DRAFT REPORT

Video consultations in the NHS: summary findings from a UK-wide survey

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Our thanks go to Joanna Crocker in the Nuffield Department of Primary Care Sciences at the University of Oxford, for advice on data presentation.

CONTACT DETAILS

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Please note that this is a draft report. Given increases in video consulting and calls for information to support development of this service model, we summarised findings from a national survey on video consulting and rapidly disseminated these. Further detail is available using the contact details above. Final analysis will be presented in an academic paper in due course.

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EXECUTIVE SUMMARY

BACKGROUND

1. To gain a picture of video consulting in the UK NHS since the start of the COVID-19 pandemic, we surveyed NHS staff involved in video consulting during September 2020. The survey was distributed through multiple channels, including both formal and informal networks.
2. Given increases in video consulting and calls for information to support development of this service model, we produced this draft report summarising findings from 809 respondents across the UK. Final analysis will be presented in an academic paper in due course.

OVERVIEW OF SURVEY RESPONDENTS

3. Survey respondents represented a range of locations, organisational settings and NHS roles. Just over half of the responses were from NHS staff in England, around 35% from Scotland, 8% from Wales and 5% from Northern Ireland. The vast majority of respondents were located in urban or mixed urban and rural areas.
4. At the time of the survey, most respondents were working in NHS Trusts/Boards (including acute, community, mental health and integrated organisations), with around a quarter from general practice. Four respondents were based in ambulance services.
5. The majority of respondents were clinicians, with most being doctors. The largest single speciality responding to the survey was primary care. Responses from other clinicians and specialists enabled insights into a wide range of settings for video consulting. We also had responses from managers and support staff.

USE OF VIDEO CONSULTING AND GROUP VIDEO CONSULTING

6. The majority of people responding to the survey had established video consulting (VC) in response to the pandemic. Most respondents had not established group video consulting (GVC), defined as two or more patients consulting with one or more clinicians. Increased VC was commonly part of emergency planning responses to the COVID-19 pandemic.
7. Video consulting was most commonly used in general practice for acute presentations. In NHS Boards/Trusts, video consultations were more commonly used for active management of an ongoing condition. Survey respondents also reported common use of video consulting for giving advice, support and routine review. Other uses included patient assessments, provision of therapies/treatment, palliative care and connecting with care homes.
8. Those working in primary care frequently reported the value of phone over video consultations. They indicated that this was due to (i) the limitations of video technology (e.g. time taken to set up, poor video quality and connectivity), (ii) not always needing visual cues, and (iii) face to face contact being possible throughout the pandemic. Primary care respondents did however report that video consulting offered the advantage of 'eyeballing' certain patients, particularly children and care home residents. It also allowed assessment of movements (e.g. inhaler techniques).
9. Those working in mental health and children and young people (CYP) services were the largest group of speciality respondents after primary care. Uses of video consulting ranged from enabling outpatient appointments and the provision of therapy in mental health services to 'home' visits and observations, as well as provision of advice to parents in CYP services.
10. Responses to questions about group video consulting generally showed less widespread use than video consulting more generally. Nearly half (c400) of all survey respondents reported that

group video consultations had been set up in their organisation. However only 114 respondents went on to provide an estimate of how many group video consultations (GVC) had been provided during the pandemic. Of these, 14 said that no GVC had been provided, and 45 indicated that 10 or fewer GVC had been conducted during that time.

11. Four video consulting platforms were used by more than 80% of the survey respondents: Attend Anywhere, AccuRx, Microsoft Teams and NHS Near Me. Reasons for selecting these platforms included: ease of use, availability and security. Respondents also reported use of a range of other platforms. One reason given for use of other platforms was reported limitations of the main four platforms for hosting group video consultations.

SCALE UP AND SPREAD

12. Respondents generally reported that video consulting was moderately widespread (i.e. with increased activity, but not yet routinely embedded in services). Responses from Scotland and from Health Boards/Trusts indicated that video consulting was perhaps more widespread than in other countries or settings. Across the UK, the single biggest reported factor reported as enabling an increase in video consulting was the cancellation of non-essential face to face appointments. Changes in staff and patient attitudes were also considered important.
13. Survey respondents indicated certain organisational changes that aided the spread of video consulting during the pandemic, including updates to essential hardware, attention to security and privacy concerns and increased motivation from clinical colleagues to use video consulting.
14. Approximately 75% of respondents said that clinicians were able to work from home to provide video consulting, with changes to support home working focused on ensuring that patients' information was secure (e.g. via provision of appropriate hardware, remote and secure access to patient records). Additional IT support and training was considered important. However, some respondents reported limited support for working from home.
15. Respondents indicated that executive support for video consulting enabled spread. This included provision of resources (e.g. equipment, training, policies), a clear policy of 'digital first', and encouragement through staff communications. The highest levels of perceived support were reported in Scotland, and in Health Boards or Trusts. Local spread of video consulting was hindered by lack of equipment, connectivity and support.
16. NHS organisations that had already established video consulting (e.g. for specific patient groups or rural populations) prior to the pandemic were able to spread video consulting more quickly than those that had not. Those organisations with digital strategies in place also appeared to be able to mobilise easily.
17. Increased support for patients to use video consulting was the single most important thing that respondents across the UK identified as potentially enabling further spread of video consulting.

CONCLUSION

18. Use of video consulting, and to a lesser extent group video consulting, has increased as part of the response to the COVID-19 pandemic. There appears to have been moderate spread across the NHS, varied by speciality and setting. Development and spread of video consulting has been challenging where equipment, software and skills are less readily available.
19. Significant work has been undertaken to set up video consulting across the NHS. There is more to do to make video consulting services routine, including supporting patients in accessing and using video consulting.

