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https://wihsc.southwales.ac.uk · https://wihsc.southwales.ac.uk/cymraeg · wihsc2@southwales.ac.uk

With 2020 Vision: lessons for health, care and well-being: COVID-19 and primary care

Jonathan Richards

PLUS ÇA CHANGE: PERSONAL CARE OR PERSONALISED CARE?

A personal introduction

There are four recent generations of doctors in my family. My grandfather and great grandfather were general practitioners in Cardiff, an uncle was a surgeon in Poole and my working life was in general practice in Merthyr Tydfil. At the centre of one hundred and forty years of our collective careers — the doctor-patient relationship.

From my great grandfather consulting in his family home and visiting on his bicycle in the 1880s to my training to use video consultations and the latest NHS Apps as I prepared to return to support the National Health Service during the early months of COVID-19, we doctors were in the business of responding to people who considered that they needed our help.

I registered as a patient in my grandfather's old practice when I started at Medical School in 1973. It was a modified family home. I had to join everyone else waiting in the front room, queuing for my turn. There was a hatch through which a distant receptionist called my name to consult with the general practitioner who had taken over when my grandfather died.

Ten years later, I was starting out in general practice myself. I worked in a purpose-built Health Centre opened in 1973. Our receptionists were all older ladies and traditional 'dragons' who protected the doctors from trivia and nuisance. I had been trained to be "patient-centred" and felt very uncomfortable. Gradually we were able to recruit a younger team who benefitted from some training in "customer service."

A further ten years on, I was in a new general practice team, working in an up-to-the-minute building. The 'Primary Care-Led NHS'[1] was our aim and ambition. We had the latest computer hardware and software. We adopted the recommended best practices and were proud of our practice systems and organisation. When we were inspected by the Community Health Council (CHC), I was shocked by their first comments:

[1] Meads G ed. (1996) *A Primary-Care Led NHS: Putting it into practice*. FT Healthcare London.

> *You have impressive systems here. However, they are all designed to make your lives easier. It is hard to be one of your patients and access the services that you offer.*

We had not expected this and spent the next twenty years experimenting with different systems to make it as easy as possible for people to access our services.[2]

Towards the end of my working life as a general practitioner my team was an early adopter of one of the most popular software packages designed to make the most of the opportunities afforded by email for communication and the internet for information and advice. The marketing came with banner headlines of "95% user satisfaction". I eventually discovered the report on which this claim was based: a survey of young commuters in London using the app for minor illness and health worries while they were at work. There were almost no respondents from any disadvantaged group or people living with a long-term condition and there were no responses from those not able to access a digital service. Our practice stopped using the system because we did not think that it saved us time or improved access for people.

PERSONAL CARE BEGINS WITH ACCESS

Access to a consultation is one of the most important priorities for the general public and has been a priority of Welsh Government since its inception.[3] When Jane Hutt was the Minister, she changed the promise to the people from "you can access a doctor…" to "you can access a health professional…" There were trials of extended opening hours as well as "sit and wait" and "telephone first" systems.

The COVID crisis has changed the ways in which people can access services in complex ways. Many of the changes that we experience now were hoped for when Welsh Government published their latest strategy for Health and Social care in 2019 – 'A Healthier Wales':[4]

> *New technologies and digital approaches will be an important part of our future whole system approach to health and social care, but they will only be a part. Some people will be unable to access digital services, others will choose not to. Face-to-face and hands-on human contact is an extremely valuable and absolutely essential part of care and treatment. There are many things which cannot be delivered digitally or through technology.*

As the lockdown began to have its impacts in Spring 2020, Wales led the United Kingdom in the introduction of remote consulting for general practitioners and community nurses, together with placing media devices into care homes to improve communication and safety between them and Primary Care Teams. Six months on, the expected benefits of greater use of information technology are being experienced by many and further innovations are planned: *remote consultations including telephone, video and e-consultations having become the norm.*[5]

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[2] I was fascinated to read a critique of Tony Blair by the medical philosopher Raymond Tallis in *Hippocratic Oaths: medicine and its discontents* (Atlantic Books, 2004) that in order to win the next general election Tony Blair promised everyone that they had the right to be the first in the queue for NHS treatment. "This has had a terrible effect on people and staff. The NHS works with community spirit, each of us prepared to wait for those in greater need to go first."

[3] Who can forget each Welsh First Minister arguing that our access times were better than those in England?

[4] https://gov.wales/healthier-wales-long-term-plan-health-and-social-care

[5] https://bjgplife.com/2020/06/22/general-practice-post-covid-time-to-put-equity-at-the-heart/

Many do not want to "go back" since the changes have provided more flexibility in how people access services, when they access them (no longer tied to a fixed appointment system either for clinician or patient), together with the possibility to add images and web pages for example.

