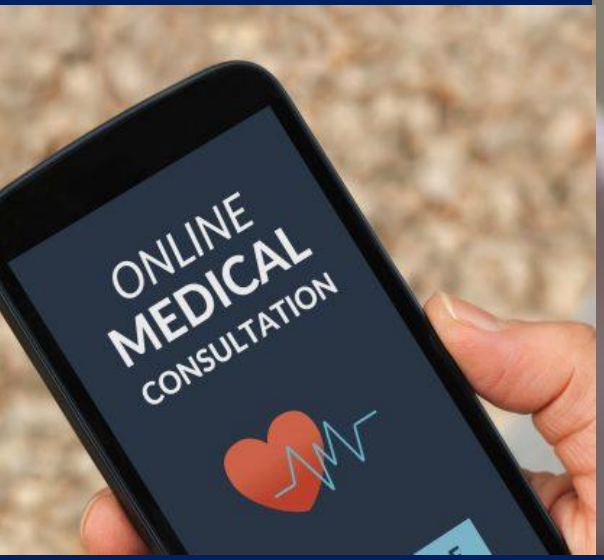
@trishgreenhalgh @oohgpwales





UK Perspective: The Remote by Default 2 study

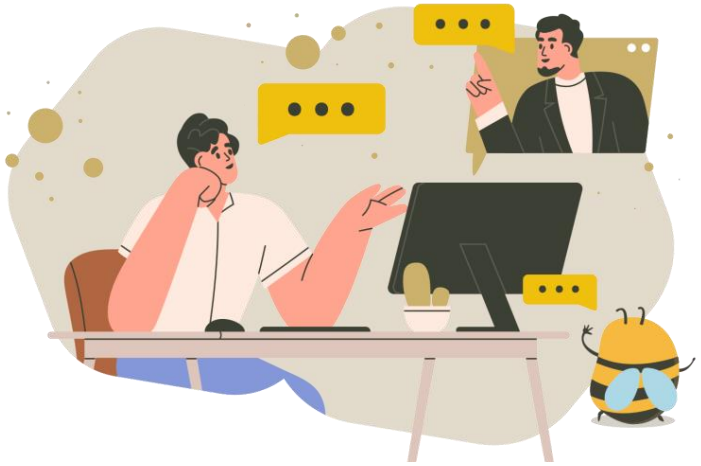
Professor Trisha Greenhalgh, Dr Rebecca Payne, University of Oxford

Acknowledging the wider research team and funding from UK National Institute for Health and Care Research

Remote by Default 2 study: Summary of methods

12 general practices across UK, followed for 28 months using 'researcher-in-residence' model

Longitudinal case studies of the introduction, adaptation, routinization and abandonment of remote and digital technologies and pathways



31 'elite' interviews with (e.g.) policymakers, industry and patient advocacy groups

- Raise awareness
- Build relationship
- Ascertain priorities

National context; engaged network of senior stakeholders

4 multi-stakeholder workshops (210 participants), covering

- Access and triage [*equity*]
- Quality and safety
- Workforce and training
- Technologies and infrastructure

Focused follow-on activities

Theme 1: Patient safety

Credit: Rebecca Payne

12 GP practices, followed for >2 yrs

- No ‘never events’
- No major safety incidents
- We started looking at “how do GP practices avoid safety incidents when providing remote care?”

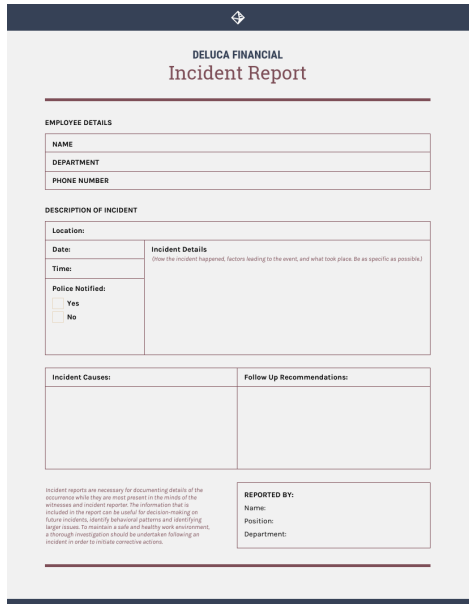
Extensive hunt for safety incidents

National patient safety reports
Urgent care cases

Cases used for training

Indemnity claims (closed)

Complaints



→ 95 incidents over several years

How do practices avoid safety incidents?