1. Background, survey design and analysis

With a view to containing novel coronavirus (COVID-19), healthcare organisations rapidly introduced new service models at the start of the pandemic to avoid direct clinician-patient contact. The focus shifted from in-person to remote consulting, with video consulting having a potentially important role to play.

We know from health systems research that disruptive technological innovation, especially in heavily institutionalised environments, is complex, uncertain, challenging and risky. Success is not just about new technologies but also about their clinical safety, how we make them work, and whether NHS infrastructure can accommodate them at speed and scale. There is much to learn. Not only from the immediate crisis, but also its evolution (e.g. from initial mobilisation to enable access to services to, for instance, addressing a backlog of routine care) and what this means in terms of the longer term drivers for video consultations.

In this context, and with support from the Health Foundation, we conducted a UK-wide survey to understand the scale up and spread of video consulting during the pandemic[1]. The survey was drafted in collaboration with partners at Barts Health NHS Trust, NHS England, NHS Scotland, NHS Wales and NHS Northern Ireland (see Appendix 1 for final version). The survey went live on 7 September 2020, via Survey Monkey, and closed on 30 September 2020.

Distribution and sampling

We used a combination of opportunity and snowball sampling to identify and circulate the survey across the UK, making use of formal and informal networks within the NHS, research and across social media. Formal networks included the Future NHS forum; the NHS in England, Scotland, Wales and Northern Ireland with a focus on groups working on digital and technology implementation; NHS provider networks (primary and secondary care); NHS Trust Chief Information Officers; the Health Foundation and other networks focusing on group video consultations. The research team also circulated the survey through informal and personal networks. The survey was also distributed by social media (Twitter and LinkedIn), with regular tweets by Professor Trisha Greenhalgh to around 100,000 followers, and targeted tweets aimed at increasing diversity of respondents (e.g. geographical areas, specific service settings such as primary care and ambulance services, BAME and LGBT NHS networks).

A total of 1306 respondents attempted the survey and 809 completed it fully. The main reason for the difference between attempted and completed surveys related to dropout at essential questions (i.e. questions that needed to be completed before respondents could progress). Adjustments were made to the set-up of questions in the first week that the survey went live, allowing respondents to skip some items and clarifying instructions. No changes were made to the wording of any questions.

Analysis

Analysis focused on the 809 fully completed surveys. GW carried out quantitative data analysis using SPSS, using the package's Case Summaries function (and 'Select Cases' filter), to organize free text comments by grouping variables such as country, organisational setting, and platforms used.

Initially, a set of descriptive statistics (frequencies) were run using the on-board platform to give an idea of the 'headline' figures. Then the data were exported to SPSS for the main analysis, new codes were created for 'other' (free text) options, and cross-tabulations performed to verify consistency

[1] The survey forms one part of a lager study, funded by the Health Foundation from June 2020 to March 2021, focused on *Video consulting during and beyond the COVID-19 pandemic: implications for scale up and sustainability*. Further detail about the study can be found at https://www.health.org.uk/funding-and-partnerships/programmes/video-consulting-during-and-beyond-the-covid-19-pandemic.

between categories of respondent and responses. Additional variables were computed such as quartile differences to examine broad trends in response.

Using comparisons of group means on two measures, it was established that there was no significant difference in group means between respondents who offered comments, and those who did not. Also, no significant difference was found for those who offered interviews and those who did not. The measures tested were 'percentage of executive encourage to adopt VC within the organisation' (Q11) and 'percentage take up and spread of VC in the organisation' (Q17).

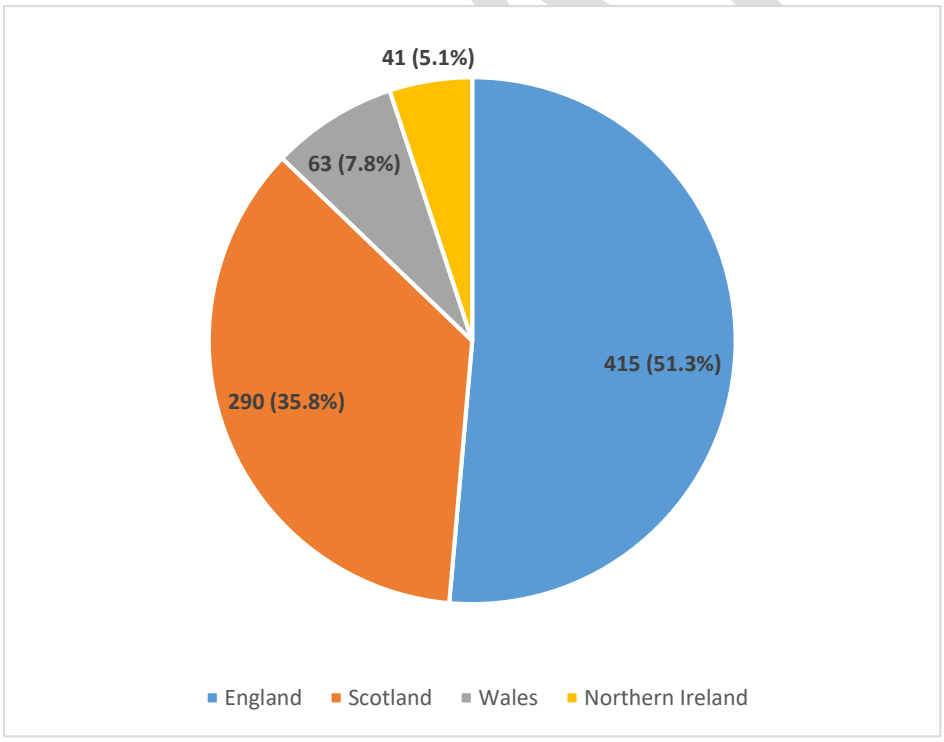
GH analysed free text comments with a combination of context analysis (identifying and counting common content in responses) and thematic analysis (reading all responses to identify common themes).

