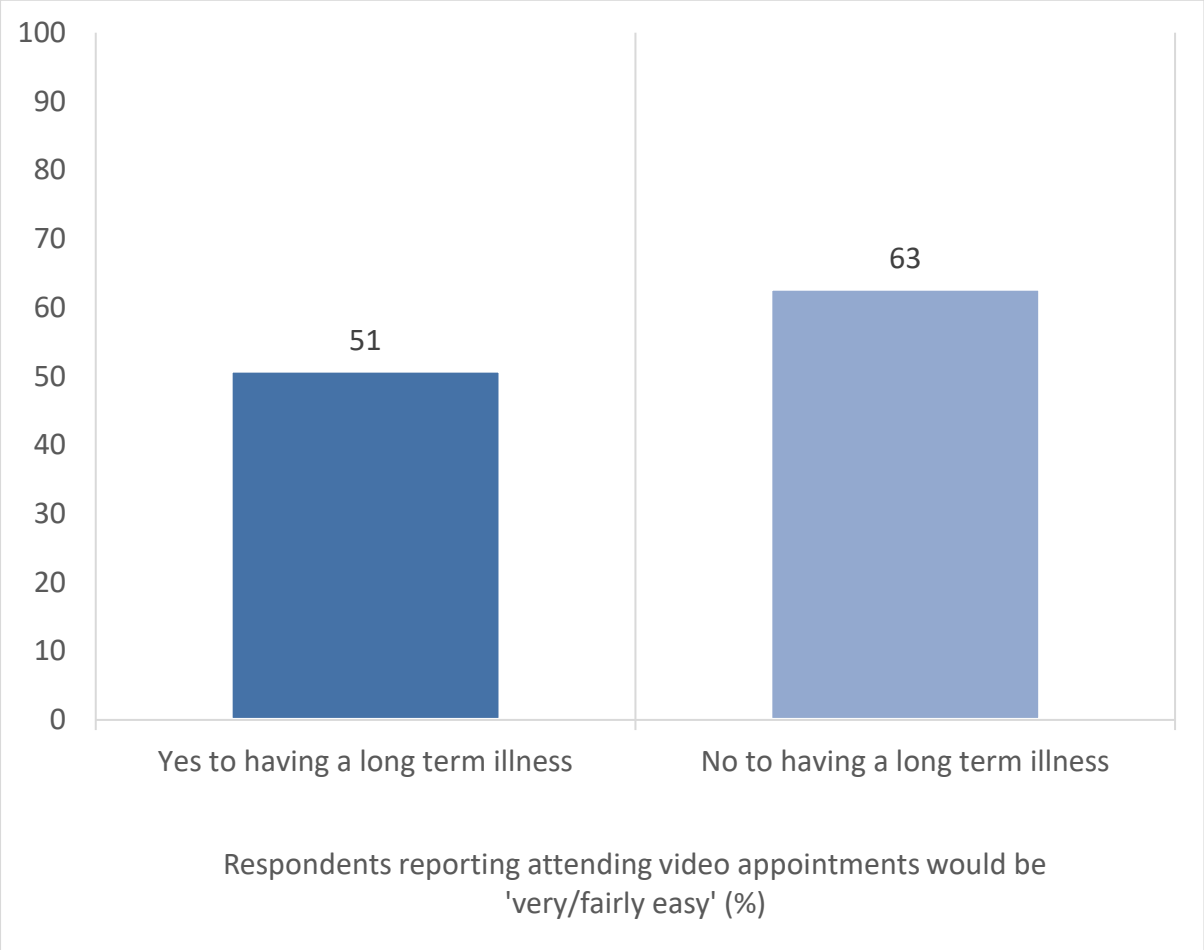
Long Term Illness, Health Problem or Disability

Figure 9: Respondents with/without a long term illness, health problem or disability who selected that attending a face-to-face appointment would be 'very easy'.



In the above graph, those who reported that they did not have a long-term illness were more likely to say that attending an in-person appointment would be ‘very easy’ (51% n=682) than those with a long term illness (40%, n=443).

Figure 10: People with/without a long term illness, health problem or disability who selected that attending a video appointment would be 'very/fairly easy'.

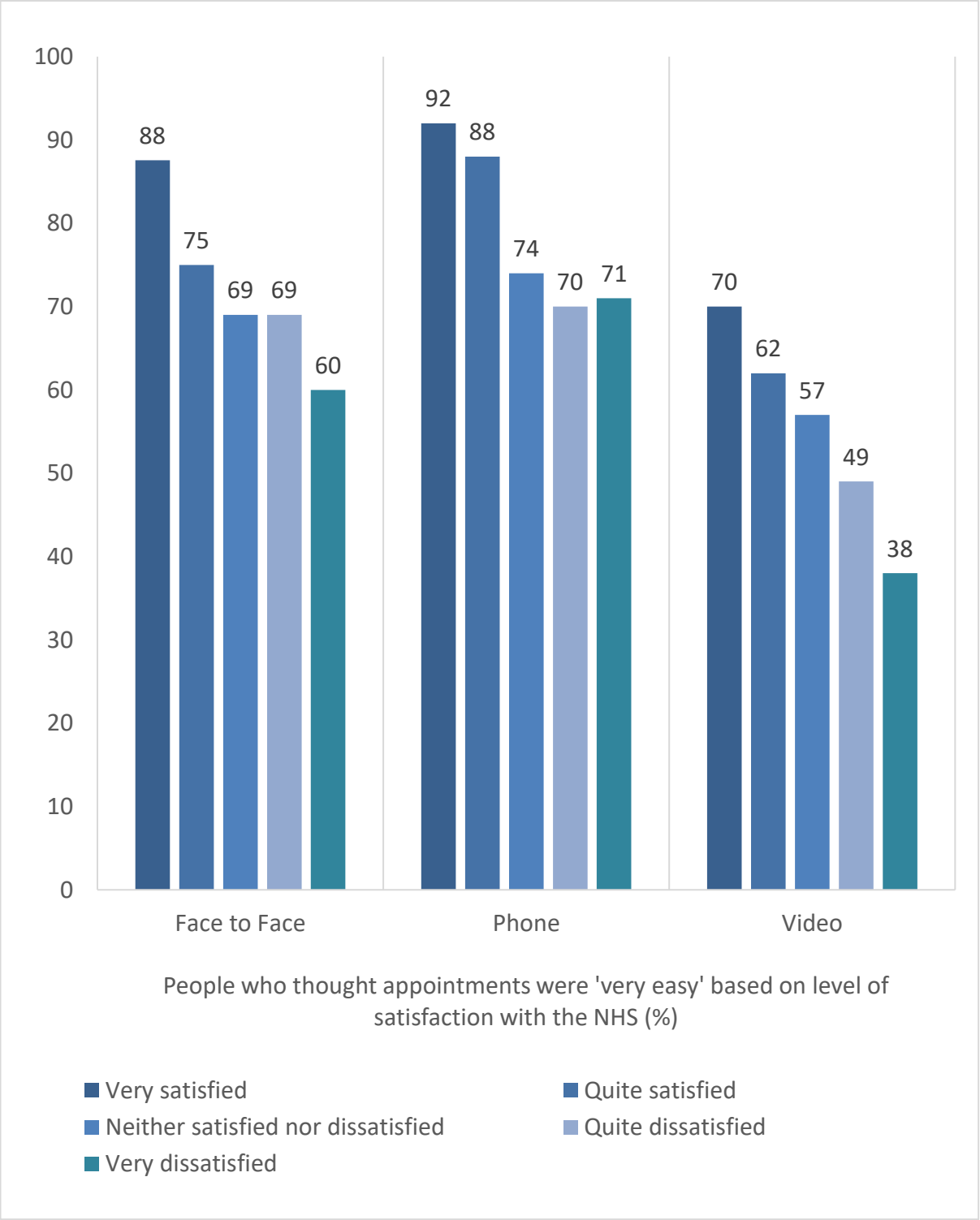


In the above graph, those who said they do not have a long-term illness or disability were more likely to say that video consultations would be ‘very/fairly easy’ (63%, n=682) than those with a long term illness (51%, n=443).

There were no significant differences between long term illness and phone appointments.