Staff err on the side of caution: “bring the kid in”

Staff are well supported, can pass problems up the line

GP practices know [most of] their vulnerable patients

Duty doctor call-back lists are used flexibly and adaptively

Staff are creative: they BREAK THE RULES, invent useful stuff, which then becomes formalised into business-as-usual

(some of many reasons)

But… some questions to ask…

Is the telephone being used well?

Do the practice workflows still work when the patient isn't in front of you?

Can you identify ALL your vulnerable patients (look for them, adapt for them)

Are remote working staff adequately trained and supported?

Are interruptions minimised in busy reception areas?

Are all staff aware of the key clinical conditions and trajectories that are <u>unsuitable for remote</u>

(some of many things)

More information here:

UNIVERSITY OF OXFORD

UNIVERSITY OF PLYMOUTH

nuffieldtrust

ORIGINAL RESEARCH

OPEN ACCESS

Patient safety in remote primary care encounters: multimethod qualitative study combining Safety I and Safety II analysis

Rebecca Payne,[1] Aileen Clarke,[1] Nadia Swann,[1] Jackie van Dael,[1] Natassia Brenman,[1] Rebecca Rosen,[2] Adam Mackridge,[3] Lucy Moore,[1] Asli Kalin,[1] Emma Ladds,[1] Nina Hemmings,[2] Sarah Rybczynska-Bunt,[4] Stuart Faulkner,[1] Isabel Hanson,[1] Sophie Spitters,[5] Sietse Wieringa ,[1,6] Francesca H Dakin,[1] Sara E Shaw,[1] Joseph Wherton,[1] Richard Byng,[4] Laiba Husain,[1] Trisha Greenhalgh [1]

NAME TO WATCH:
Rebecca Payne

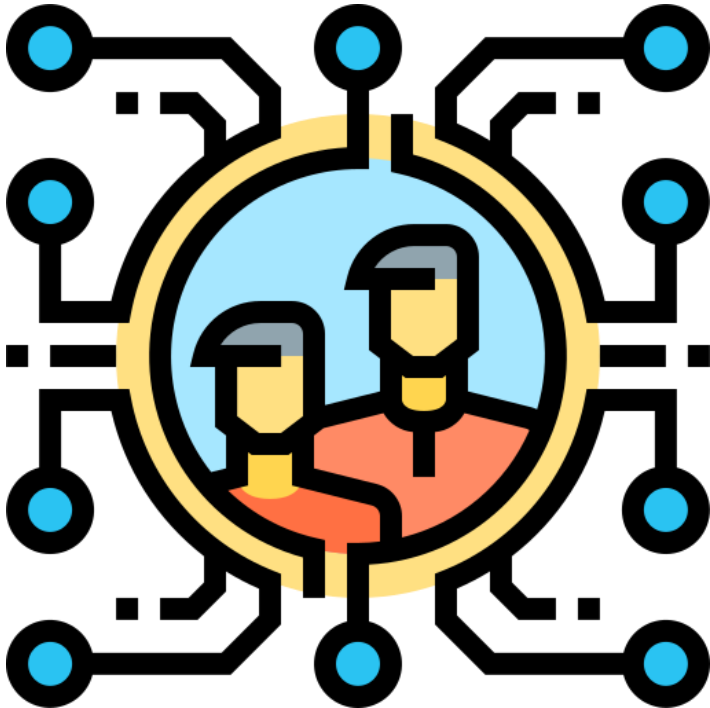
Payne R, *et al*. *BMJ Qual Saf* 2023;**0**:1–14. doi:10.1136/bmjqs-2023-016674