GH, GW and SS regularly reviewed emerging analysis, with on-going discussion feeding back into the analytic process. GH produced the first draft of this report. Comment from SS and GW, along with discussion with collaborators (e.g. NHSE), further informing analysis and interpretation.

2. Respondents

Completed surveys were received from 809 respondents: 415 from England, 41 from Northern Ireland and Isles, 290 from Scotland and 63 from Wales (Table 1, Figure 1).

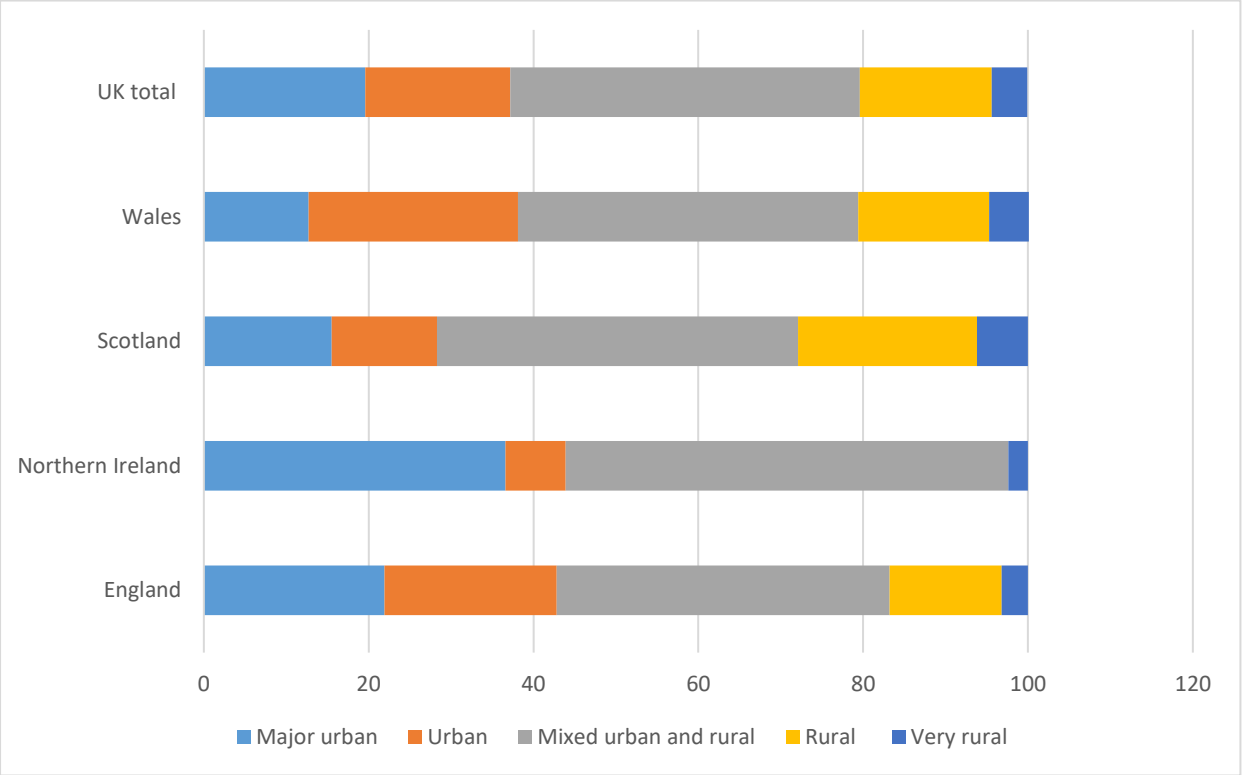
Figure 1: 809 respondents by country



Around 80% of surveys were completed by people in urban or mixed urban and rural areas and around 20% in rural or very rural areas. Major urban areas accounted for 19.6% of responses (n=158), urban areas for 17.6% (142 people), mixed rural and urban areas for 42.4% (n=341), rural areas for 16% (n=129) and very rural areas for 4.3% (n=35).

The pattern of respondents across urban/rural settings was similar to the national picture in England and Wales (Figure 2). Northern Ireland and Isles had more respondents from mixed urban and rural areas. Scotland had a higher proportion of respondents from rural and very rural areas.