Satisfaction with the NHS

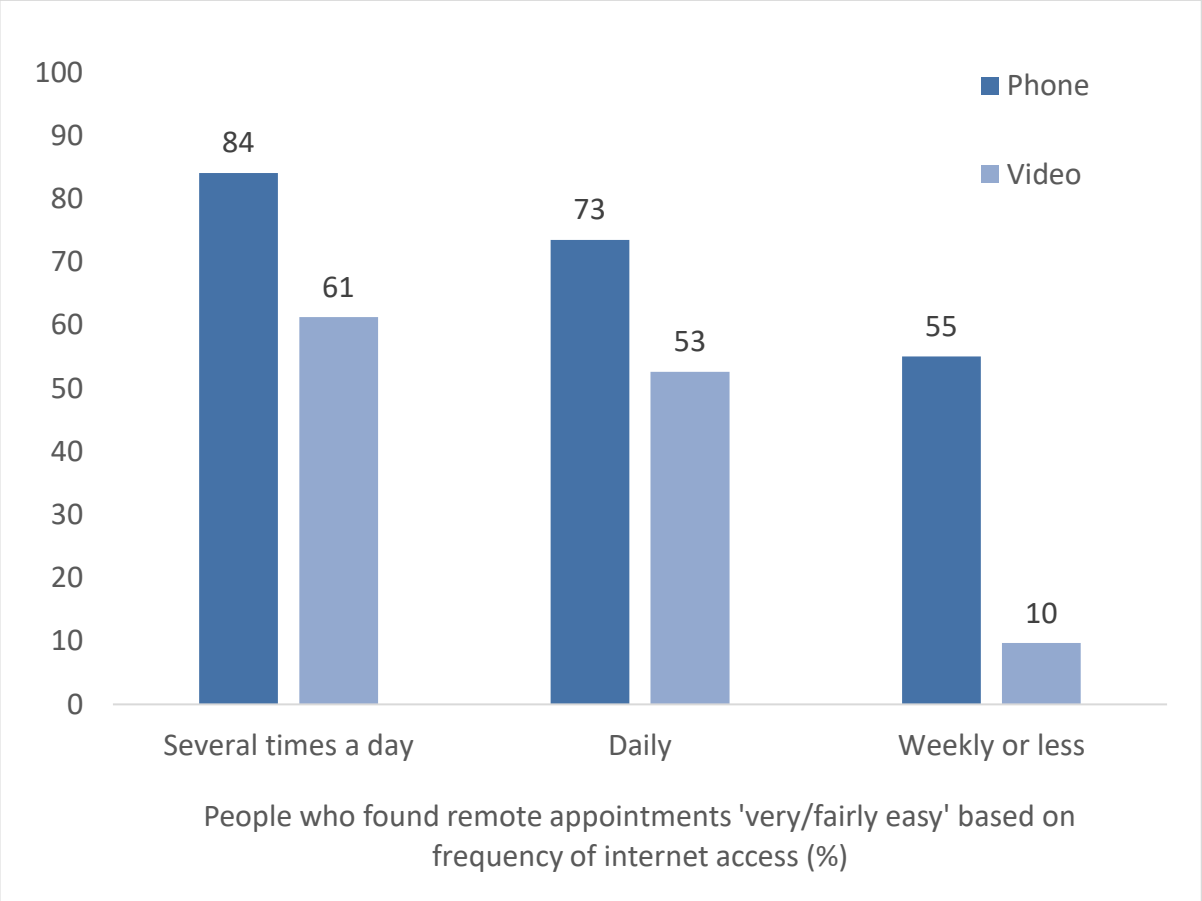
Figure 11: Percentage of people who found appointments were 'very easy' according to their level of satisfaction with the NHS.



Higher satisfaction with the NHS also emerged as a correlating factor with those who said attending an in-person, video, and phone appointment would be ‘very/fairly easy’. The proportion of people who said that these would be ‘very/fairly easy’ decreased as satisfaction with the NHS decreased.

Frequency of Internet Use

Figure 12: Percentage of people who found attending remote appointments would be ‘very/fairly easy’ according to their frequency of access to the internet.



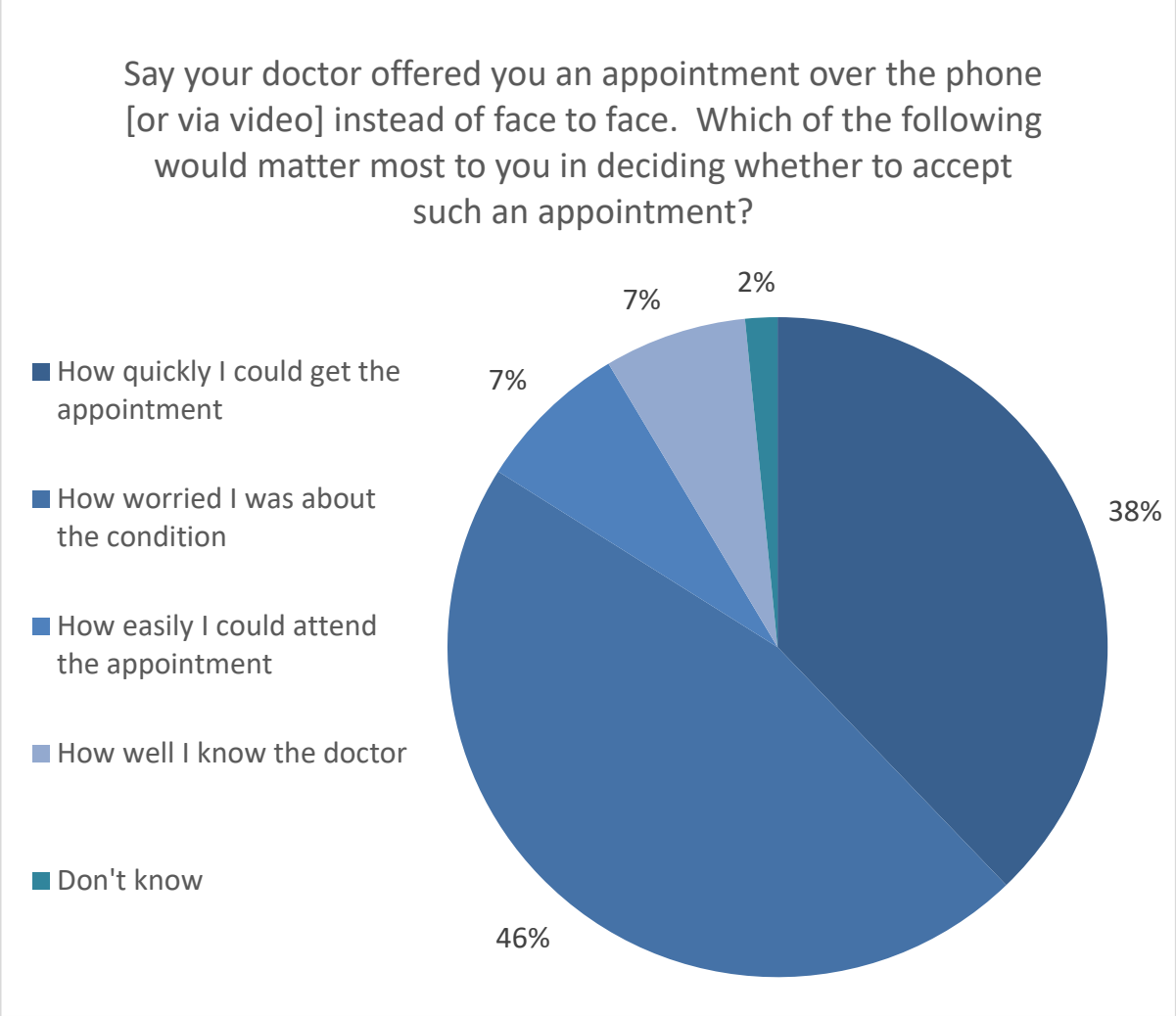
As with levels of comfort with appointments, internet use emerged as a factor contributing to phone and video appointments. Those who reported using the internet ‘several times a day’ were also the most likely to say that talking to

their doctor or nurse via phone or video would be ‘very/fairly easy’. As internet access would be required to attend a video appointment these results are not surprising.

4.3 What impacts people's chosen method of accessing healthcare?

People in Scotland were asked what mattered most to them when considering whether to accept a remote appointment over a face-to-face appointment.

Figure 13: Impacts on chosen method of appointment.



As shown in figure 14 above, 46% (n=1130) of people in this research stated that how worried they were about their condition would dictate whether they would accept a remote appointment over face-to-face. The next most frequent

answer was based on how quickly they could get an appointment (38%, n=1130).

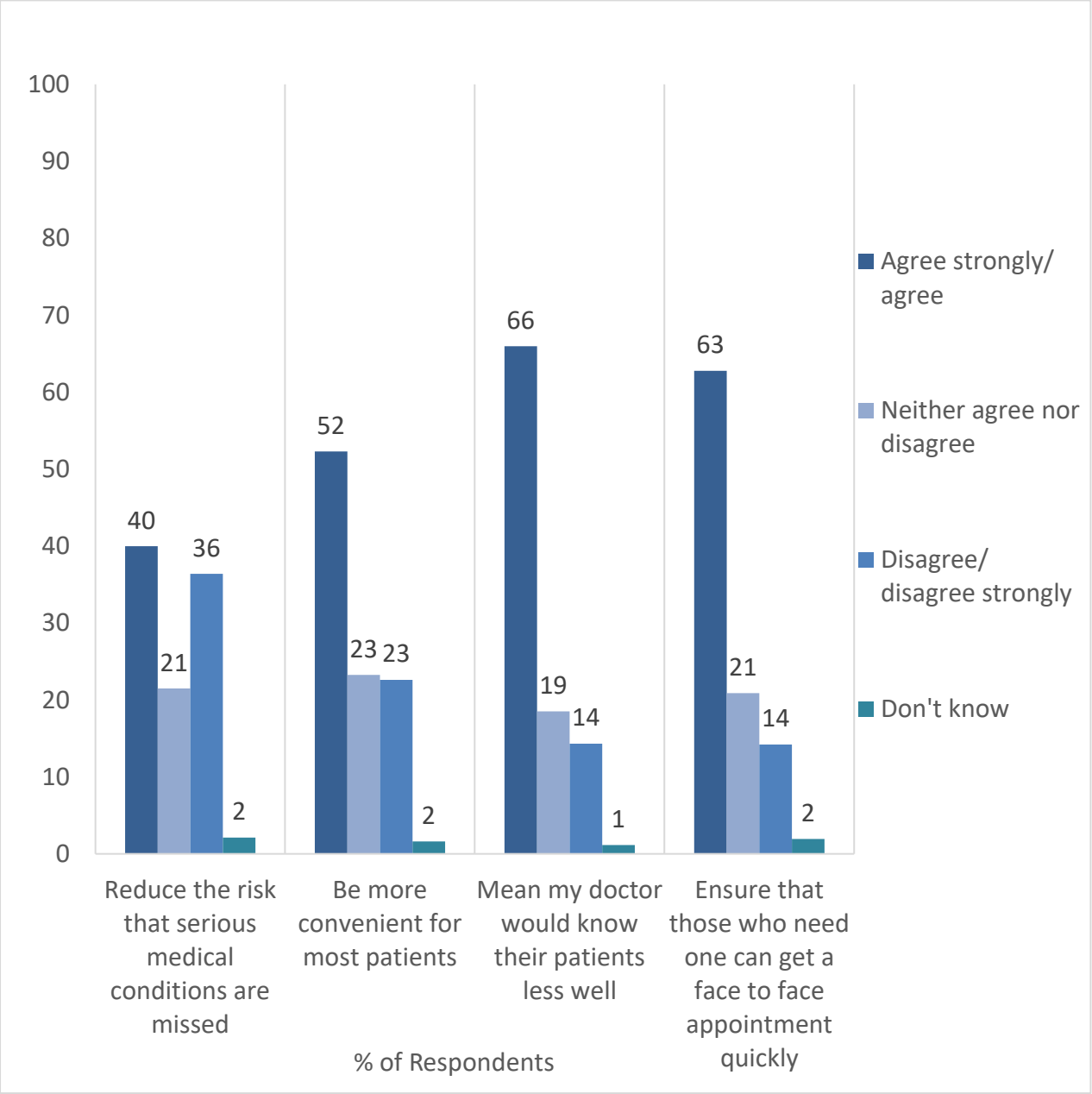
There were no noted significant differences in the data related to any characteristic or demographic variables.