USEFUL RESOURCES

- Patient leaflet/poster
- Competencies for staff providing remote care

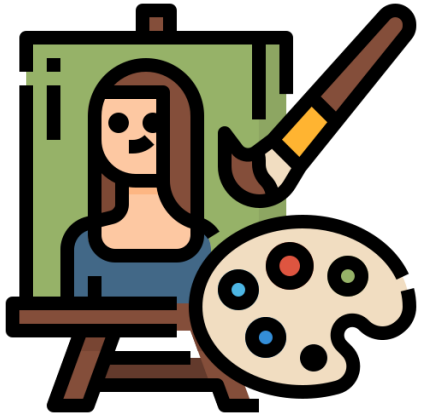
Theme 2: Access, triage, and equity

Credit: Francesca Dakin and Sarah Rybczynska-Bunt



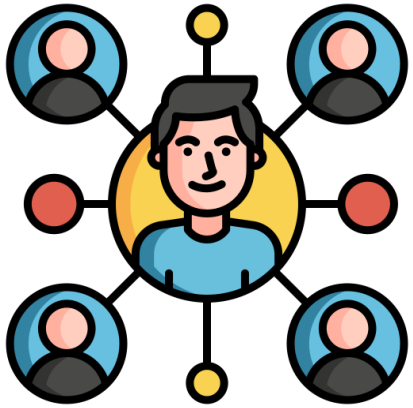
Patients must: **locate and navigate services**, **explain and classify their symptoms**, and **negotiate** with front-desk staff.

Technologies **configure the user** (e.g. touch-tone telephony assumes patient can hear and is able to ‘press 1 for pharmacy, 2 for appointments’ etc). If patient can’t do what is expected, they are excluded.



In an e-consultation, patient must create an accurate and persuasive **digital facsimile on their electronic record** (e.g. to convey “severe pain in lower abdomen 3 days, not getting better”). Patients with low **digital literacy, health literacy, and system literacy** are less able to do this.

Staff use the digital representation of the patient to determine eligibility for care and allocate an appointment. **Safe triage depends on the accuracy of the digital facsimile.**



Sometimes, staff can fill in the gaps when the digital facsimile is inaccurate or incomplete. But this depends on their experience and knowledge of the patient.

Patients' experiences at the 'digital front door' of general practice influenced their **ongoing engagement** with the healthcare system.

Social Science & Medicine 349 (2024) 116885

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Access and triage in contemporary general practice: A novel theory of digital candidacy

Francesca H. Dakin [a,*], Sarah Rybczynska-Bunt [b], Rebecca Rosen [c], Aileen Clarke [a], Trisha Greenhalgh [a]

[a] Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford, UK
[b] Peninsula Medical School (Faculty of Health), University of Plymouth, Plymouth, UK
[c] Nuffield Trust, London, UK

ARTICLE INFO

Handling Editor: Medical Sociology Office

ABSTRACT

To access contemporary healthcare, patients must find and navigate a complex socio-technica and digital actors linked in multi-modal pathways. Asynchronous, digitally-mediated tri largely replaced synchronous conversations between humans. In this paper, we draw on dataset from a multi-site study of remote and digital technologies in general practice to ur inequities of access.

We theorise our data by bringing together traditional candidacy theory (in particular assessment, help-seeking, adjudication and negotiation) and socio-technical and technolog ories (in particular, concepts of user configuration, articulation, distanciation, disembeddin thus producing a novel theory of *digital* candidacy.

We propose that both human and technological actors (in different ways) embody soci affect how they 'act' in social situations. Digital technologies contain inbuilt assumptions al ities, needs, rights, and skills. Patients' ability to self-assess as sick, access digital platforms, navigate multiple stages in the pathway, including adapting to and compensating for limi

NAME TO WATCH:
Francesca Dakin

Received: 23 November 2023 | Accepted: 14 June 2024

DOI: 10.1111/1467-9566.13811

ORIGINAL ARTICLE

SOCIOLOGY OF HEALTH & ILLNESS

The reflexive imperative in the digital age: Using Archer's 'fractured reflexivity' to theorise widening inequities in UK general practice

Sarah Rybczynska-Bunt[1] | Richard Byng[1] | Sophie Spitters[2] | Sara E. Shaw[3] | Ben Jameson[4] | Trisha Greenhalgh[3]