Figure 2: Urban/rural location of respondents (%) by nation

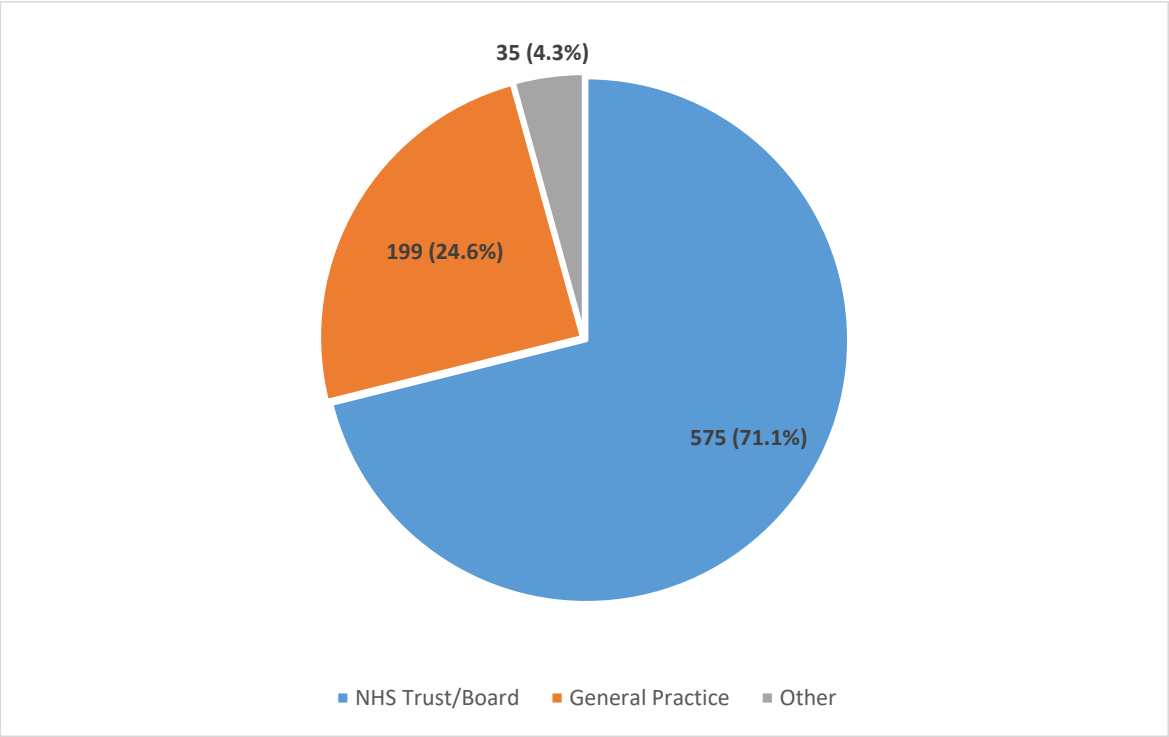


Respondents' organisations

We grouped respondents into three broad care settings: 1) secondary care (NHS Trusts or Boards), 2) general practice, and 3) other organisations (Figure 3).

The majority of respondents (71.1%, n=575) were from NHS Trusts/Boards, with fewer from general practice (24.6%, n=199) and other organisations (4.3%, n=35). Other organisations included integrated care organisations in each of the 4 nations, commissioning organisations (CCG and ICP), out of hours services, hospices, local authority, private providers, elective centre, tertiary care and training/education.

Figure 3: responses by organisation type



There was a broad spread of respondents across the UK (Table 1). A quarter of responses came from GPs, around a quarter from acute providers (specialists and non-specialists), and good representation from community and mental health providers. There were only 4 responses from people working in ambulance services (0.5%).

Table 1: Respondents for the UK for each type of organisation

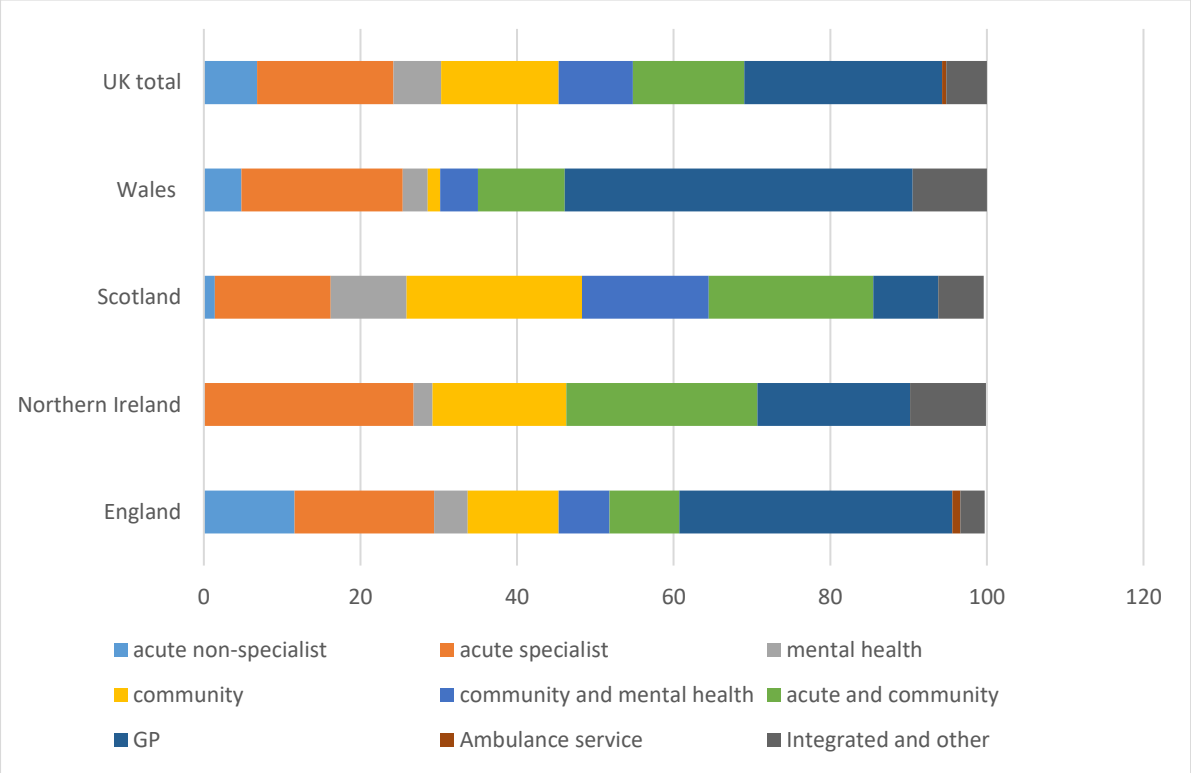
Type of organisation	*Number of responses (percentage)*
Acute non-specialist providers	55 (6.8%)
Acute specialist providers	141 (17.4%)
Mental health providers	49 (6.1%)
Community providers	121 (15.0%)
Community and mental health providers	77 (9.5%)
Acute and community providers	115 (14.2%)
General practices	205 (25.3%
Ambulance services	4 (0.5%)
Other (including integrated organisations)	42 (5.2%)
TOTAL	809 (100%)