NEW FORMS OF TECHNOLOGY

The phrase '*patient-led digital triage*' is increasingly common in the general practice literature with an expectation that people will use online tools, apps and self-assessments to assess their needs before making contact with the service.[6] The Secretary of the Royal College of General Practitioners reported in a speech in October that people "love this":[7]

> *I can see that 10-minute face-to-face consultations don't have to be the most common mode of consultation in general practice. We've demonstrated how a menu of access options best serves patients and clinicians – telephone, video, email or other text-based approaches – all have their advantages, particularly when face-to-face contact is less desirable because of the need for effective infection control. And of course, we've made the strong case to tech enthusiasts that face-to-face consultations are essential for a significant proportion of our consultations to enable us to provide safe, effective and personalised care for our patients.*
>
> *And while we're on technology, I'm starting to think that some form of near-universal triage is here to stay and that increasingly it will probably be patient-led digital triage. I know some patients don't like it and I know that we have much to do in designing a process which is patient-friendly and equitable. And I know that the distinction between triage and substantive consultations is blurring.*

NHS Wales has just established a "Value-Based Care" resource online.[8] Similar ideas occur in an essay by a general practitioner on the site:[9]

> ***Total Triage:*** *Almost overnight during March 2020, Primary Care teams adopted total clinical triage, primarily to ensure that face to face appointments was offered only when the risk-benefit ratio of such a consultation justified that approach. For telephone triage, initial signposting by receptionists enabled skilled clinical decision-makers to focus their attention on patients who most needed a medical opinion, in keeping with the principles of prudent healthcare. What of the outcomes from this shift to total triage? Evidence pre-COVID suggests up to 50% of GP consultations can be safely managed remotely, so similar studies involving both clinical measures and patient-reported outcome measures (PROMS) would be ideal to determine is this also applies during the COVID-pandemic.*
>
> ***ICT Innovations:*** *There was rapid progress in digital connectivity, enabling Primary Care staff to work remotely from home, linking clinical software between practices in the same clusters, and multiple virtual meeting platforms, all of which contributed to the sustainability and efficacy of Primary Care services at a time when staff sickness might have shrunk the available NHS workforce. Such flexible working practices represent value both for individuals and their families, in terms of staff wellbeing; for Primary Care teams and patients, by maximizing the*

[6] https://www.rcgp.org.uk/about-us/rcgp-blog/a-message-from-your-chair-of-council-19-june-2020.aspx

[7] https://www.rcgp.org.uk/about-us/news/2020/october/building-the-future-of-general-practice.aspx Accessed on 2/11/20

[8] https://vbhc.nhs.wales/

[9] https://vbhc.nhs.wales/about-value-in-health/covid-19/

productivity of the workforce; and also for the environment, as commuting miles to work shrinks proportionately.

WHAT SORT OF CONSULTATION: TRANSACTIONAL OR RELATIONAL?

The lessons learned from research into the doctor-patient relationship apply to all 'conversations between strangers'.[10] For teaching and assessment purposes there are five components to a good 'patient-centred'[11] consultation between a person and someone who they are consulting with that can be broken down into seventy-three processes, steps or tasks.

In January 2020, the British Medical Journal published an essay by Oxford general practitioner, Helen Salisbury entitled '*Is Transactional Care enough?*'[12] In it, she questions the contemporary drive for people to get the care they want, where they want it when they want it, to meet their needs at this moment. The correspondents responding to the essay asked about "old fashioned general practice", commenting that health care is more than accessing your bank account, shopping or taking the car to the garage.

I have realised that, thinking more deeply, this is something that WIHSC is interested in and researching at the moment. We are part of a large team evaluating the Social Services and Well-being Act in Wales (the IMPACT study).[13] The legislation enshrines in law a series of duties for both social care and health care services, and establishes legal rights for service users and carers. Two of the five principles underpinning the Act are:

- Voice and Control, whereby people are to be heard and their views taken on board in the decisions made about their care and support; and
- Co-production, providing an opportunity for the power relationships between professionals and people to be equalised so that plans can be made jointly about what matters.

Surely, these are all about giving people the choices about what they want, when and how?

Another principle of the Act is on 'prevention and early intervention'. I am one of the team that is working on this theme and we have encountered a fascinating paper discussing the social determinants of health and recommending a life course approach that takes into account individual agency and the choices that people make within their complex social circumstances.[14] If many, perhaps a majority, of the population want this sort of care and can access it, should we not change what we do and how we do it to meet their preferences?

WHAT MIGHT BE LOST, AND IS IT A PRICE WORTH PAYING?

Relationship-based care is described eloquently in an essay published in 2019[15] with the subtitle: *how general practice developed and why it is undermined within contemporary healthcare*

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[10] Thanks to Professor Paul Kinnersley for this description of the consultation in the twenty first century.