Abstract

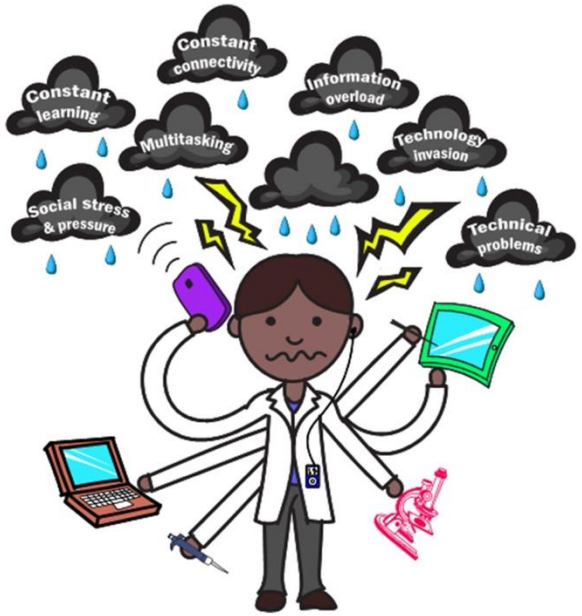
'Reflexivity', as used by Margaret Archer, means creative self-mastery that enables individuals to evaluate their social situation and act purposively within it.

NAME TO WATCH:
Sarah Rybczynska-Bunt

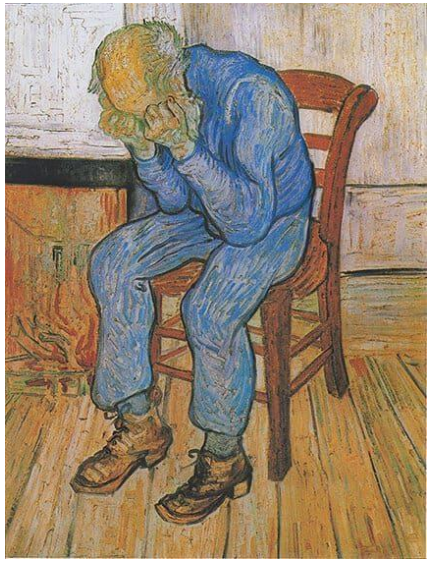
Theme 3: Education, training and workforce

Credit: Trisha Greenhalgh and others

workload



technostress



confidence

TRAINEES' unmet training needs

- Technical competencies
- Triage
- Ethics/medicolegal
- Communication by phone

Experienced GPs' unmet training needs

- Making complex judgements
- Working within the limits of technologies
- Coordinating multi-professional care in a distributed environment
- Supporting trainees

Education, training and workforce

LINK TO PAPER:
(see also next slide for link to specific competencies)

Research

British Journal of General Practice, January 2024

Training needs for staff providing remote services in general practice: a mixed-methods study

Trisha Greenhalgh, Rebecca Payne, Nina Hemmings, Helen Leach, Isabel Hanson, Anwar Khan, Lisa Miller, Emma Ladds, Aileen Clarke, Sara E Shaw, Francesca Dakin, Sietse Wieringa, Sarah Rybczynska-Bunt, Stuart D Faulkner, Richard Byng, Asli Kalin, Lucy Moore, Joseph Wherton, Laiba Husain and Rebecca Rosen

Abstract

Background

Contemporary general practice includes many kinds of remote encounter. The rise in telephone, video and online research; and grey literature (such as training materials and surveys). Data were coded thematically and analysed using theories of individual and team and technology focused. While basic knowledge was often gained using such methods, the ability and confidence to make complex judgements were usually

