Getting the best out of the new world of remote and digital general practice

Covid-19 brought perhaps the most dramatic shift in general practice since the dawn of the NHS, with hundreds of millions of requests and appointments shifting to the telephone or to apps. As the pandemic calmed, early political enthusiasm for GP consultations being "remote by default" waned as patient frustration grew. The growth in remote consulting has brought a range of new digital tools into general practice. But it has also brought fears that patients with a clinical need to be seen face-to-face will not be, and that some will be left behind.

The Remote by Default research project, conducted by a team of academics and funded by the National Institute for Health and Care Research, asks whether remote consultations should really be the default option. When is this safe? What does it mean for different patient groups trying to get treatment, for doctors and their colleagues? We closely observed 11 general practices working, and held workshops and interviews to understand more. This briefing summarises key findings, and actions required now from government and the NHS.

Key points

- There are benefits of digital and remote care but they are hard won, and just having the technology does not achieve them. Huge effort is needed for implementation, and poorly designed digital services can be more inefficient. The way patients access general practice has to be carefully redesigned ensuring fair access for all; additional support for vulnerable patients; quality assurance and safe processes.
- Practices and their registered patients are at very different stages in their ability to use technology, and this needs to be reflected.
- Making remote consulting safe requires fundamental changes in every part of the journey from requesting an appointment to consulting a clinician. It requires new skills and behaviours in both staff and patients. We have developed guidance on what needs to be done, and this needs to be a national priority.
- Quality for some is achieved at a cost to others, with vulnerable populations at particular risk of exclusion. The processes through which people are excluded are currently hidden in the day to day activities of practices and need further research.
- The way technology is purchased is often much too focused on just installing whatever the supplier offers, not reflecting how the practice wants to work. Training needs to improve and staff culture has to evolve. There are still fundamental problems with hardware and broadband in places.

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1. Is remote general practice safe?

Safety errors are rare in remote general practice. But a small number of deaths and harms can be attributed to the shift to greater remote consulting. Alongside our other research, we published a paper reviewing 95 incidents of safety complaints and reports[1] to look into what can happen, why, and what to do about it.

What we found

We found that remote consultations risk losing both clinical and non-clinical types of information including about social circumstances and safeguarding. And a failure to develop rapport with patients contributed to some of these incidents. In a system originally set up to see patients in person, information can be lost in the move to in digital ways of booking appointments and screening patients, and in not seeing their body language in person.

Remote consultations carry more risk for patients with certain serious conditions including new chest or abdominal pain, physical injuries or diabetes. Safety risks include missed or inaccurate diagnoses, under-estimating how severe a problem, delayed referral and treatment and inadequate follow-up.

Remote consulting can carry particular risks among very old or very young patients, patients in some care settings, and those facing more difficulty communicating such as people who are hard of hearing or speak a language the clinician does not. Remote consulting can also be riskier for patients who struggle to understand how the health system works or if they lack technology such as a smartphone or are unable to use it.

What needs to be done?

We found the communication between the clinician and the patient is vital. Practices need to make sure patients don't get lost in the system of electronic contacts and referrals. A public information campaign should inform people about what they can expect from remote consultations and when they are safe. At the end of a patient consultation, clinicians should ensure the patient knows what the next steps are in their care, and who to contact if things do not go to plan. Verbal advice should be backed up with a text or email and the clinician should get the patient to repeat back the instructions so that everyone is clear.

The government should explore options for developing national guidance on safe consulting through an expert group or organisation such as NICE, looking at key issues like when people need to be "red flagged" for assessment in person – for example, if their condition

deteriorates. National guidance to GPs should tell them which conditions and patient characteristics tend to be high risk if they are dealt with virtually.

2. What is the effect on NHS staff?

The move to remote booking and appointments has transformed what it means to be a GP, a practice nurse, or a receptionist. It comes at a time when the number of GPs per patient has been falling, creating great pressure on staff and concerns about burnout and early retirement.

What we found

Most staff have embraced remote care models. They have adapted the way they work and see a number of advantages, including convenience for themselves and for some patients. It has become easier for some roles to work flexibly, so staff can increase their NHS work by choosing working hours that fit around personal responsibilities. However, improved efficiency or capacity can be offset by inefficiencies. Remote work may mean more contacts without the patients needing to travel, but an increase of clinical and admin time spent on dealing with the same health problem over all.

Many staff thought that the increased ease of booking a virtual appointment meant people with minor problems who did not need an appointment took up more time. Some clinicians felt less satisfied with their jobs as a result of limited opportunity to build rapport with patients, and more isolation. Often, reception staff feel they work in a ‘call centre’ with intense back-to-back calls and hostility from patients.

Many staff, from the most senior GP to the newest receptionist, said that they had not been fully and properly trained to deliver remote care at the pace expected. Most current training is focused on new technologies and takes place in classroom or self-study online, but staff perceived themselves to learn better ‘on the job’, and felt formal training should reflect this through the use of shadowing and learning as a team.

What needs to be done?

Alongside our case studies, we arranged a series of interviews with people who trained GP staff, and staff themselves to understand the skills needed.[2] We believe national UK bodies like Royal Colleges, and the General Medical Council should endorse the list identified through this study of the competencies and capabilities people need. The government should

run a trial of a national programme for training reception staff, as the Netherlands has successfully introduced.

NHS England should draw on its £240m reform fund for practices to train staff in digital competencies through training focused on coordinated teamwork, so that doctors, other clinicians, and admin staff build skills working smoothly together. Practices should be supported by national bodies to introduce flexible working, so that staff can offer time whenever it is available – potentially by giving them IT equipment.