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1119673/

[12] https://www.bmj.com/content/368/bmj.m226

[13] https://wihsc.southwales.ac.uk/evaluation-implementation-social-services-and-well-being-wales-act-gwerthuso-gweithrediad-deddf-gwasanaethau-cymdeithasol-llesiant-cymru/

[14] https://journals.sagepub.com/doi/full/10.1177/1403494819894789

[15] https://www.tandfonline.com/doi/full/10.1080/02813432.2019.1639909

systems. The essay is an excellent review of the issues at stake with some telling quotations in the conclusions:

> *The future seems to belong to primary care medicine, where the GP is the doctor of the disease and the organisation rather than of the patient and the relationship.*
>
> *The critical transition from relationship based practice to primary care medicine is when the relationship is no longer recognised as a vital professional asset.*
>
> *When this happens, clinical medicine as a whole becomes drained of the practice of its human dimension.*

IS THERE A MIDDLE WAY?

People want and need many things from general practice. In a standard medical undergraduate textbook, Fraser identified seven outcomes that patients may expect from a consultation: reassurance; advice; prescription; referral; investigation; observation and prevention.[16] A paper from his department provided some deeper insight. All general practitioners in Leicestershire and Nottinghamshire were invited to take part in a randomised control trial.[17] The authors found that 68% of patients wanted an explanation, 57% planned to request treatment and 42% to request investigations.

As Kleinman[18] and Reeve[19] have suggested, patients brought their own explanatory models to their consultations: their ideas, reasoning and opinions. Almost half of the sample had specific questions for the doctor. Many patients had reached a limit which had prompted them to consult: 42% could no longer cope with their anxieties about the problem whilst 24% could no longer tolerate their symptoms. About one fifth wished to report on specific concerns, such as hospital appointments and a further fifth wished to discuss specific health issues with the doctor.

The quality of a consultation, for both patient and clinician will depend upon the extent to which the patient's agendas are recognised and addressed.[20] Reading the book '*Meetings Between Experts'*[21] changed how I understood and respected my patients and prepared me to be an enthusiast for the principles of co-production where the patient and I collaborated to produce "better health together" to quote Dr Julian Tudor Hart.[22]

I suggest that there are agendas and tasks that can be met by transactional general practice, and there are people for whom the processes are easy and the technology is available and so satisfaction scores will be high. However, some people will always need services, care, contact and touch that can only be provided with the context of relationship. They are likely to be the people

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[16] Fraser RC *Clinical method. A General Practice Approach* 3rd Edition Oxford Butterworth-Heinemann 1999

[17] McKinley RK, Middleton JF. What do patients want from doctors? Content analysis of written patient agendas for the consultation. *Br J Gen. Pract*. 1999;**49:**796-800

[18] Kleinman A. *Patients and healers in the context of culture*. London University of California Press 1980

[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2894382/

[20] Tuckett D, Boulton M, Olson C, Williams A *Meetings Between Experts: an approach to sharing ideas in medical consultations* London Tavistock 1985

[21] One of the insights from the research that led to the book was that 'expert general practitioners' were no better than 'ordinary' ones at identifying the Patient's agenda. I was interested to read a paper published in May 2020 that found that training and support did not lead to improvements in identifying the patient's agenda! https://bjgp.org/content/70/694/e339

[22] https://www.sochealth.co.uk/socialism/feasible-socialism/6-consultations-as-units-of-production/

who are disadvantaged already, struggling to access care and support; people excluded and at the margins; people who do not shout loudly.

NHS England have launched an initiative called "Personalised Care"[23] which has six components:

- Patient Choice;
- Shared Decision Making;
- Patient Activation and Supported Self-Management;
- Social Prescribing;
- Personalised Care and Support Planning; and
- Personalised Health Budgets.

The Royal College of General Practitioners in England is a partner in this initiative.[24] I was fascinated to learn about this since in the first half of the 2010s I and colleagues pleaded with Welsh Government to resource its predecessor "Care Planning for Long Term Conditions".[25] Implementation of such programmes requires training of staff, changes to 'call and recall' systems for clinical review, new approaches to embed the patient's agenda and priorities, shared decision making and the co-production of care plans.

My general practice team tried to implement what we could at our own expense without staff training or any investment in the co-production elements. The doctors and nurses considered it to be a success since their systems were improved and worked well. However, I was reminded of the CHC comments many years earlier and was ashamed that we had failed to meet our patients where they were.

This initiative across Offa's Dyke is based on a decade of work and learning that has been resourced. It does contain all the elements to indicate success, and much can be delivered by the transactional approach, so hopefully people in England living with long term conditions will not lose out.

Words and aspirations and will not deliver anything like this in Wales. As our current research develops, it will be instructive to learn more about the role that voice and control, co-production and prevention are playing to inform our future discussions.

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Professor Jonathan Richards
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[23] https://www.england.nhs.uk/personalisedcare/

[24] https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/person-centred-care-toolkit.aspx

[25] I can no longer reference the document electronically since the link on the RCGP website now takes you to the current toolkit!