A REPORT FOR PATIENTS

Talking to a computer when you ring your GP

What patients across South Yorkshire told us about "Emma" and systems like her, and what we are doing about it.

Healthwatch Doncaster 2026

In one minute

- Some GP surgeries now use a computer, often called **Emma**, to answer the phone instead of a receptionist.
- It suits some patients very well. It does not suit everybody, and for some people it has made things worse.
- Most of the problems we found can be fixed by the surgery. Many surgeries did not know that.
- If you struggle with it, you can ask to be put on a list, so your calls always go to a real person. Hardly anyone knows this list exists.
- We have written a guide, we want it to go it every surgery, and it says patients must be asked **before** a surgery brings one in, not afterwards.

WHERE THIS STARTED

One surgery, one phone line

This did not begin as a big piece of work. It began with one GP surgery telling us they were bringing in a computer to answer their telephone.

We said we did not think it was a good idea.

The surgery had a fair answer. Every time they asked their patients what was wrong — through the Friends and Family Test, the short survey you may have filled in after an appointment — the number one complaint was the same. **People could not get through on the phone.** It came top every single time. They had to do something about it, and this was what they had found.

That surgery is still using the system today, and it is going well. They have put real work into running it properly, and as this report explains, that is very largely what separates the places where these systems work from the places where they do not.

So we watched, and we waited to see what happened elsewhere.

A different surgery, and how it unravelled

A **different surgery** then brought Emma in, and they had come at it from another direction entirely. They had been losing reception staff faster than they could replace them, could not pay enough to hold on to the ones they had, and could not recruit. The telephone had to be answered somehow.

What happened next happened in a particular order, and the order matters.

How it unravelled

1. Patients could not use Emma. So they did the obvious thing and came to the building instead, arriving before the doors opened at eight in the morning to get an appointment in person.

2. That set patients against each other. The people sitting on the phone working through the computer's questions could see what was happening. While they answered, others were walking through the door and taking the same-day appointments. By the time the phone callers got to the front of the queue, there were none left. They called it queue jumping — and they had a point.

3. Staff took the anger for all of it. Aggression towards the receptionists went up sharply. They were being blamed at the desk for a system they had not chosen and could not fix.

4. So the surgery effectively shut the front door — no more same-day bookings in person.

5. And that is when we were called in.

Closing the door was meant to make things fair. It did not work — because it took away the one route that had been working for the people who could not manage the phone. Nobody was better off, and the staff were still in the middle of it.

Where that surgery is now

They have turned Emma off. It did not work for their patients, and they no longer use it.

We are still there. Being called in over the front door is why we are working with them now, and on the problem underneath all of it, which was never really the telephone. We are in active discussions about supporting their staff to handle difficult conversations with patients, and about training that keeps people in the job rather than watching them leave every few months.

That staffing problem was there before the computer arrived, and it is still there now the computer has gone.

Two surgeries. Two honest reasons for doing the same thing. One is going well and one has turned it off — **and nobody had asked a single patient about either of them. So we went and looked properly**.

WHAT WE DID

We went across South Yorkshire

We reached out to a great many places — GP surgeries, practice managers, reception staff and patients — and we listened to what came into Healthwatch from people who had struggled. We deliberately looked beyond Doncaster, because we needed to know whether this was one or two surgeries having a bad time or something bigger.

It is something bigger. Two examples stood out.

A surgery in Sheffield that stopped

They put a system in, ran it, and **turned it off**. It did not work for their patients, so they stopped. They are not the only ones — but they are a clear example of something patients should know: a surgery can change its mind, and some have.

A surgery in Barnsley that has run one the longest

This is the longest-running example we found, and they are still using it. That does not mean it was easy. Morale among their staff "went through the floor" at the start. The accent caused real problems. The practice manager told us honestly that she had been keen to stop it early on, and that six months in, knowing what she knows, she would do it again.

She also told us something that shaped everything we have done since: **she wished she had had a pack like this before she started.** She would have wanted to speak to surgeries already using one, and there was nowhere to do that.

Same technology. One surgery going well with it, one that has stopped, one that has run it longest and would do it again, and one that turned it off in another town. That variation is the single most important thing we learned, and everything below follows from it.

What is actually happening when you ring

It helps to know what the thing on the other end of the line is doing.

- **Your call is answered straight away.** No queue, no hold music. The computer can answer everybody at once.
- **It asks why you are ringing**, and you answer in your own words — there is no "press 1 for appointments".
- **It works out what you need** and asks you some questions, usually including your name, date of birth and address.
- **It writes it down and sends it into the surgery** as a written request.
- **A person then reads it.** A member of staff decides what happens next, and where it is a medical problem, **a GP makes the clinical decision.** The computer does not decide whether you are ill.

That last point matters, and patients have told us nobody explained it to them. Emma is not diagnosing you. She is taking the message.