Spread of respondents across the UK

The survey captured varied responses across the four nations (Figure 4).

There was a greater proportion of responses from GPs in Wales and England, and a lower proportion of responses from GPs in Northern Ireland compared to the overall UK responses. The differing responses from each country also reflect different configurations of health care in each of the nations (Scotland having health and social care partnerships, Northern Ireland integrated trusts and Wales health boards).

Figure 4: Percentage of respondents by organisation for each nation



England

Surveys were completed by 239 respondents from 97 of the 220 NHS trusts in England and 147 from general practices. Surveys were also completed by 29 people from other organisations including commissioning organisations, social enterprises and private providers contracted by and working in partnership with NHS services, hospices, a care home and a local authority.

Of the 147 respondents from general practice in England, 143 (97.3%) were clinicians, 4 (2.7%) were managers. No support staff from general practice in England responded to the survey.

Of the 239 respondents from English NHS Trusts, 72% (n=172) were clinicians, 16.7% (n=40) were managers and 11.3% or 27 were support staff. Seventeen clinicians, 8 managers and 4 support staff responded from other English organisations. From all 415 English respondents, 80% (n=332) were clinicians, 12.5% (n=52) were managers and 7.5% (n=31) were support staff.

Scotland

Survey responses were received from all 14 NHS Boards in Scotland. General practices also responded to the survey (17 respondents from at least 6 practices), as did people from the national

waiting times centre and local/national decision makers across Scotland. Of the 17 respondents from general practice, 16 were clinicians and 1 was a manager. No support staff responded.

Two hundred and sixty-nine respondents from Health Boards included 75.8% clinicians (n=204), 14.5% managers (n=39) and 9.7% (n=26) support staff, and from other Scottish organisations 1 clinician, 1 manager and 2 support staff responded.

A total of 221 (76.2%) clinicians responded, 41 managers (14.1%) and 28 (9.7%) support staff.

Northern Ireland and Isles

Responses were received from 5 out of the 6 NHS Trusts in Northern Ireland, with the Northern Ireland Ambulance Service Trust not represented in the response. Eight responses were received from at least 5 general practices, and one from the Public Health Agency.

There were 8 responses from general practice in Northern Ireland. All were clinicians. Of the 32 responses from Health Trusts, 26 were clinicians, 4 were managers and 2 were support staff. There was one response from another organisation in Northern Ireland who identified as support staff.

From the 41 responses from Northern Ireland, 34 (82.9%) were clinicians, 4 (9.8%) were managers and 3 (7.3%) were support staff.

Wales

Surveys were completed by 6 of the 7 Health Boards in Wales (Powys Teaching Health Board was not represented) and 27 people from at least 9 general practices.

In Wales, there were 27 responses from general practice, including 23 clinicians and 4 managers (no support staff). Of the 35 responses from Health Boards, 28 clinicians, 5 managers and 2 support staff responded. One clinician from another organisation responded.

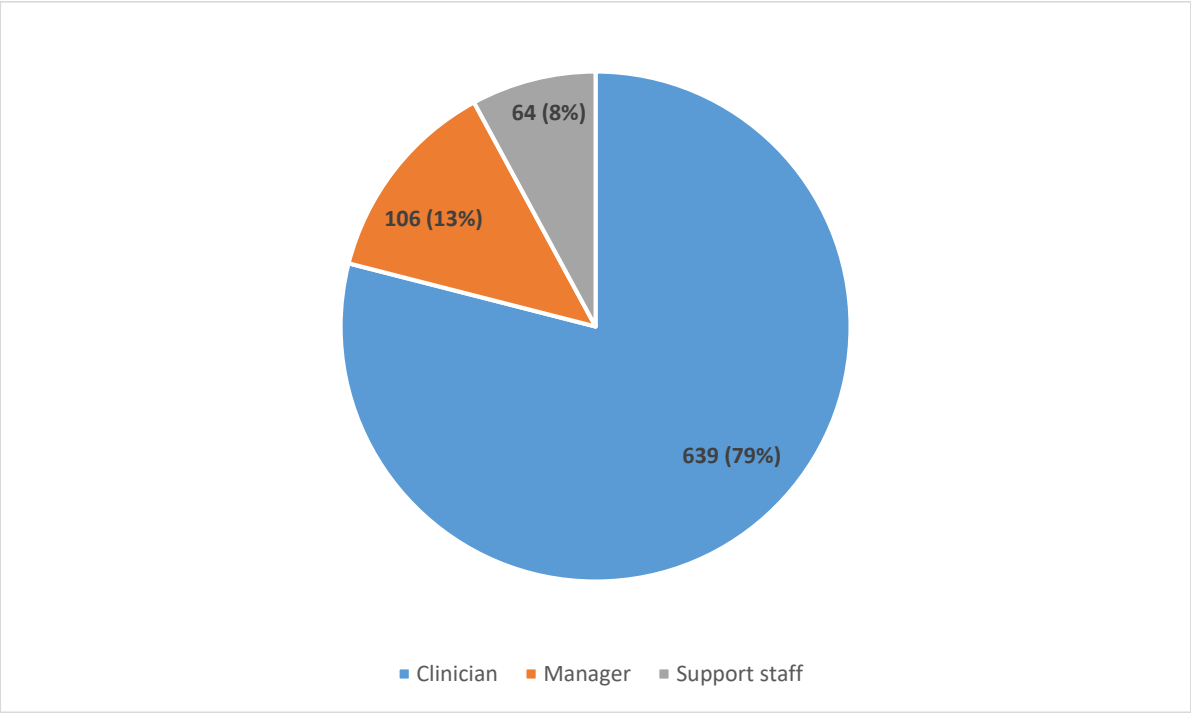
The breakdown of 63 respondents across Wales provided a total of 52 (82.5%) clinicians, 9 (14.3%) managers and 2 (3.2%) support staff.

