EVIDENCE BRIEF

Making Remote General Practice Safer

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SUMMARY

This briefing covers

- Summary of research findings on patient safety
- Who should be seen face-to-face?
- Staff training for remote primary care, including specific competencies

The material presented in this pack is based on the findings of the Remote by Default 2 (RBD2) research study, a collaboration between the University of Oxford, University of Plymouth and Nuffield Trust, which ran from mid 2021 to end 2023. RBD2 was funded by the National Institute for Health and Care Research, grant number 132807.

See also:

Payne R, Clarke A, Swann A et al. Patient safety in remote primary care encounters: multi-method qualitative study combining Safety I and Safety II analysis. BMJ Quality and Safety 2023, https://doi.org/10.1136/bmjqs-2023-016674

Greenhalgh T, Payne R, Hemmings N, et al. Training needs for staff providing remote services in general practice: a mixed-methods study. British Journal of General Practice 2024; **74**(738): e17-e26. https://doi.org/10.3399/BJGP.2023.0251

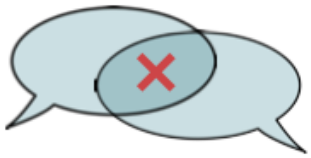
Remote by Default 2 website https://www.phc.ox.ac.uk/research/groups-and-centres/interdisciplinary-research-in-health-sciences/remote-by-default-2

KEY FINDINGS ON PATIENT SAFETY

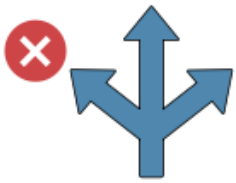
When we studied 12 general practices over 28 months, we didn't find any examples of patients coming to harm as a result of telephone or video encounters. This was mainly because staff were very aware of potential safety issues and tended to 'err on the side of caution'.

Using various national sources (e.g. complaints, closed medico-legal cases), we collected 95 examples of patients who had come to harm following a remote consultation. It's important to learn from these rare examples.

Safety incidents were sometimes caused by a busy staff member becoming distracted (e.g. a receptionist taking a call from a sick patient but forgetting to tell the doctor), especially when there was high workload and staff shortages.



Some incidents were linked to poor communication – such as the doctor not listening sufficiently closely, not asking enough probing questions, or jumping to conclusions about the likely diagnosis.



Sometimes, a patient was allocated to the 'wrong algorithm'. For example, a patient telephoned about 'throat pain' and was treated as a sore throat when the actual problem was a heart attack.

Some cases were difficult or impossible to assess safely by telephone. These included acute emergencies (e.g. possible appendicitis), very young patients, patients with complex medical or social needs, and patients unable to communicate fluently in English.

The bottom line:

- A well-staffed practice is a safe practice. Cover busy periods adequately and have contingency plans for staff absences.
- Train all staff to use the telephone to its full potential.
- Without visual cues like body language, it's even more important to listen closely and give patients time to tell their story and say what's troubling them.
- Identify potentially vulnerable patients (e.g. hard of hearing, elderly with limited English) and flag their record.
- Have protocols for problems that need in-person assessment, e.g. sick baby, acute chest / abdominal pain.
- Patient who haven't improved despite two previous phone consultations should be seen in person.

WHO SHOULD BE SEEN FACE-TO-FACE?

The following table gives examples. It is not intended to be exhaustive or rigidly applied. Use it flexibly and with attention to contextual factors.

DOMAIN	EXAMPLES
Clinical conditions for which an in-person assessment is often required (e.g.)	Acute emergencies e.g. chest/abdominal pain, breathing difficulties Breast lump Palliative care Physical injury New psychosis Diabetes reviews where eye or foot examination needed Persistent or progressive skin lesion Acute history that does not make sense
Clinical trajectories for which an in-person assessment is often required (e.g.)	Condition has not resolved as expected, or has progressed, after previous remote consultation(s) Escalating parental concern Acute condition overlaid on pre-existing complex illness (including mental health)
Patient-level features that make remote assessment more difficult and suggest a lower threshold for defaulting to in-person (e.g.)	Extremes of age Care home residents if on-site staff not confident to undertake observations Language non-concordance Relevant impairment (e.g. deafness) Conditions that may complicate communication (e.g. autism) Low health literacy or system literacy Lacks key technologies or the ability to use them
Key features of effective safety-netting	Make clear to patient what the next steps in their care are, what to do if things get worse and action to take if expected care (e.g. a call-back) does not happen Make all points explicit; do not assume the patient already knows Fully document what safety-netting advice has been given Back up verbal advice with text or email, including leaflet or web link if appropriate Avoid rigid protocols and over-scripting (but if non-clinicians are giving safety-netting advice, consider some basic standard scripts) Ask patient/family member/carer to repeat back safety netting instructions