THE PATIENT VOICE

What you told us

People tend to contact us when something has gone wrong rather than when it has gone right, and this report should be read with that in mind. But every single thing below was raised by more than one person, at more than one surgery.

"She cannot understand me"

This came up more than anything else. Emma struggles with the Yorkshire accent.

People told us they were asked to repeat themselves again and again. One patient could not get her answers understood across four separate calls, and nearly gave up altogether. A practice manager put it simply — the local accent, she said, "is not easy to pick up on". At her surgery it could not manage a patient's postcode.

When it cannot understand you, it asks you to spell things out. And then it may ask you to spell them the alpha-bravo-charlie way.

> ### Why it does that — and why it still is not fair
>
> There is a real safety reason. If the computer mishears a medicine name, a patient could be given the wrong drug. Saying "M for Mike" removes the doubt.
>
> But think about who that lands on. Most of us cannot spell our own medication. Almost none of us know the phonetic alphabet. And the people most likely to be asked are those with the strongest local accents and those whose names are not common in English.
>
> The reason is sound. The burden does not fall evenly. Both things are true.

Not everybody is online — and this is a big group

Plenty of people do not have a smartphone. Plenty do not have the internet at home. Some have neither.

If a system deals with your call by sending you a link, there is nothing there for you. You are not refusing to engage. There is nothing for you to engage with.

We asked the suppliers directly what happens if you say at the start of a call that you have no smartphone or internet. The answer was that you would **not** automatically be put through to a person — although a surgery can set it up so that you are. Most had never thought to check.

Older patients

Older patients told us they found it hard to follow — what it was asking, why it was asking, and what they were meant to say. Several said they were frightened of saying the wrong thing and being cut off.

> *"It should not be a guessing game. The weakest will fail."*
>
> A patient, to Healthwatch

When you are really unwell

One patient had already tried the app and been offered an appointment a week away. She needed to be seen that day, so she rang. The system kept repeating itself and could not understand her. She was in serious pain and ended up in tears. She explained her symptoms and was told to go to A&E. She hung up.

Nothing about that call shows up in any figure a surgery is shown. As far as the reports are concerned, that call was answered.

The queue at the door

This is where we came in, and we heard it everywhere. When the phone does not work for you, you come to the building instead. Surgeries told us the same from their side — the phones went quiet, the front desk got busier, and staff rotas had to be changed to put more people downstairs.

And it sets patients against each other, which is the saddest part of all of this. The person who rang and did everything properly cannot see why the person at the door gets seen first. The person at the door only came because the phone let them down.

Some people have simply left

Patients have changed surgery over this. They told us they no longer believed they could reach their doctor, and what they wanted was a person — a receptionist, a human being.

If you leave, you do not appear in the complaints figures. Nobody counts you. Nothing gets fixed.

And some people much prefer it

We would be misleading you if we only told you the bad half.

Plenty of people — younger patients especially — told us this suits them far better than what came before. You ring, you say what you need, it goes to the right place, and somebody comes back to you. No queue. No ringing at eight in the morning. No explaining yourself to a person if you would rather not. You can get on with your day.

One woman who works with us put it this way: she can do everything online, she would rather not talk to anybody, she knows a real person will see it and deal with it, and she gets a proper answer. She does not expect it instantly. She just wants it done.

That group is real, and it is growing. Any honest report has to say so.

THE GOOD NEWS

Most of this can be fixed

This was the biggest surprise of the whole piece of work. Much of what patients experience as "how the system is" is not the system at all. It is a setting, chosen by the surgery — or left as it came out of the box because nobody knew it could be changed.

The list that solves it for most people

Every surgery using one of these systems can keep a list of phone numbers that always go straight to a real person. The computer never picks up. It is sometimes called the **vulnerable patients list**, the **bypass list**, or the **VIP list**.

Put an older person's number on it and their phone works the way it always did. Practice managers told us it is one of the most valuable things they have.

Two things go wrong with it. Almost no patient knows it exists — we have dealt with complaints about vulnerable people who were already on the list, where nobody had told the patient or the worried relative. And at some surgeries the only way to ask to go on it is by email or an online form, which means a patient asking to be excused from a digital system has to use a digital system.

If you are struggling, or you are worried about an older relative, ask your surgery to put the number on that list. You can ask on someone else's behalf.

Other things your surgery controls

- **How many times you have to ask before you get a person.** That is a number someone at the surgery has set. Suppliers told us plainly it is adjustable. Some clinicians argue asking once should be enough.
- **Which words get you straight through.** Asking for reception, saying you need to book a follow-up, saying the surgery asked you to ring back — all of these can be set to transfer you immediately.
- **What happens when you say you have no smartphone or internet.**

- **Whether it can speak your language** — and whether anyone has told you so.

The languages point, which could matter enormously

These systems can hold the conversation in other languages. Where that works properly, two good things happen at once: you hear everything — including any safety advice — in a language you understand, and your doctor receives a fuller account of what is wrong, in English, than they would otherwise have got.