Breakdown of respondents' roles across the UK

Seventy nine per cent of those who responded to the survey across the UK were clinicians (n = 639), 13% managers (n=106) and 8% support staff (n=64). Clinicians outnumbered managers and support staff across the four nations (see above) and across the different organisational settings (Figure 5).

There was a higher proportion of managers responding from Health Trusts/Boards than in general practice.

Figure 5: respondents' roles across the UK



Clinicians

From the total UK response, the biggest group of clinicians who responded to the survey was doctors (44.7%, n=285). These were followed by physiotherapists (12.7%, n=81), occupational therapists (11%, n=70), nurses (8.6%, n=55) speech and language therapists (7.4%, n=47), dietitians (4.9%, n=31), psychologists (3.5%, n=22), dentists (0.9%, n=6), pharmacists (0.3%, n=2) and a midwife (0.1%, n=1). Thirty seven respondents (5.8%) indicated an 'other' role, including podiatrist, orthotist, health visitor, audiologist, employment specialist, paramedic, hand therapist, genetic counsellor and social worker.

Doctors were the biggest group of respondents for England, Northern Ireland and Wales, and the second biggest group in Scotland (where there was a total of 51 occupational therapists compared to 36 doctors, i.e. 23.2% compared to 16.4% of clinical respondents).

Focusing on all UK respondents, the most common speciality was primary care (32.4%, n=207), followed by children and young people (11.5%, n=74), mental health (10.6%, n=68), musculoskeletal disorders (8.9%, n=57), neurological disorders (6.1%, n=39) and diabetes (2.7%, n=17).

Clinicians from other specialities each made up less than 2% of responses (i.e. 12 or fewer). These other specialities were: cardiovascular disease; ear, nose and throat; respiratory disorders; surgery; learning disabilities; genomics and rare diseases; stroke; gastroenterology; cancer/oncology.

Clinicians from the following 25 specialities made up less than 1% of responses (comprising 1-7 people from each speciality): elderly care/geriatrics, anaesthesia, perioperative medicine and pain management, haematology, occupational therapy, oral and dental health, palliative care, dementia and neurodegeneration, liver, public health and prevention, wound care/tissue viability, metabolic and endocrine disorders, reproductive health, trauma and emergency care, sexual health, dietetics, dermatology, kidney disorders, occupational health, immunology, rheumatology, clinical research, urology, physiotherapy audiology and cystic fibrosis.

Managers and support staff

The majority (71.4%, n=75) of 105 managers who responded described themselves as middle managers. Senior executives (including Board members and Associate Directors) made up 16.2% (n=17) of respondents, with project managers (6.7%, n=7), administrators (2.9%, n=3) and others (2.9%. n=3) making up the remaining responses from managers. This pattern of response was similar across the four nations and across organisational settings.

Organisation, service, or team responses

The survey asked respondents to indicate if they were answering on behalf of their organisation/practice, their service or their individual team or clinic (Appendix 1). Across the UK, 46% (n=371) answered on behalf of their individual team or clinic, 30% (n=245) answered on behalf of their organisation or practice, and 24% (n=189) on behalf of their service. Answers to this question were provided by 805 of the 809 respondents.

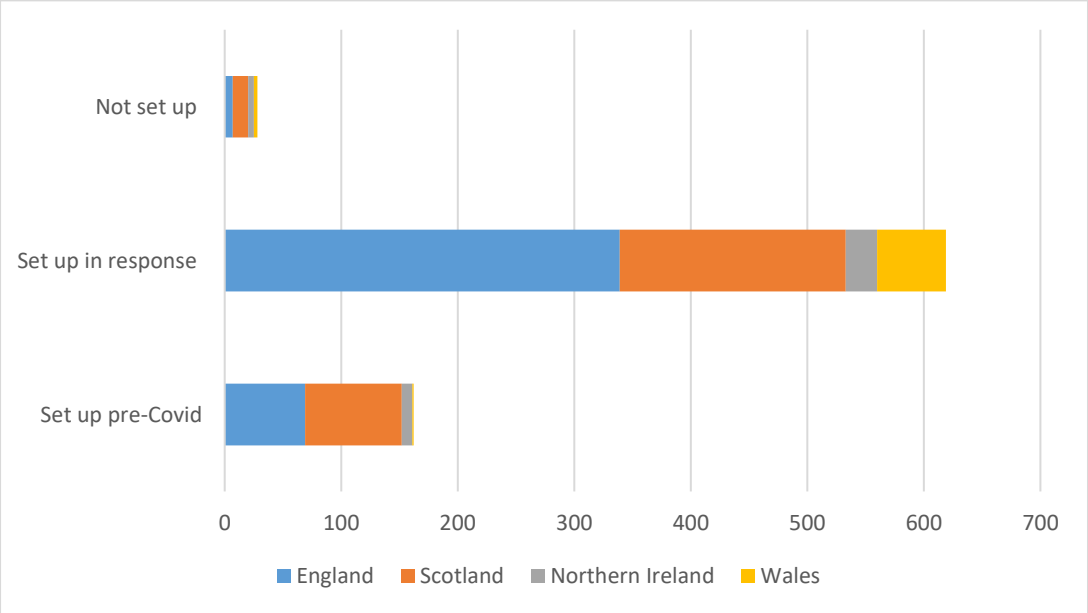
In England, more people (43% English respondents, n=178) said they were answering on behalf of their organisation or practice than the other categories, although 37% (n=154) said they were answering on behalf of their team or clinic in England. In Scotland, the majority of respondents were answering on behalf of their team or clinic. In Northern Ireland, more respondents were answering on behalf of their team or clinic than their service, or organisation. In Wales, the same number of people (40%, n=25) answered on behalf of their organisation and their team or clinic, with 20 % (n=13) answering on behalf of their service.