4.4 Use of remote services (in place of face-to-face)

4.4.1 General Overview

People in Scotland were asked whether they agreed or disagreed with four hypothetical impacts from different modes of appointment in general practice.

Figure 14: People's attitudes towards the increased use of remote appointments (in place of face-to-face).



Shown in Figure 15, people (n=1130) were asked about increasing remote appointments.

- 66% agreed or strongly agreed that this meant that their doctor would know their patients less well
- 63% agreed or strongly agreed that it would ensure those who needed a face-to-face appointment would get one quickly.

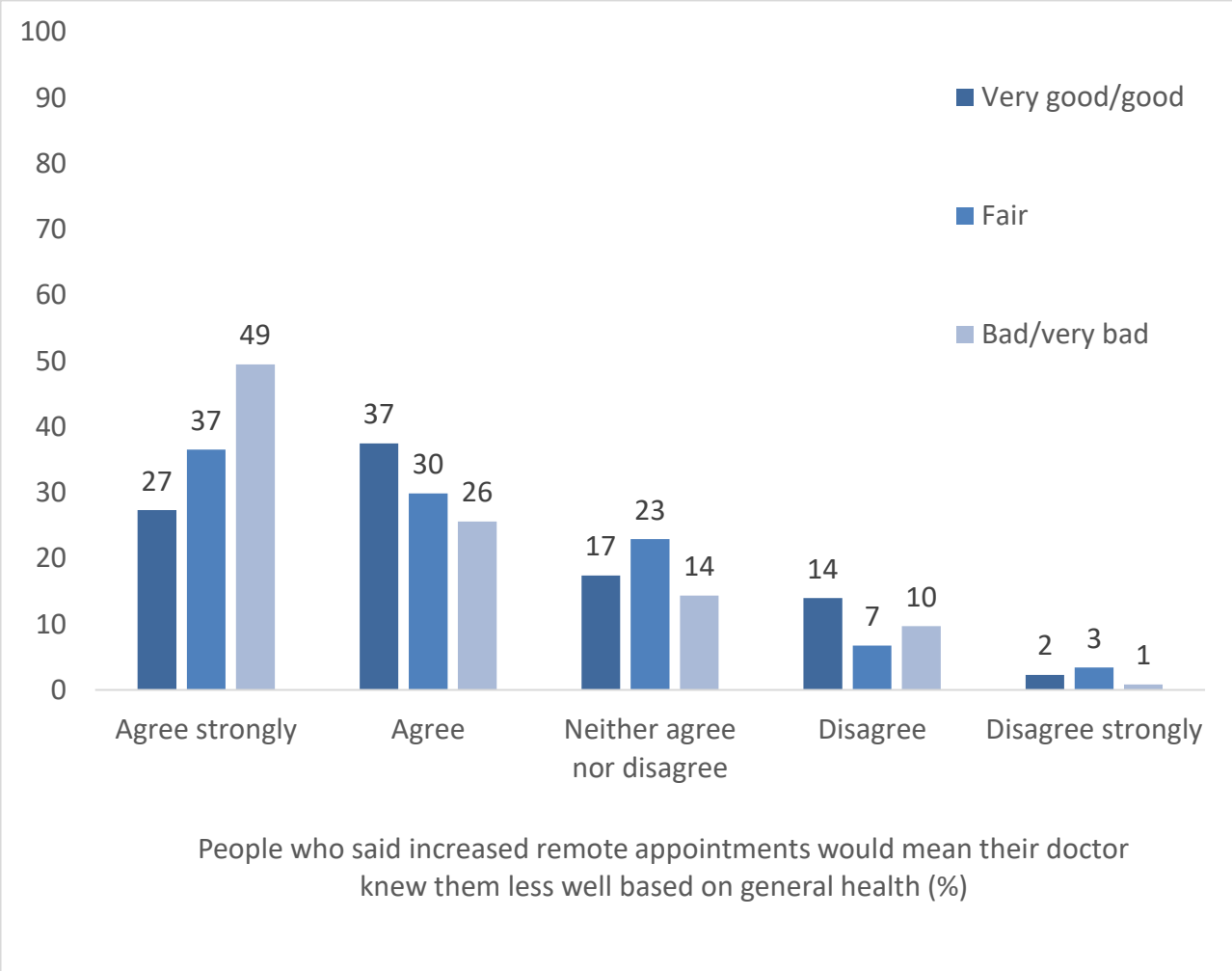
Those who did not know may highlight those who have had no experience of remote appointments and, thus, could not comment on the above question with certainty.

4.4.2 Respondent Characteristics Significant Differences

Only two significant differences were found in relation to two of the scenarios, general health and patient-doctor relationship as well as people with/without children under 16 and convenience of appointment. There were no significant differences found in relation to any of the other demographic variables such as age or gender. There were no significant differences related to the respondent characteristics variables for the other two attitudes in this question: ‘reducing the risk that serious medical conditions are missed’ or that remote appointments ‘would ensure that those who need one can get a face-to-face appointment’.

General Health

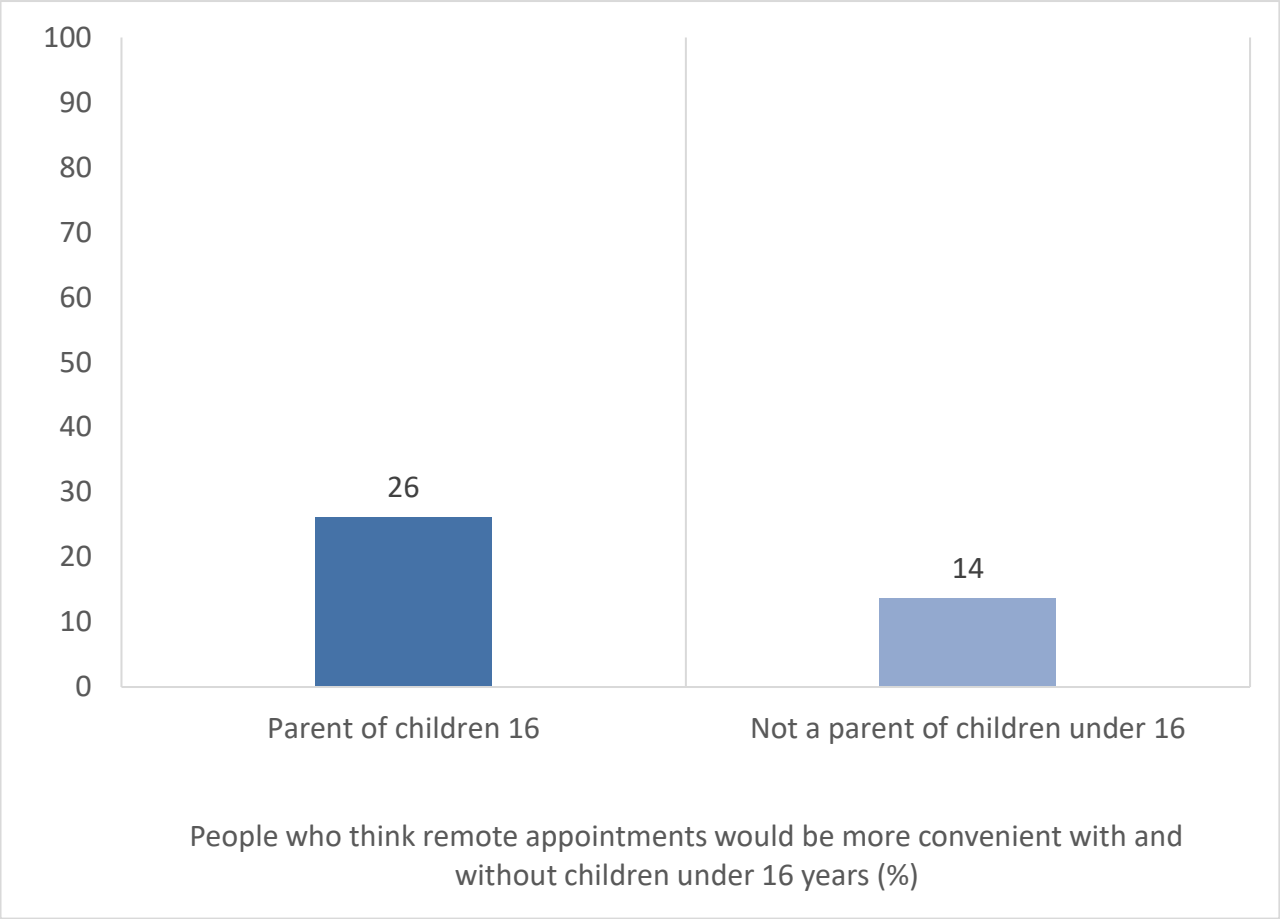
Figure 15: People who agreed/disagreed with the assumption that increasing remote appointments (in place of face-to-face) would mean their doctor would know their patients less well according to their general health.