Compare that with what usually happens now, which is a relative ringing on your behalf. That relative may get it slightly wrong, may not know your history, and may be the last person you want to tell.

A doctor seeing what you actually said, in your own words, could one day be the difference between spotting something and missing it. This is the single biggest opportunity we found — and at one surgery we spoke to, nobody was aware the function had ever been used.

It gets better — but only if someone does the work

You will be told these systems learn, and they do. What is rarely said is that the learning does not happen on its own.

Somebody at the surgery has to read what comes out of it, spot what has gone wrong, feed it back, ask for changes and check they worked. Realistically that is a full-time job for someone. The surgeries where this has gone well are the ones that put that person in place. The surgeries where patients are still struggling six months later are the ones that did not.

THE OTHER SIDE

Why your surgery is doing this

It would be easy to assume your surgery has done this to save money. That is not what we found, and you are entitled to know what we did find.

They have to answer the phone

Surgeries are now required to keep the phones and the online route open right through the working day, so that when you make contact you get a response rather than "ring back tomorrow". That is a lot to deliver, every day, and they have to find some way of doing it.

They cannot get the staff

The obvious answer is more receptionists. Surgeries told us they cannot afford them and cannot recruit them. It is a hard job — busy, pressured, and receptionists take a good deal of abuse from the public. It is paid at or near the minimum wage. People leave, and where turnover is high you feel it every time you ring.

One of the surgeries in this report came to the system for exactly that reason — not because they were dazzled by the technology, but because they had run out of options. They have since stopped using it, and the staffing problem that drove them to it has not gone anywhere. That is the part that needs solving, and it is why we are now working with them on keeping and supporting their staff rather than on their telephone.

It is not cheaper

One practice manager told us that for what the system costs, she could employ a full-time member of staff — and that a member of staff is what she would personally prefer. Another surgery told its own patients, in writing, that the system had not been brought in to save money and in fact costs **more** than employing a receptionist.

Neither surgery cut a single reception post. One still employs eight receptionists for more than 16,600 patients.

> *"If they could hire more real people and have every call answered by a human being, most of them would. They are stuck between a rock and a hard place."*
>
> What we concluded after six months of asking

And nobody can order them either way

Every GP surgery is an independent business. It makes its own decisions. The NHS locally — the Integrated Care Board, or ICB, the organisation that plans health services across South Yorkshire — cannot tell a surgery to use one of these systems, and cannot tell a surgery to switch one off.

That is why your experience can be completely different from your friend's two miles away. And it is why the answer had to be something other than a rule.

WHAT HAPPENS NOW

What we have done about it

We have written a guide.

A toolkit for any surgery thinking about one of these systems, and for any surgery already running one.

It is not a campaign against the technology. It exists because we found surgeries making a decision this big with very little to go on beyond a sales meeting — and patients living with the consequences.

What the guide asks surgeries to do

- **Ask their patients first.** Not tell them afterwards. Not a notice in the waiting room the week before — which by definition never reaches the people who telephone.
- **Look at who their patients actually are** before they speak to a salesperson. A surgery whose patients are mostly older will get a very different answer from one where many patients speak little English.
- **Work through their legal duties** — including the duty to involve patients in changes like this, and the duty to make reasonable adjustments for disabled patients.
- **Ask the supplier the hard questions** — how it copes with our accents, what happens to someone with no smartphone, what it does with a caller who is crying.
- **Tell patients plainly** what is changing, what to say to reach a person, and that the bypass list exists.
- **Check afterwards whether it is working** — including counting the people who gave up, which almost nobody currently does.

If your surgery does not use one of these systems

This is the part we most want you to take away.

Meaningful patient engagement has to happen before a surgery can bring one of these in. Being informed after the decision is not good enough, and it does not meet the legal duty either.

So if your surgery starts talking about answering calls differently, you should expect to be asked what you think — properly, in a way that could actually change the outcome, including the outcome of not doing it. If that does not happen, tell us.

We cannot make any surgery use the guide. What we can do is make sure that no surgery in South Yorkshire can say afterwards that nobody warned them, and that no patient is the last to find out.

A few words you may come across

- **Triage** — sorting requests so the most urgent are dealt with first, and so you reach the right person rather than automatically a GP.
- **ICB (Integrated Care Board)** — the NHS organisation that plans health services across South Yorkshire.
- **PPG (Patient Participation Group)** — a group of patients that meets with the surgery. Useful, but usually small and not representative of everyone.
- **Bypass or VIP list** — the list of phone numbers that always go straight to a human being.
- **Friends and Family Test** — the short survey asking how your care was.

Tell us what happens to you

Good or bad. If your surgery has brought one of these in and it has worked well for you, we want to know that just as much as we want to know when it has not.

We will keep listening, and we will report on how this plays out across South Yorkshire.

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