3. Use of video consulting during the COVID-19 pandemic

When was VC first used?

Across the UK, most respondents (76.5%, n = 619) set up video consulting in response to the COVID-19 pandemic. Only 20% (n=162) of respondents indicated that video consultations were set up pre-COVID, i.e. before February 2020 (Figure 6).

Figure 6: when VC was first set up in each country (number of respondents)



Only 3.5% (n=28) of respondents (the majority (n=25) from Trusts/Health Boards) across the UK said that video consulting was not set up at the time of the survey in September 2020. One respondent was from a general practice in Northern Ireland that had not set up video consulting at the time of the survey.

Out of the 147 responses from general practice in England, all had set up video consulting at the time of the survey; 10.2% (n=15) had them in place prior to COVID, and 89.8% (n=132) had set up video consulting in response to COVID.

A small number of respondents (2.5%, n=6) from NHS Trusts in England did not have video consulting set up at the time of the survey. Some (22.2%, n=53) had video consulting in place prior to COVID, but the majority (75.3%, n=180) had only established video consulting services in response to the pandemic.

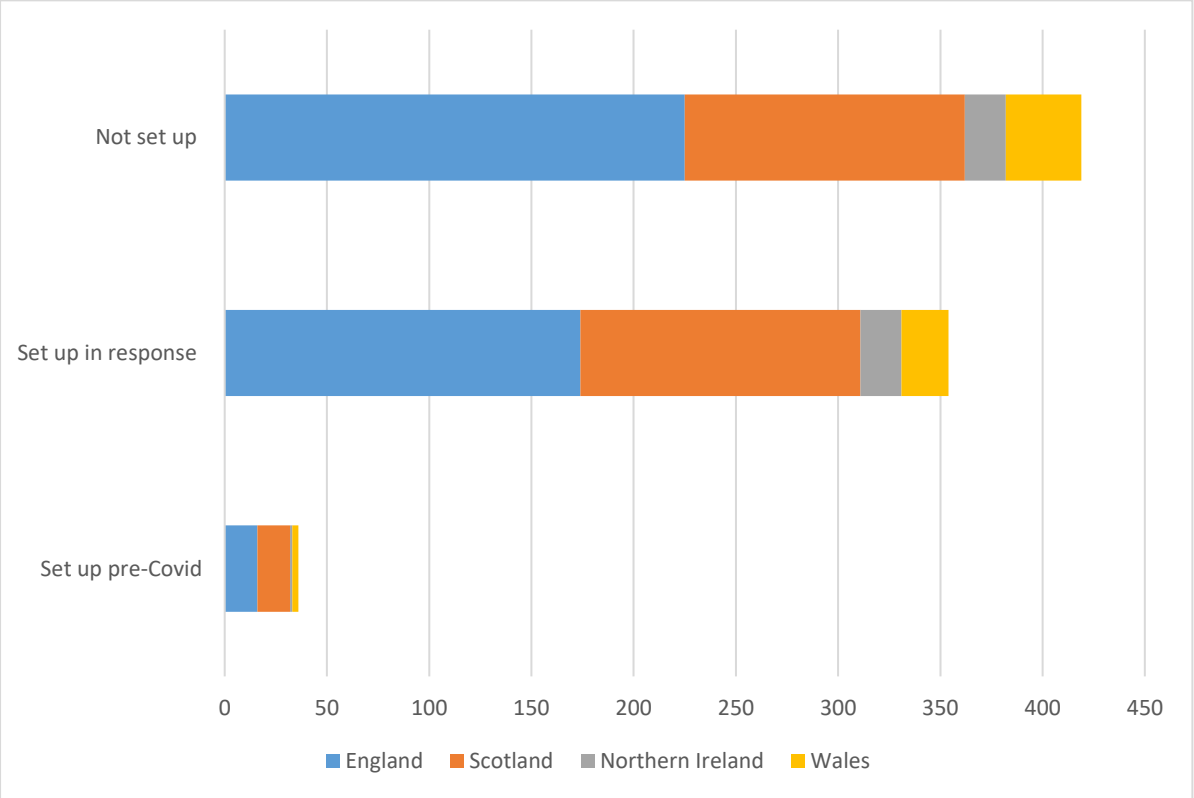
A similar pattern was found in Scottish Health Boards, with a small number (4.5%, n=12) not having VCs set up, but with more already being in place (29.7%, n=80) and the majority of respondents (65.8%, n=177) reporting that video consultations were set up as part of the emergency response to COVID-19.