In response to this question, people with 'bad/very bad' general health were more likely to select 'agree strongly' (49% n=84) to the assumption that doctors may know their patients less well if there was an increase in remote appointments (replacing face-to-face).

People with/without children under 16

Figure 16: People with/without children under 16 who 'strongly agree' that increasing remote appointments (replacing face-to-face) would be more convenient for most patients.



There is a significant difference in convenience of appointment and having children under 16 to care for. Those with children under 16 were more likely to ‘agree strongly’ (26%, n=203) that remote appointments would be more convenient for most patients in comparison to those without children under 16 (14%, n=927).

5. Discussion

This section will now discuss the results above in more detail. As the survey questions were not open-ended, there are no definite reasons as to why people chose their answer. Thus, the discussions here are based on exisiting and relevant literature as well as assumptions.

5.1 Comfort accessing healthcare by video/phone compared with face-to-face

A higher percentage of the public thought they would be ‘very/fairly comfortable’ with face-to-face in comparison to phone and video.

One key finding of the Public Understanding and Expectations of Primary Care in Scotland: Survey Analysis Report showed that satisfaction was highest for face-to-face appointments and lowest for video appointments among the respondents of that study. In relation to the results of remote appointments linked to doctors knowing their patients less well, this could indicate that there is also a missed relationship or physical interaction between patient and clinician.

5.2 Ease accessing healthcare by video/phone compared with face-to-face

A higher proportion of people said phone appointments were easier to access than those who said the same for face-to-face or video appointments in this study.

The ability to attend a phone appointment more quickly than getting to a face-to-face appointment or setting up a device for a video appointment, impacts the availability and flexibility of appointment times, thus reducing time spent in waiting rooms or travelling to and from appointments. As mentioned in the introduction of this report (and in the section below), other research reports that clinicians find telephone appointments easier for follow up appointments and non-acute emergencies.

5.3 What impacts people's chosen method of accessing healthcare?

How worried people were about their condition and how quickly they could get an appointment were the two main factors that influenced people to accept/decline a remote appointment.

This could be linked to the above response where people found it easier to attend phone appointments than face-to-face or video. Clinicians have also reported that they find face-to-face appointments are not necessary when the patient can be seen over the phone or video where the condition does not present as high risk.

5.4 Thoughts towards more use of remote health services (in place of face-to-face)?

Doctors not knowing their patients well and ensuring that people who needed a face-to-face appointment could get one were the top two scenarios that people

were most likely to agree with when asked what they thought of remote replacing face-to-face appointments. This was closely followed by the attitude that remote appointments would be more convenient for most patients.

A Scottish case study examining the impacts of COVID-19 on video consultations, showed that respondents considered video appointments based on "home and work commitments, travel and transport access, the nature of the clinical problem, a desire (or not) to establish or strengthen a personal relationship with the clinician, and sheer convenience". This highlights similar themes to this survey's findings, where remote appointments may ease the pressures brought on by arranging and attending face-to-face appointments, yet may also mean losing a clinical-patient relationship. Further research would be required to understand these results in more depth.

5.5 Respondents' Characteristics – Significant Differences

5.5.1 Age

Age was found as a significant difference between comfort levels with face-to-face appointments, where those aged over 65 were more likely to find these appointments 'very comfortable' in comparison to other age groups. No significant differences were found for either of the remote appointments. As mentioned in the background to this report, a mixed methods case study suggested that older populations are more likely to be given face-to-face appointments as they are considered to be less digitally literate than younger generations. The Public

Understanding and Expectations of Primary Care in Scotland: Survey Analysis Report also highlighted that those aged 65+ were less likely to use the internet to decide what their health problem would be than any other age group. Therefore, this question could suggest that older populations are more likely to be comfortable with face to face than other age brackets as they have more experience of this type of appointment and are less likely to turn to online resources to explore a potential medical issue. This report did not capture that data, yet it is interesting to note when seeking to understand how public attitudes towards remote appointments may be based on previous actual experience.

5.5.2 Gender

Males were more likely to say they would be 'very/fairly comfortable' with video appointments than females. According to the Office of National Statistics in 2019, men were higher users of the internet than women which was in keeping with previous years. Findings related to gender and internet use were not produced for the most recent ONS report. This may suggest that men are more comfortable with remote appointments as they use the internet more frequently than women.

5.5.3 Level of Satisfaction with the NHS

Higher satisfaction with the NHS correlated with how easy or difficult people perceived all three appointment methods. Those with higher satisfaction rates (very/quite) were more likely to say that face-to-face or remote consultations were

‘very/fairly easy’. Those who said they were very or quite satisfied with the NHS were more likely to say they would be ‘very/fairly comfortable’ with appointments over the phone or through video. This could be linked with respondent characteristics such as general health. If the respondent is in good health and only attends appointments for minor illnesses they may not have to access the NHS as frequently and thus may have a better satisfaction rate with them. Again, this report did not capture concrete evidence for this and further research would be required.

5.5.4 Frequency of Internet Use

Frequency of internet use was highlighted as a factor linked to higher comfort levels and ease of access for appointments via phone or video. Those who use the internet several times a day mostly likely access it through a smart phone and/or are more comfortable with using technology and/or have a portable mobile phone. As less than 25 of the 1130 respondents reported having no internet access, no meaningful statistical tests could be drawn. Therefore this report cannot make conclusions for attitudes about remote appointments that could be impacted by not having access to the internet. Equally, issues such as poor connection or quality, lack of private space or those with little technological literacy were not discussed yet may impact attitudes towards remote appointments.

5.5.5. General Health and Long-Term Illnesses

Those with very good/good general health were more likely to be comfortable with

and find it easier to attend remote appointments. Those that reported they did not have a long-term illness were also more likely to say that attending an in-person or video appointment would be easy. No significant differences were reported for the use of phone appointments and long-term illness.

According to the results of the overall 'Primary Care Understanding and Expectations of Primary Care in Scotland: Survey Analysis Report', "Respondents with a limiting long-term illness were more likely than the overall total to report that their most recent mode of treatment/advice was by telephone". The Near Me Evaluation found that 66% of clinicians interviewed preferred video appointments for follow-up consultations of long-term conditions. Rosen et al also suggests that clinical staff found remote appointments resulted in better management of long-term illnesses as patients did not have to travel into and wait in the practice, although this was based on a small sample size combined with previous evidence about remote consultations.

Those with poor general health were more likely to agree strongly that increasing remote appointments (in replace of face-to-face) would result in their doctor knowing them less well. This is interesting in relation to the point made by Rosen et al that clinicians prefer management of long-term illnesses over the phone. Thus, there may be a contradiction between the clinicians' management of long-term illnesses through remote appointments and the clinical-patient relationship that is impacted by this. Although this will be influenced by multiple factors such as patient

specific conditions, preference, location of their practice, and ability to access remote appointments.

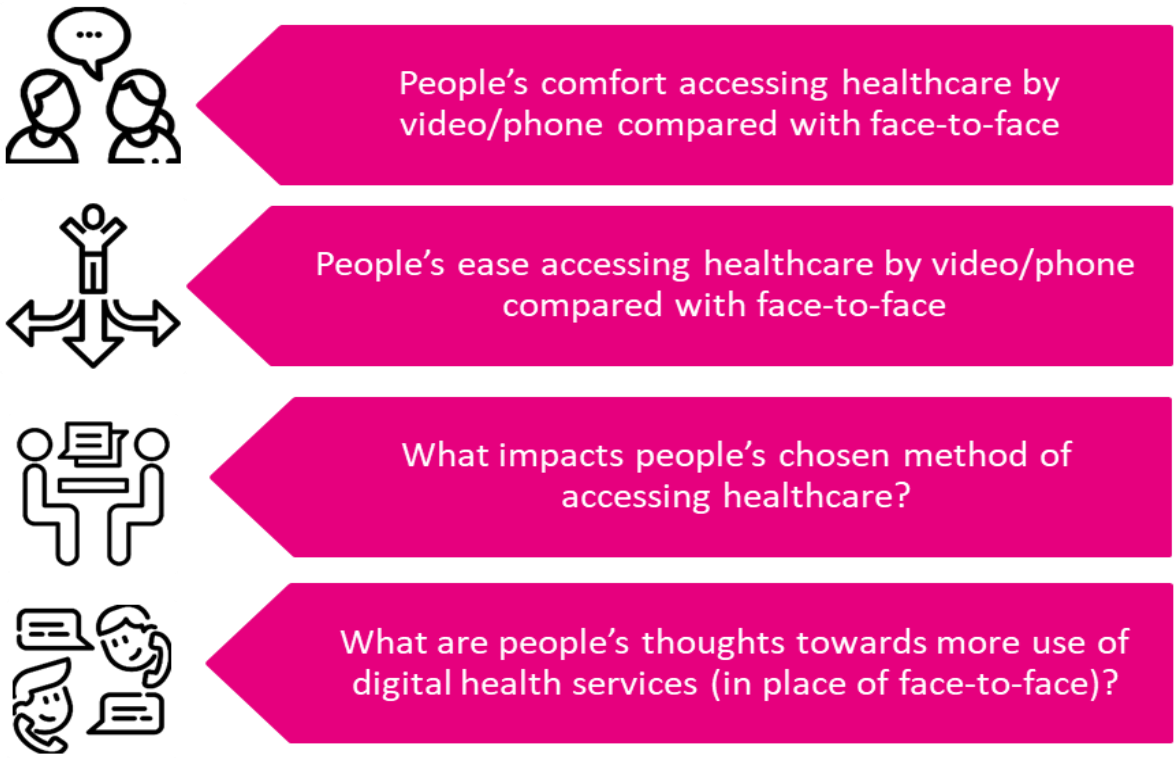
5.5.6. Respondents with Children under 16

Based on the results of this study, there is significant difference between convenience of remote appointments and having children under 16 to care for. Those with children under 16 were more likely to agree that remote appointments were more convenient. This is perhaps due to travel/time limitations when being offered a face-to-face appointment, as remote consultations offer the opportunity to have appointments within the home without the need to arrange childcare. Although this will be largely dependent on the type of consultation being discussed.