3. Do these changes make it easier or harder for patients to get fair, equal access to care?

Digital general practice means more than just remote appointments, including booking done through apps and handled by algorithms and phone systems, and reviews of long-term conditions and other routine checkups via texts and online forms. We studied whether these processes were easier for all patients, or if they were difficult or unsuitable for some.[3]

What we found

Some practices give every patient the option of a face-to-face appointment. Others, though, simply don't have enough staff available in person and so are not doing this.

GP practices are using very different ways to decide which patients need and receive different types of appointments. Some have a GP reviewing every contact and deciding based on information patients put into an app; others have a receptionist; and others have a mix of patients coming into the surgery and calling the reception, being screened by receptionists in different ways. There is a lack of evidence on what is best for providing the care people need. Partly, this reflects that practices are simply at very different stages in their competency and ability to use these technologies successfully.

Approaching general practice digitally with multiple apps and forms can be difficult and confusing, and leave people feeling that it isn't worth it or their problems aren't serious enough. We should not assume that groups with chronic illnesses do not want face to face appointments, when in reality they might be struggling to make it happen.

Some patients are very happy with remote consultations. Others, even when they can access them easily, feel "fobbed off". We found that even where doctors thought a remote

consultation had been good and appropriate, patients could feel less confident about what the clinician's real response to their problems was than if they had sat with them in person.

There is a real risk that better, more convenient care for some people is at the expense of others. Strong evidence shows that "continuity of care" – seeing your own GP or clinician – is associated with better outcomes, but it can be squeezed out in attempts to simply maximise the rate of appointments.

Articulate, educated patients may be better placed to play the system to obtain more care. But vulnerable groups including homeless people, refugees, and people with visual or cognitive impairments struggle with access across multiple services and are particularly likely to be overwhelmed by these barriers. They need personalised support to navigate health, social care and other agencies. Those with long-term conditions may have come to view difficult symptoms as normal, and not enter them in forms. Poverty can be a barrier to the Wi-Fi or mobile internet which is a necessity to approach GPs in this way, and the data show clear inequalities.

What needs to be done?

In England, a Delivery Plan exists for rolling out digital telephony that allows automatic booking, logging symptoms, and quick decisions. But implementing it requires big changes to how practices run. Much of this is down to local leaders in "primary care networks", but MPs who are approached by constituents may wish to identify opportunities to help local practices get it right.

The UK Government digital inclusion strategy is a decade old, and a new one should be drawn up to reflect that fact that the NHS now relies much more on digital contact. This should include plans to let people use local amenities like libraries and community centres to access digital services. They should ensure this is aligned with the strategies published in Scotland and Wales, and establish a cross-government unit to oversee implementation, as recommended by the House of Lords Communications and Digital Committee.

4. How do we get better use of technology in general practice?

Underlying all these changes is the technology itself – from telephone systems, to algorithms, to artificial intelligence – and how ready general practices are to make good use of it. The NHS contains some state-of-the-art digital infrastructure such as the Health and Social Care Network ('The Spine'), along with much older local and regional IT systems, many of which cause frustration by not working well together, and don't cover all services. The telephone is often the first option, and still the universal backup. Our study is also working to draw out how to improve the purchasing and use of technology in general practice, nationally and locally.

It is not as simple as just buying new kit

Having access to technologies, and the basics they require like high-speed broadband, is necessary but it is not enough. We have seen too many examples of purchasing which focuses more on trying to embed a new product than it does on making sure that technology is actually playing a useful role helping to make decisions, giving different options for treatment, and arranging things conveniently for patients and staff. This is where real progress can happen – and it is often hard-won in a service under so much pressure that any time to step back can be difficult to find. Progress means having periods of time set aside for people to learn and reorganise. This was partly recognised by funding in the recent GP Access Recovery Plan: it needs to keep being recognised as change continues.

There is no one-size-fits-all solution

Technologies introduced to support remote consulting are effective when they align with the ways that each individual practice manages their work. The choices that each practice makes around digital and remote care is shaped by the infrastructure they started with and the way they organise themselves, leading to the selection and use of particular technologies and process. This means each one will have a different path to adapt and improve, and it is important to acknowledge and foster those different approaches.

General practice must not be forgotten

Compared to health services in other countries, general practice is particularly central to the NHS. It controls patient journeys across the whole NHS and their records, and if it is not ready to use digital technology smoothly to get patients the right treatment, the entire health

service will fail to do so. A crucial decision later this year will be how much of the planned £3.5bn in additional investment spending for NHS technology – and equivalent funds for Scotland, Wales and Northern Ireland – is used to support the kinds of training and investment we have shown are needed for remote general practice.

Rules and regulations matter

During the pandemic, red tape was relaxed to allow video conferencing tools such as Skype, WhatsApp and Facetime, and a plethora of other commercial products. This helped drive rapid change. But there are real trade-offs: some practices are still stuck with the firms which signed them up for "free trials" during COVID-19, while remote digital providers who can sign up disproportionately young and healthy patients will not be competing on an even footing with traditional GPs.

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[1] Payne R et al. (2023) 'Patient safety in remote primary care encounters: multimethod qualitative study combining Safety I and Safety II analysis'. *BMJ Quality & Safety*.

[2] Greenhalgh T et al. (2024) 'Training needs for staff providing remote services in general practice: a mixed-methods study'. *British Journal of General Practice*.

[3] Dakin F et al. (2024) 'Access and triage in contemporary general practice: A novel theory of digital candidacy'. *Social Science and Medicine*.

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