Organisational- and system-level measures	Adequate staffing and appropriate mix Optimise triage pathways and workflows for remote encounters Protocol for times of extreme stress (staff absence, high demand) Reduce distractions Optimise relational continuity for complex and vulnerable patients (e.g. elderly) and continuity of illness episode for all patients Provide training for all staff (not just in the technology); train for capability (taking initiative, playing hunches Encourage workarounds and purposively develop norms for flexible working
Advice directed at patients and carers (for example…)	Think about how to describe your symptoms clearly before the appointment (write down key points if that helps you). Think about whether you need to have someone with you when you have your remote appointment (e.g. to help with the technology or with communication). If you think an in-person consultation is needed, say so when you book the appointment and explain why. An in-person appointment is likely to be needed for (for example): • Chest pain/shortness of breath • Abdominal pain • Injury caused by a fall or accident • Unusual lump • Urgent mental health problem • Persistent skin problem • A child or someone in care who is unwell • If you have already had two remote appointments for a problem that isn't improving Be sure to tell the clinician all the key points about the current problem, even if you have told someone else from the surgery beforehand. Mention other conditions that may be relevant—for example, diabetes, a heart or chest condition, or a mental health condition. If you are very concerned about the problem, especially if things are getting worse, say so clearly. Ask the clinician to explain what happens next after the appointment and what to do if your symptoms do not improve. If you would like them to explain something again (to you or the person helping you), ask. Ask them to send you instructions (e.g. via text message) if you would like this, and to include any further information e.g. a leaflet.

STAFF TRAINING AND CAPABILITY

Training needs to take account of the fact that general practice is a busy and complex environment which is often understaffed. Workflows are complex, posing challenges for staff and patients. Patients often have encounters with many different team members during the course of an illness, sometimes over several years.

We asked staff what their priority training needs were:

Experienced clinicians felt they needed training in:

- Technical skills to use remote technologies
- Communication and clinical skills to help them work effectively when using remote technologies
- Implementation skills to help them embed remote care within the practice
- Teaching skills so they could train staff and patients in using remote healthcare

New clinicians felt they needed training in:

- Technical skills to use remote technologies
- Correctly triaging patients
- Dealing with privacy, consent and information governance in remote consultations
- Communicating effectively with remote patients
- Assessing and examining a patient

Support staff felt they needed training in:

- Technical skills to use remote technologies within the practice's workflows
- Efficiently and safely assessing whether patients were suitable to use remote technologies
- Triaging and prioritizing patients
- Communicating effectively with patients by phone, text or other remote modalities

In the next few pages, we offer some draft competencies for different staff groups.

Outline competencies and capabilities for staff providing remote general practice services

Based on Greenhalgh et al: *British Journal of General Practice*, 2023; DOI: https://doi.org/10.3399/BJGP.2023.0251

STAFF GROUP	DOMAINS AND EXAMPLE CONTENT	
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

Established clinicians

In addition to demonstrating a high level of competence in all the above:

Advanced technical knowledge and skills	› Remain up to date on new and emerging technologies to support remote encounters › Adopt, select and use a range of technologies to support remote encounters, including traditional (e.g. telephone) and digital modalities › Demonstrate a sophisticated understanding of how particular remote and digital technologies fit with workflows and routines across their own organisation › Use remote and digital technologies to help achieve team-based multi-professional care in a multi-modal care environment (e.g. through continuity of record-keeping for episodes of illness) › Be aware of how informational and managerial continuity are achieved between organisations eg: pathways for electronic referrals, results and discharge or outpatient letters between primary and secondary care, and how breaches in continuity may occur › Know how to obtain technical help when troubleshooting fails
Advanced triage capability	› Work within the limits of remote technologies and care models, supporting patient choice as far as possible and knowing when to advise a patient that they need in-person assessment › Quickly and accurately identify patients who are sick and require physical assessment or more urgent care › In situations where in-person appointments are limited, prioritise patients for those slots › Make creative use of digital technologies to support the triage process and associated workflows consultation
Advanced communication and clinical capability	› Build and maintain therapeutic relationships through remote modalities, conveying attentiveness and compassion to the patient › Practice appropriate telehealth etiquette, adapting to different patients' communication preferences and styles › Cope with minor technical glitches such as lag or crackle using linguistic techniques such as repetition and repair › Negotiate with patients who request a particular modality that does not align with clinical need or capacity constraints › Use advanced history-taking, questioning and probing skills, and elicit and interpret patient self-assessment data appropriately, to compensate for lack of in-person clinical assessment › Ensure that the clinician's full duty of care is realised in terms of responsibility for assessment, investigation and treatment, onward referral, outcomes and documentation › Show awareness of, and sensitivity to, specific groups that may be more vulnerable to miscommunications or misinterpretations in remote encounters eg: older people, those with hearing impairments, those with learning disabilities, some neurodivergent people, some with emotionally unstable personality disorder, limited English speakers › Take action to mitigate inequities that arise from people's differential ability or willingness to use remote and digital modalities › When undertaking remote or digital encounters, consistently identify subtle clues that may indicate a risk to patient safety and take appropriate mitigative action
Advanced knowledge in ethical, legal and regulatory domains	› Ensure patient privacy and consent during remote assessments and data gathering, including where safeguarding issues are pertinent (such as possibly-coercive relationships, children and teenagers, cognitive impairment, limited English proficiency) › Demonstrate a good working knowledge of when and how to pursue safeguarding concerns through local processes and safeguarding leads › Demonstrate understanding of relevant security and information governance rules and regulations › Demonstrate understanding of the legal limits of care provided across jurisdictions (e.g. national borders), and the implications for indemnity
Digital implementation skills	› Contribute to selection and procurement decisions for technologies to support remote and digital care › Contribute to the on-going development and embedding of digital technologies in local settings, co-adapting technologies and workflows and identifying potential design improvements › Develop and adapt remote and digital workflows and practices to optimise safety
Supervisory, teaching and coordinating roles	› Ensure appropriate supervision and support is in place where needed when trainees and allied health staff are involved › Motivate patients to try remote technologies; explain the 'rules of engagement' for remote encounters to them; and assist them to use and troubleshoot technologies in this context › Support and motivate fellow staff members to learn to use remote technologies › Manage scenarios where team members may be in different locations (e.g. learner is with patient vs. learner is with supervisor vs none are co-located

Strategic role (e.g. senior manager, clinical director) 	**System-level perspective on remote and digital service provision**	› Ensure that the organisation adopts a variety of information and communication technologies to deliver high-quality, safe, patient-centred care to diverse populations in a variety of settings › Work within the health care team and setting to ensure that remote encounters function well within a system or programme of care that has continuity and follow-up as needed › Monitor, evaluate and continuously improve the organisation's digital maturity and success in delivering remote and digital services › Proactively address digital disparities and the needs of excluded and underserved groups by providing multiple access options and care navigation as appropriate › Assess and address the multiple training needs of individual staff members and teams, including but not limited to the introduction of new digital technologies › Put systems in place to proactively identify and address safety issues arising from the remote delivery of care, working with technology suppliers, patients, regulators and others
Support staff 	**Basic system knowledge**	› Describe the different modalities of patient encounter (triage or consultation) available in the practice › Outline the key remote and digital workflows for which their role is relevant
	Technical knowledge and skills	› Be familiar with the remote and digital technologies associated with their role, including supporting patients to use these technologies › [Where appropriate, show and support other staff members to use these technologies]
	Triage skills	› Explain why triage to allocate patients to different kinds of encounter may be needed › Gather information appropriately from patients and identify those suitable (and unsuitable) for different kinds of remote encounter (telephone, video and e-consultation, SMS messaging, email, answerphone messages) › Be familiar with measures used in the practice to aid remote triage eg: asking patients to send a photo of a skin complaint › Outline the principles of safety netting
	Communication skills	› Use professional and 'customer care' approaches to communicate with patients remotely, conveying attentiveness and compassion › Be aware of the kinds of patients who may require support or flexibility with communication › Recognise the need to mitigate digital disparities › Deal effectively and sensitively with patients who are upset or insistent in a triage encounter
	Safety-critical clinical knowledge	› Be aware of 'red flag' priority symptoms (e.g. bleeding, difficulty breathing) and the process for escalating these › Be aware of practice protocols for particular scenarios (e.g. young children, abdominal pain) and apply these during triage encounters