6. Conclusions and Limitations

This report has presented findings from the Scottish Social Attitudes Survey researching public attitudes towards different types of appointments in general practice. The results, based on a nationally representative sample of 1,130 people aged 16 and over, have been discussed in relation to the 4 themes outlined at the beginning of the document[6]:

Figure 17: Themes used to explore for survey questions.



[6] Figure 18 has been designed using resources from Flaticon.com

6.1 Policy implications and suggestions for further research

The survey results highlight the diversity in attitudes towards accessing general practice appointments remotely. Attitudes towards appointment type were impacted by both comfort and ease, where participants preferred face-to-face for comfort and phone for ease. Video appointments in general practices seemed to be the less favorable option for the people of this survey, a finding reinforced by the additional literature referenced in this report. Equally the variation of responses based on demographics and characteristics, highlight a range of factors that may influence people's preferences and concerns as well as areas that require further investigation. For example, good general health, frequent internet use, and high satisfaction with the NHS were linked to a more positive response across all three modes of appointments. This survey did not find any significant differences for SIMD and education, however this may also reflect limitations of the methodology and these may be key areas for future research. Similarly, this survey cannot account for the differences experienced by people from remote and urban settings. Therefore, the needs of the patient, clinical judgement, and service efficiency/effectiveness should be central to ensuring that digital and remote appointments are enhancing patient care and safety.

6.2 Limitations

6.2.1 Questionnaire

- The space for questions was limited in order to keep the questionnaire concise therefore the scope of the questions were not enough to give further information about the reason for choosing a particular answer (e.g. did not

include a question about what experience the respondents had with each mode of appointment thus, we are unsure if the responses are based on experience or opinion). In addition, the questions were closed and no further information could be provided about why answers were chosen. Further research, that includes both quantitative and qualitative approaches, specifically about remote services would gather a broad and more extensive evidence base.

- As the questions were based on opinions about doctors and/or nurses, further information is required that encompasses other workers within primary care and multidisciplinary teams who see patients through remote versus face-to-face consultations. There may be other preferences based on who the patient is seeing, for example they might prefer to see a community link worker remotely but a GP through face-to-face/over the phone.
- As this survey highlighted that how worried people were about their condition would impact their choice to accept or decline a remote appointment, further research would be required to assess how different reasons for contacting a primary care worker (and who they are) may impact on appointment method.

6.2.2 Respondents' Characteristics – Significant Differences

- There was little scope to assess the impact of intersectionality through this survey due to the sample size and not being able to include relevant questions. As highlighted by the 2020 Near Me Equality Impact Assessment intersectionality plays a role in experiences of health care and should be examined further. The results of this survey showed that those with better

general health, more frequent use of the internet and higher NHS satisfaction are more likely to find appointments easier/comfortable. These respondent characteristics could be linked to demographics such as being younger in age, an intersection between the above that could be explored in future research.

- Language may have an impact on preferred choice of appointment method, so good quality evidence on the attitudes and experiences of people whose first language is not English would provide valuable evidence to help services meet patients' appointment needs.
- As mentioned in the 2020 Near Me Equality Impact Assessment, those from the LGBT community or an ethnic minority background may experience more adversity in health care settings. This survey was unable to generate sufficient data in the number of responses to allow for robust analysis so cannot comment on the links. Therefore future research would require a larger, representative sample of the Scottish population to draw conclusions from. As well as creating bespoke research or surveys to focus on adversely impacted groups.
- Due to the impact of COVID-19 and restrictions limiting face-to-face contact, this survey was conducted via telephone. This method may have excluded certain populations such as individuals who do not have access to a phone and thus, who are negatively impacted by remote appointments, a key user experience that needs captured.

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8. Annexes

8.1 Remote Services Questions as part of SSA 2021/22

Say you needed to talk to your doctor or nurse in your surgery about a medical problem of yours. In general, would you be comfortable or uncomfortable if the appointment was:

Face-to-face in the surgery

Over the phone

Via video call

1 Very comfortable

2 Fairly comfortable

3 Neither comfortable nor uncomfortable

4 Fairly uncomfortable

5 Very uncomfortable

And if you had to talk to your doctor or nurse about a medical problem of yours, how easy or difficult would it be for you to:

Visit them in their surgery

Talk to your doctor or nurse over the phone

Talk to your doctor via a video call

1 Very easy

2 Fairly easy

3 Neither easy nor difficult

4 Fairly difficult

5 Very difficult

Say your doctor offered you an appointment over the phone [or via video] instead of face-to-face. Which of the following would matter most to you in deciding whether to accept such an appointment?

How quickly I could get the appointment

How easily I could attend the appointment

How well I know the doctor

How worried I was about the condition

Say your doctor reduced the number of people they saw in their surgery and instead spoke to more people over the phone or via a video call.

How much do you agree or disagree that this would:

Reduce the risk that serious medical conditions are missed

Be more convenient for most patients

Mean my doctor would know their patients less well

Ensure that those who need one can get a face-to-face appointment quickly

1 Agree strongly

2 Agree

3 Neither agree nor disagree

4 Disagree

5 Disagree strongly

8.2 Respondent Characteristics

All graphs below are representative of the 1,130 respondents. All percentages used in the results below show weighted and unweighted data. Any figures that note a 0%’ indicate that less than 0.5% of respondents selected this answer. The respondents characteristics and demographics were obtained as part of the core module of the SSA 2021/22. Relevant characteristics, such as satisfaction with the NHS, were analysed against the digital services questions shown in this report.

Figure 18: Respondents' sex.

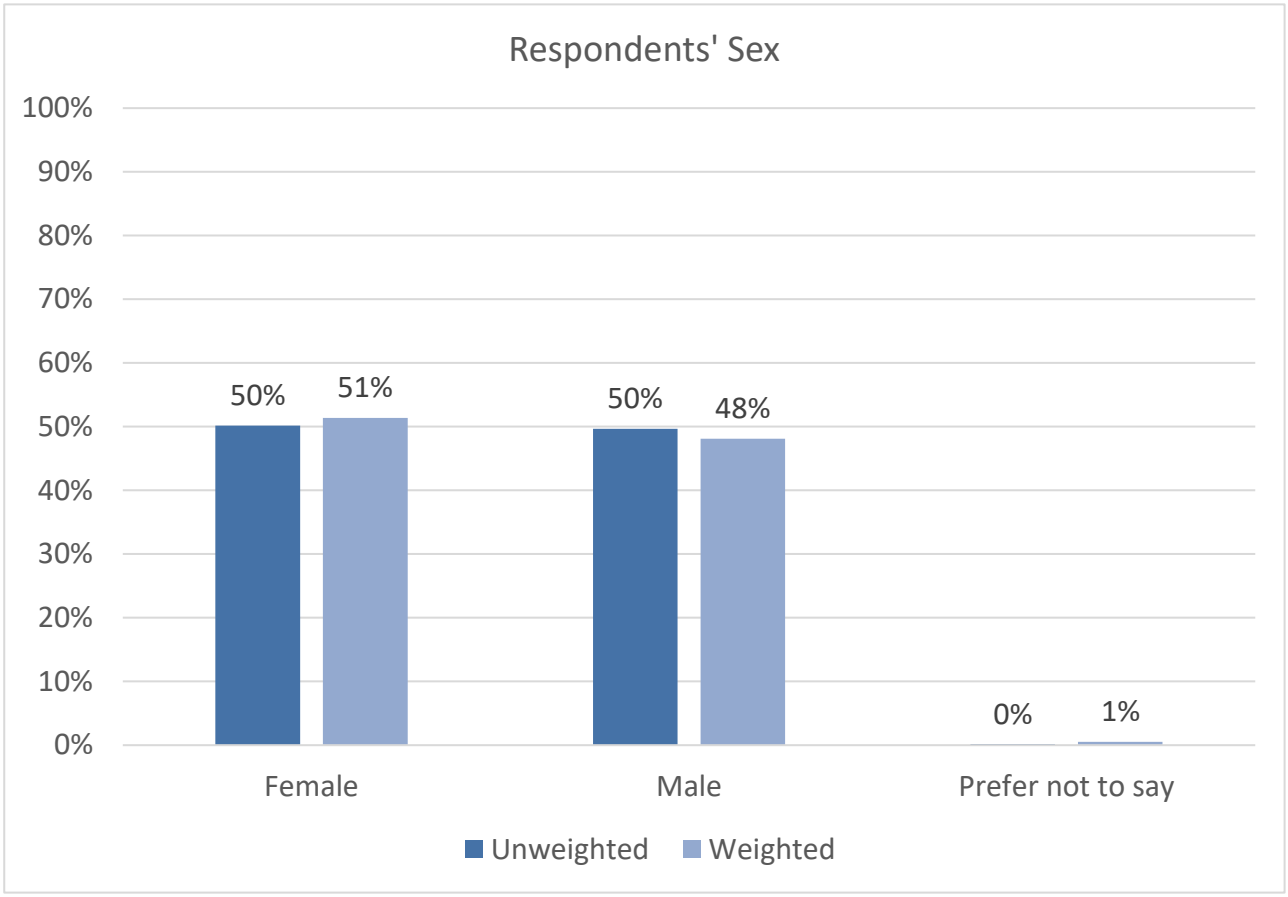


Figure 19: Respondents' age.