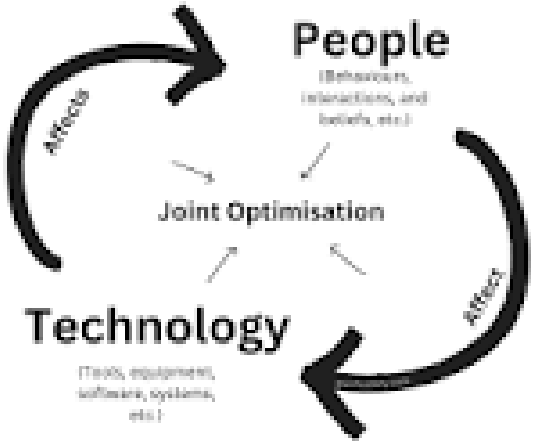
Outline competencies and capabilities for staff providing remote general practice services

Clinical students and novice trainees

Basic descriptive knowledge	› Describe the different kinds of remote consultation (e.g. telephone, video, electronic) › Describe the elements of a clinically adequate, appropriate and safe remote encounter
Technical knowledge and skills	› Make contact with a patient using remote technology including video, telephone and asynchronous electronic [e-]communication, including test calls where appropriate › Describe technical and logistical issues arising within these different modalities › Outline potential harmful impacts of a 'failed' digital encounter (e.g. due to loss of signal)
Triage skills	› Explain why triage to allocate patients to different kinds of encounter may be needed › Identify patients suitable (and unsuitable) for different kinds of remote encounter (telephone, video and e-consultation, SMS messaging, email, answerphone messages)
Knowledge of ethics and governance	› Describe the consent process for a video or telephone consultation › Discuss ethical issues (e.g. confidentiality, data handling and storage, safeguarding, digital exclusion) relevant to different kinds of remote encounter
Communication and clinical skills	› Explain why it is important to establish rapport in a remote encounter › Demonstrate attunement to the patient and their environment in a remote encounter, noticing and responding to cues within the limits of the modality › Demonstrate establishment of rapport in a remote encounter › Adapt method and style of communication appropriately to the remote modality › Take a detailed and careful history, given that clinical examination and non-verbal cues will be limited › Elicit symptoms and signs, including explaining concepts and giving instructions so as to gather information without being able to directly examine or fully observe the patient › Assess and interpret visual physical signs by video, or as described on the telephone, with appropriate caution › Explain the importance and principles of safety-netting in remote encounters › When undertaking remote or digital encounters, identify situations where there is a risk to patient safety and describe appropriate mitigative action (e.g. ask about relevant red flag symptoms, invite for face-to-face assessment, escalate to senior colleague) › Communicate appropriate safety-netting procedures in clinical cases in different remote modalities

(example)

Three (of many) take-home messages for policymakers

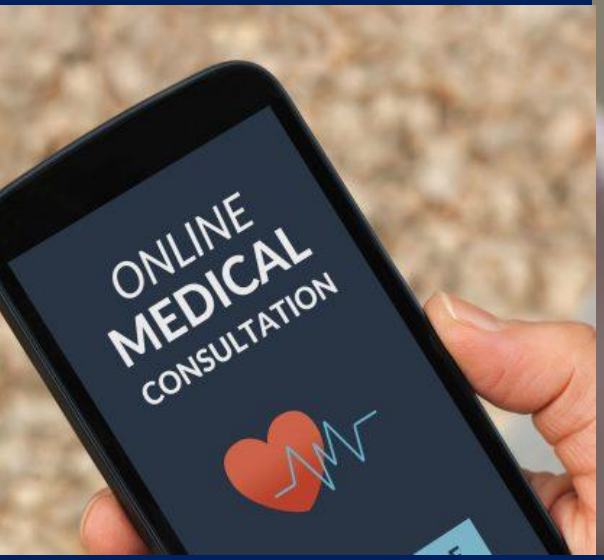


Technologies are never ‘plug and play’: they are complex interventions in complex systems which involve PEOPLE.

Modern general practice involves work that is DISTRIBUTED across people and technologies. Think about the SOCIO-TECHNICAL SYSTEM, not just individuals operating technologies.

Low health literacy
+
Low digital literacy
+
Low system literacy
=
VULNERABLE PATIENT

@trishgreenhalgh @oohgpwales





Thank you for your attention

Professor Trisha Greenhalgh, Dr Rebecca Payne, University of Oxford

Acknowledging the wider research team and funding from UK National Institute for Health and Care Research