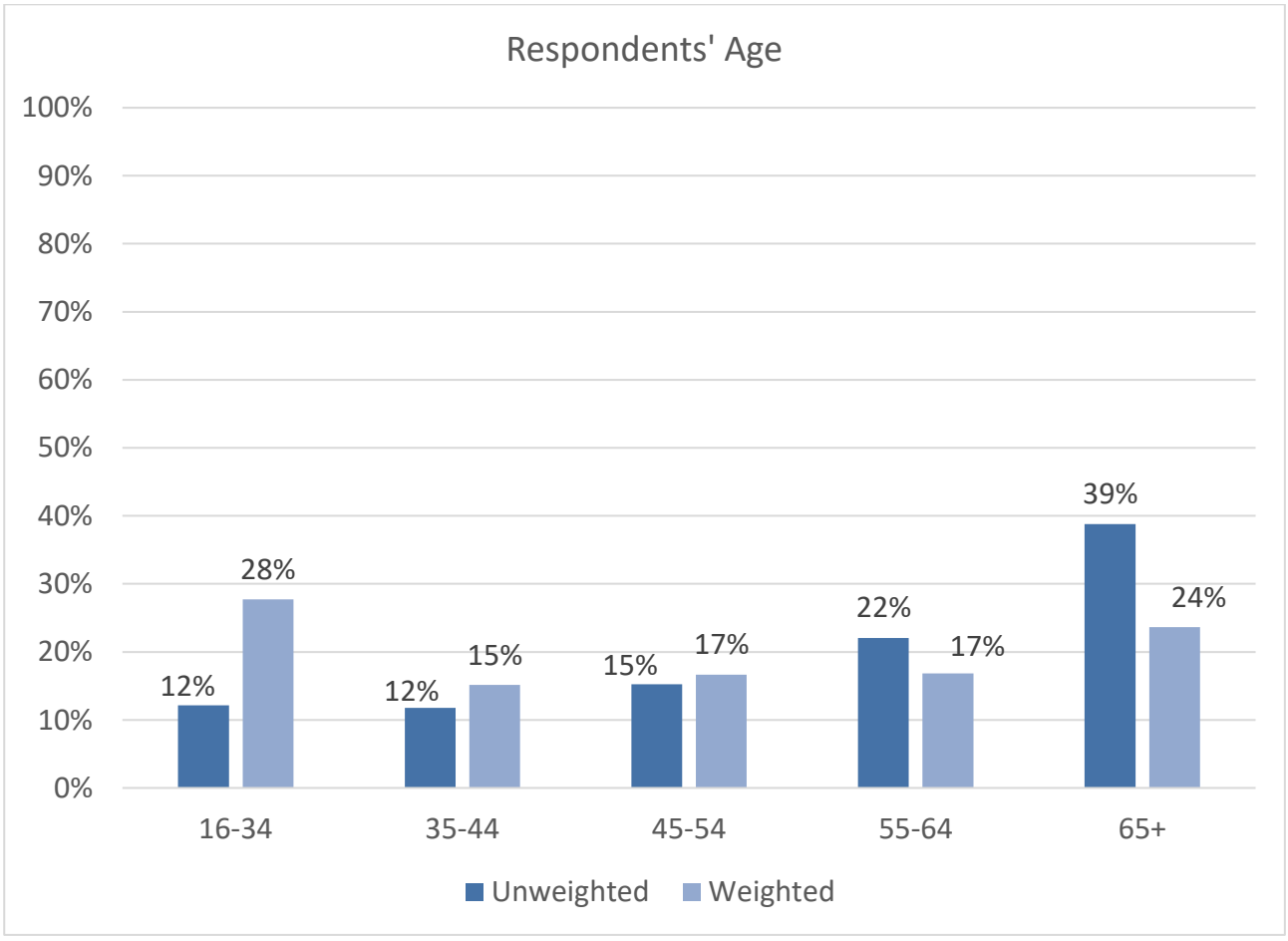


Figure 20: Respondents' highest level of educational qualification.

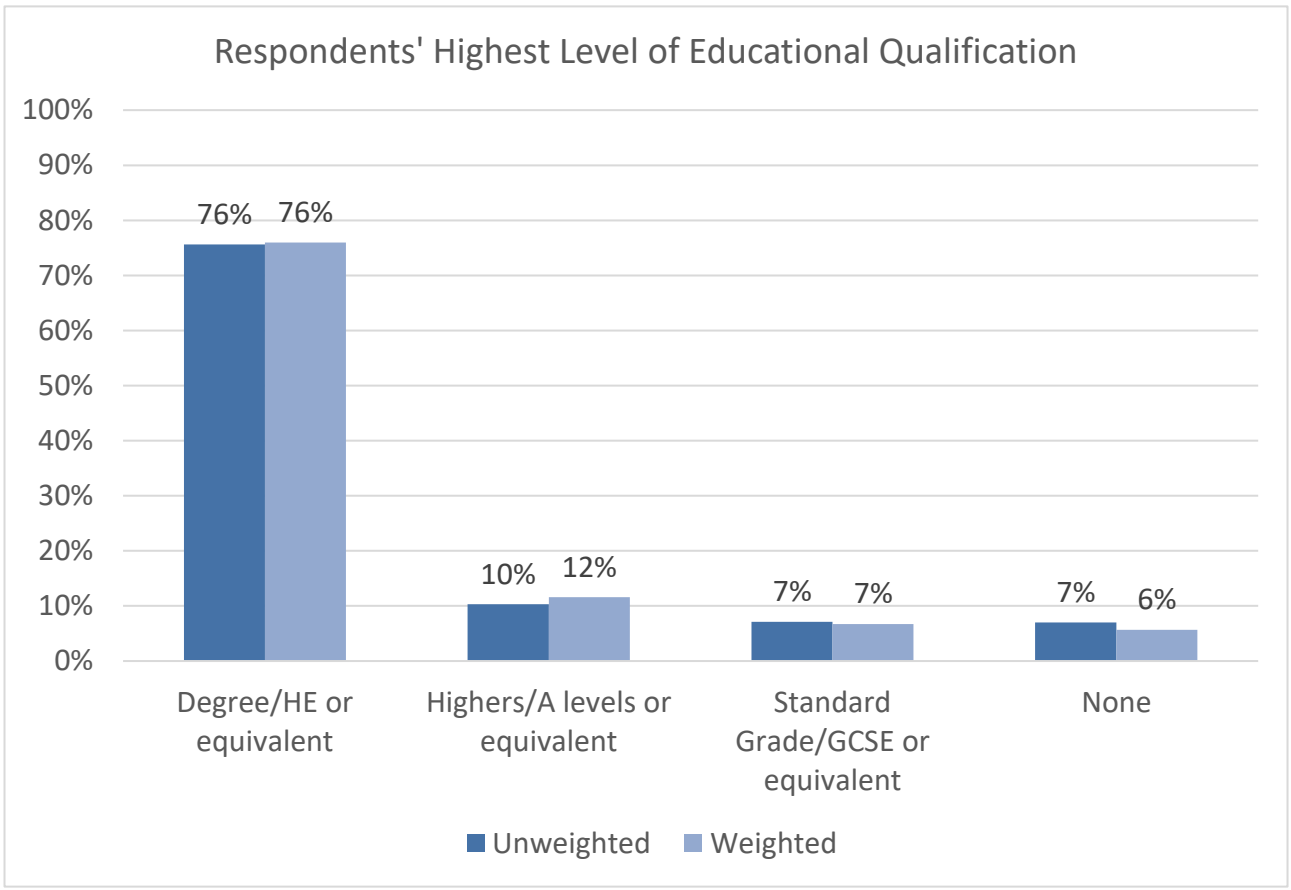
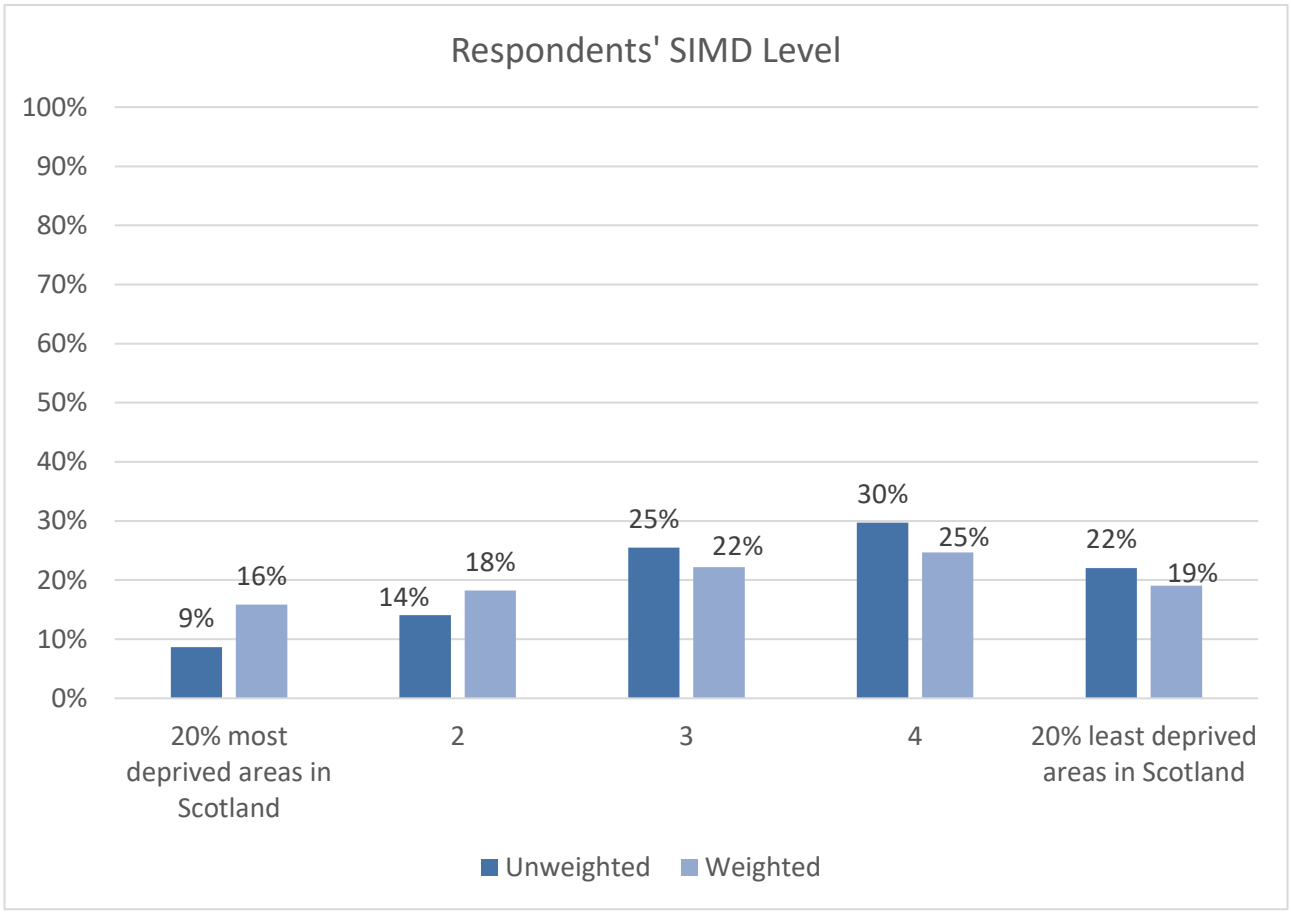


Figure 21: Distribution of respondents by SIMD quintile.



It is important to note that SIMD categorisation of an area is not representative of all the individuals that live within it. There can be individuals experiencing deprivation within areas classed as the ‘least deprived’.

Figure 22: Respondents' level of satisfaction with the NHS.

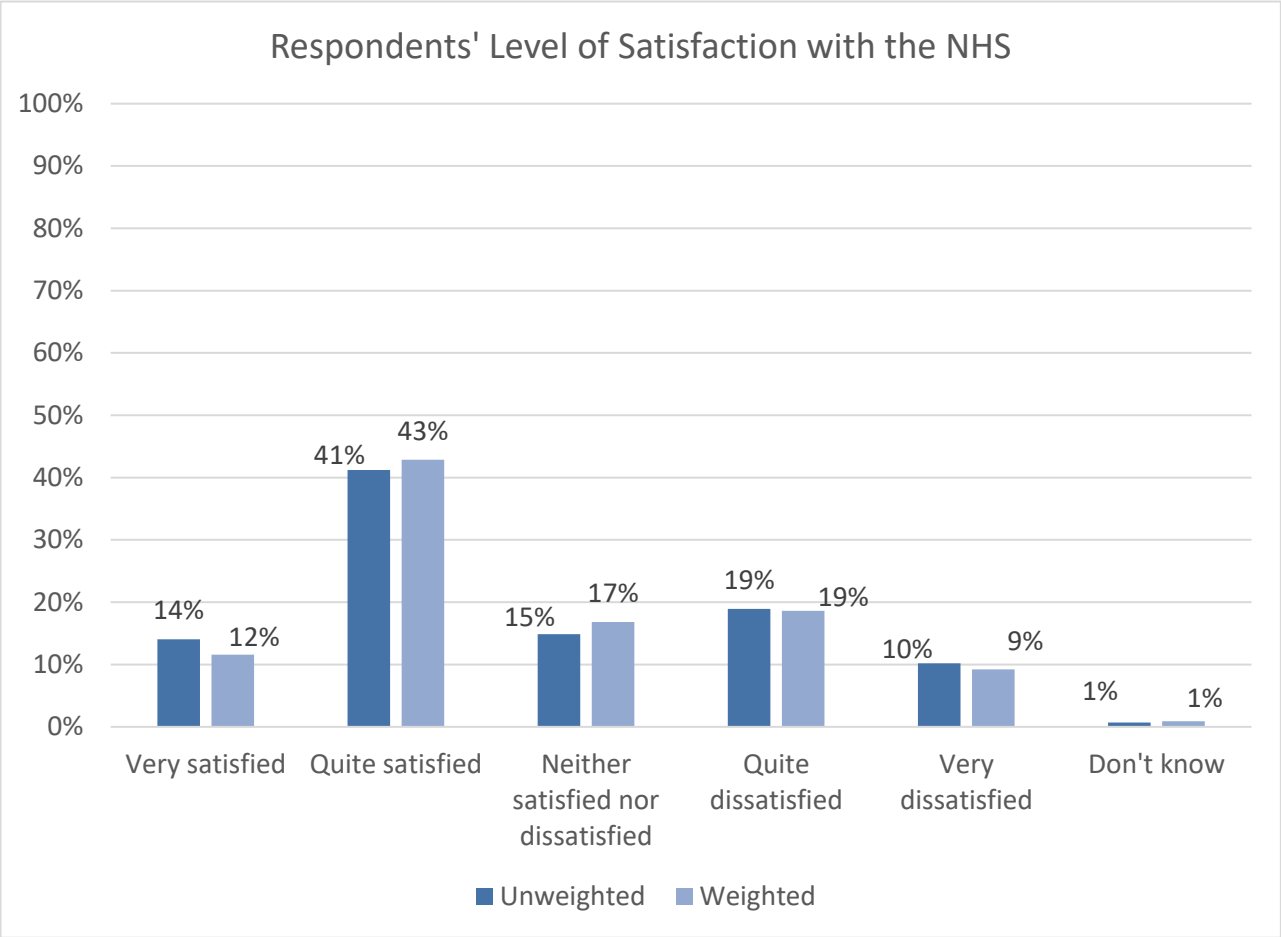


Figure 23: Respondents with/without any children under 16.

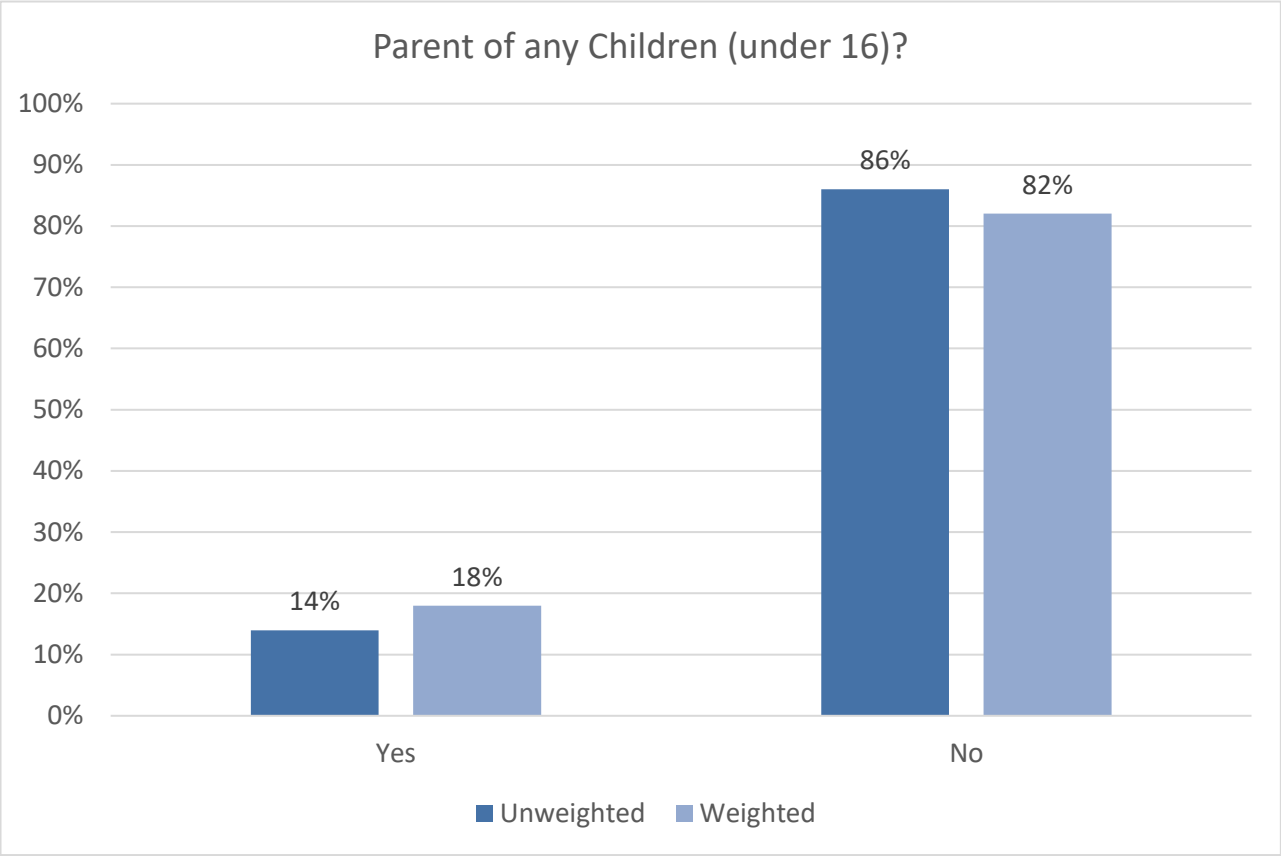


Figure 24: Respondents' frequency of access to the internet.

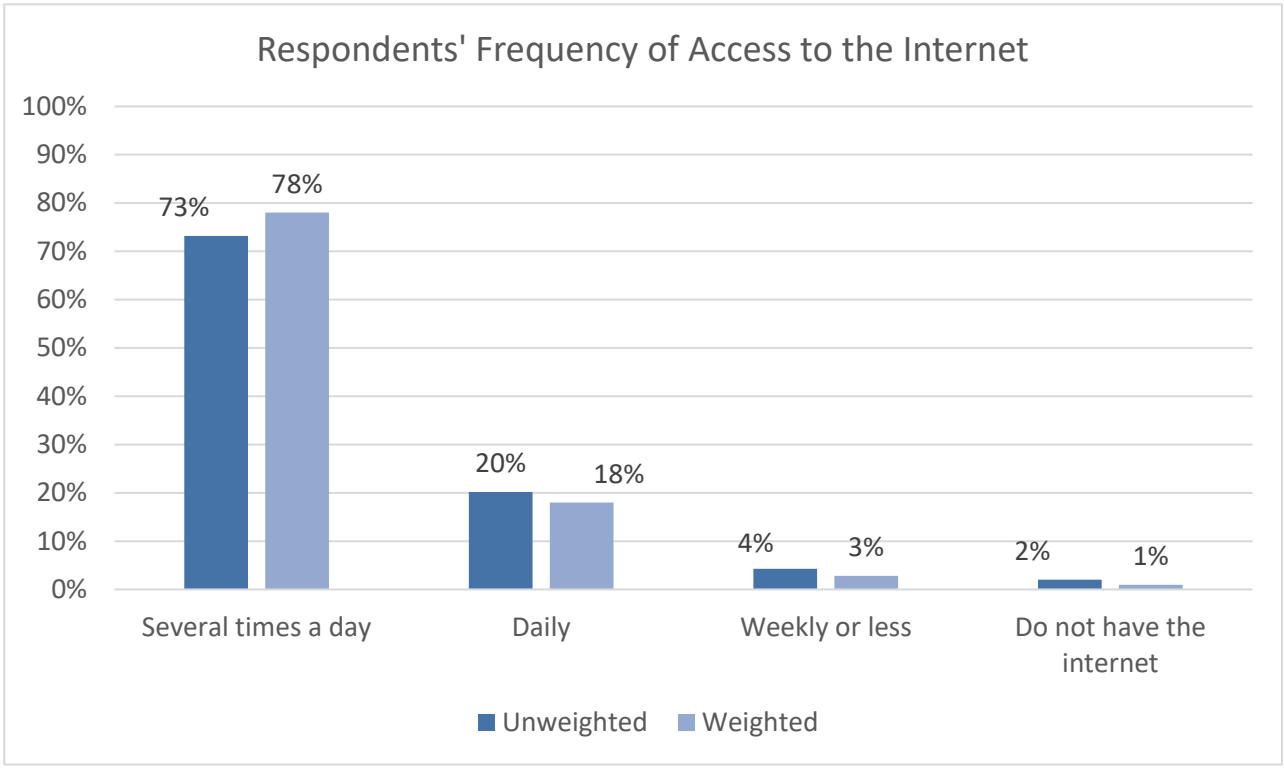


Figure 25: Respondents' general health.

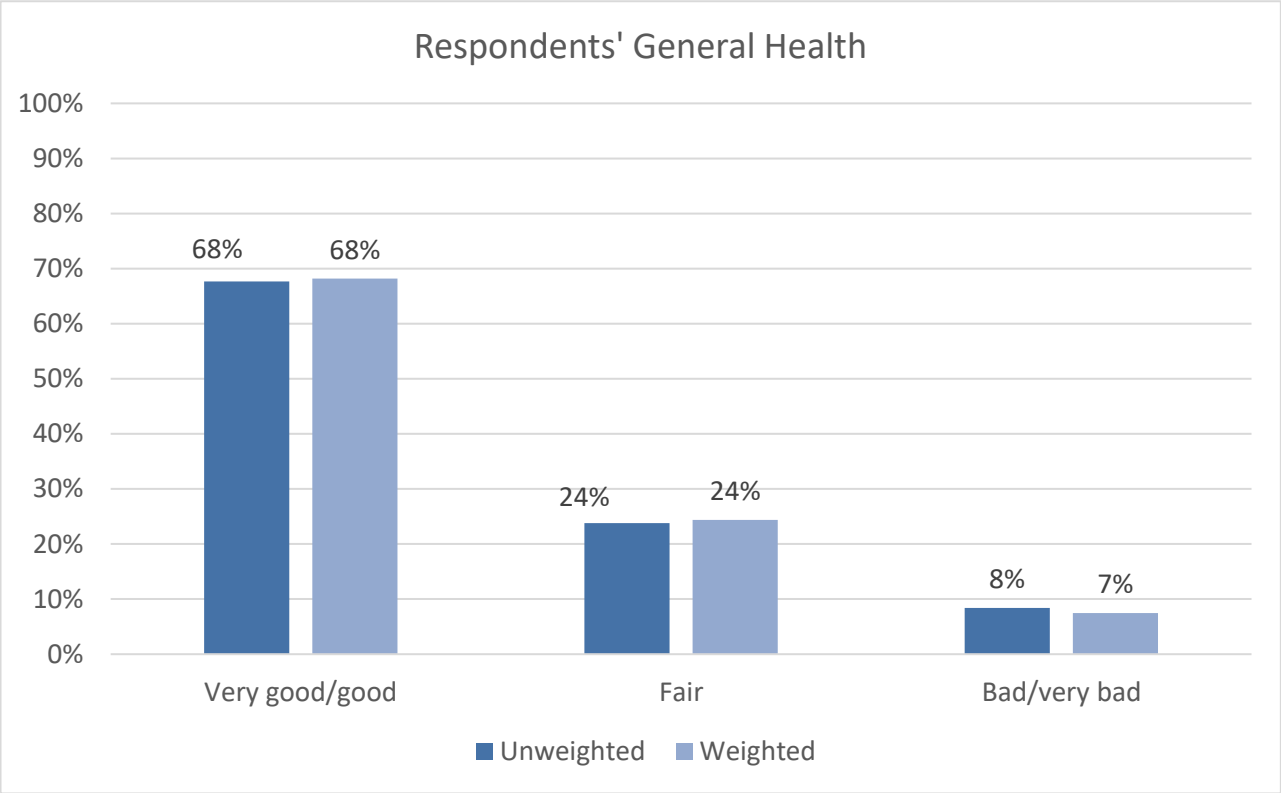
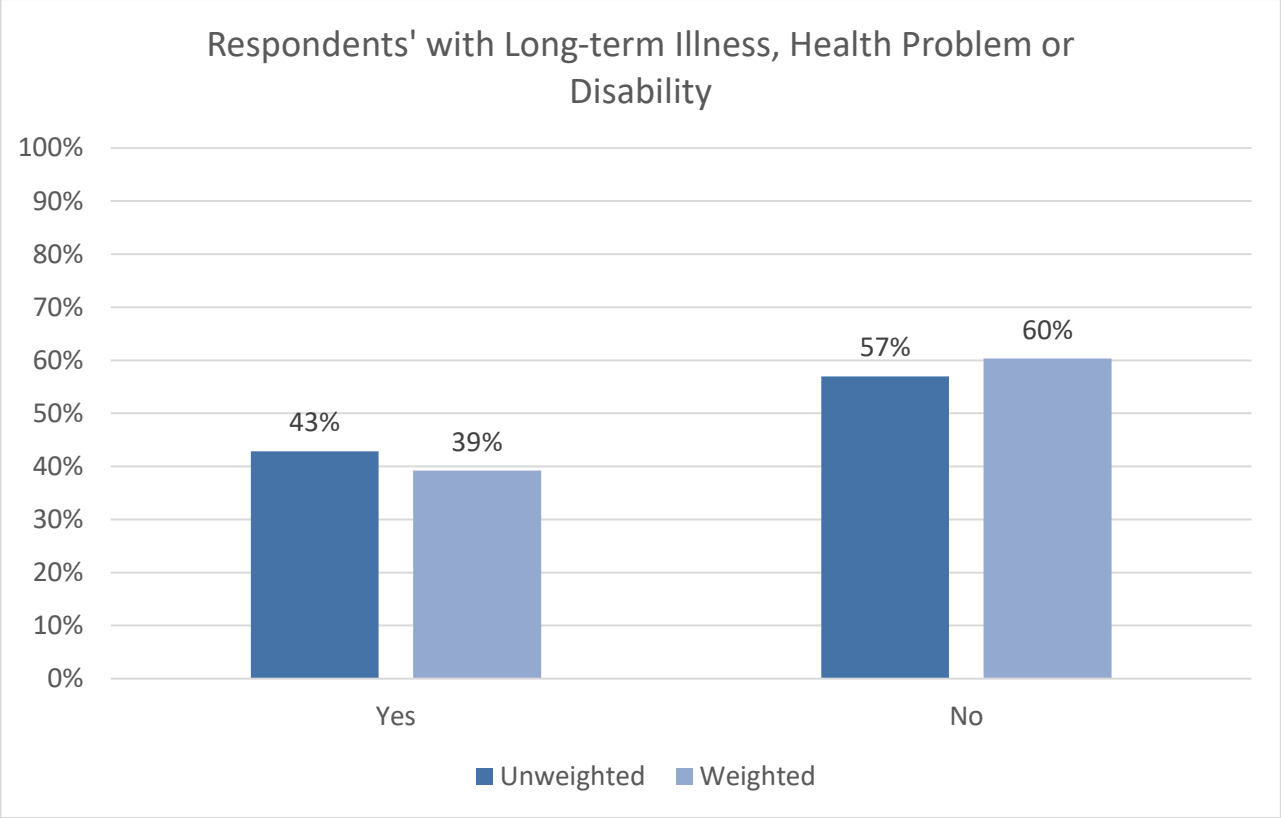


Figure 26: Respondents' with/without long-term illness, health problem or disability.



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