When were Group Video Consultations first set up?

When it came to group video consultations (GVC) (defined as involving 2 or more patients and one or more clinician), more than half of the respondents across the UK (51.8%, n=419) had not set up group video consultations. A total of 43.8% (n=354) indicated that they had set up group video consultations in response to the pandemic. A small proportion (4.4%, n=36) already had group video consultations in place prior to the outbreak of COVID-19.

Similar patterns were found across the four nations (Figure 7).

Figure 7: when GVCs were first set up in each country (number of respondents)



Across the UK, group video consulting was more common in Health Boards and Trusts than in general practice. At the time of the survey, 278 (48.3%) of the respondents from Health Boards or Trusts had set up group video consulting in response to COVID, whereas 266 (46.3%) had not, and 31 (5.4%) had group video consulting in place prior to the pandemic.

More English Trusts had set up group video consulting as part of the emergency response to COVID-19 than not (126 versus 101). In Scotland, 125 respondents from Trusts had set up compared to 129 that had not. In Northern Ireland, 16 respondents had set up group video consulting, 15 had not and 1 had already group video consulting in place. In Wales, 11 respondents from Health Boards had set up group video consulting in response to COVID-19, 21 had not set them up and 3 already had them in place.

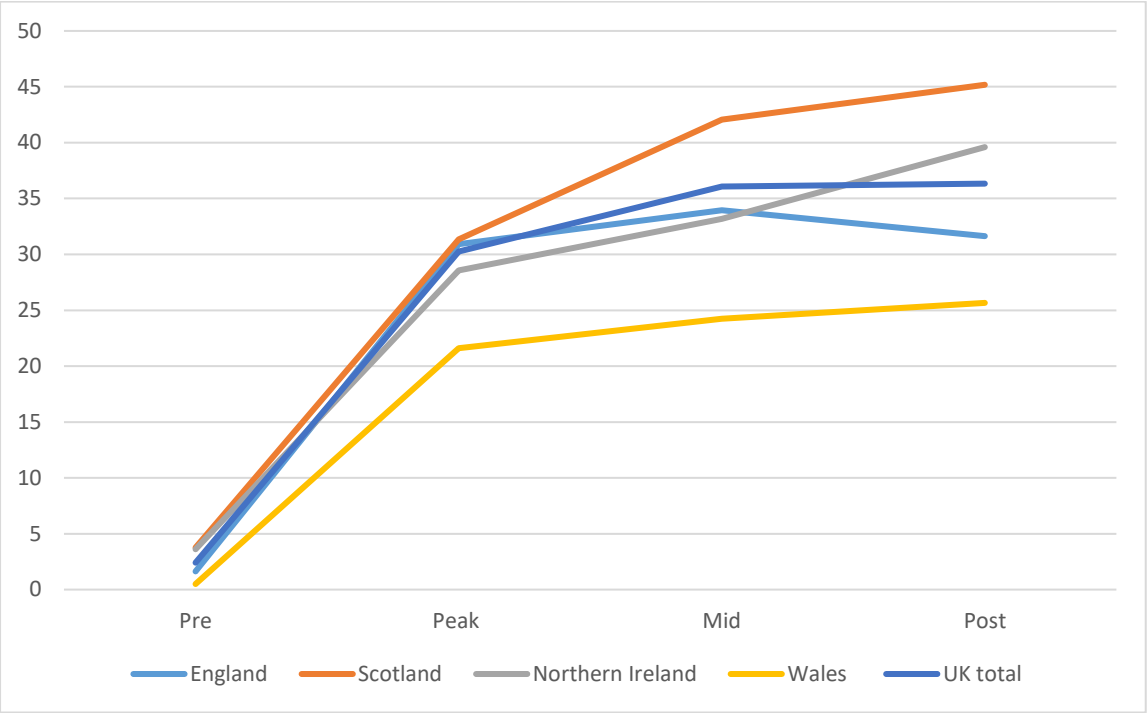
Across UK general practice, 138 (69.3% of general practice responders) had not set up group video consulting, 58 (29.1%) had set them up in response to COVID-19, and only 3 (1.5%, all in England) had them in place pre-COVID. Out of the 147 responses from general practice in England, the majority (75.6%, n=111) had not set up group video consultations at the time of the survey, with 22.4% (n=33) setting them up in response to COVID-19.

Video consulting as a response to the COVID-19 pandemic

The vast majority of respondents (90.7%, n=734) said that increased video consulting was part of their organisation's emergency pandemic response. The responses were similar across the four nations, with only a slightly higher proportion of respondents from Northern Ireland and Wales stating that video consulting was not part of the emergency planning response compared to England and Scotland.

The survey asked respondents to estimate levels of video consulting activity at the following four time points: pre-COVID (before 1st March 2020), peak-COVID (March/April), Mid-COVID (May/June) and post-Peak (July/August). Responses indicated similar increases in the proportion of video consultations over time across the UK (Figure 8), with Wales having a lower rate of increase, and England showing a slightly falling off during the post-peak period. When we compared the average (mean) responses we found similar increases in the proportion of video consultations over time across the UK (Figure 8), with Wales having a lower rate of increase, and England showing a slight falling off during the post-peak period. We also compared average (mean) responses between organisational settings to find differences in the estimated levels of activity across Health Trusts/Boards and other organisations and general practice. Health Trusts/Boards were maintaining higher proportions of consultations by video in the post-peak period (Figure 9). Other settings, particularly general practice, reported a reduction in the proportion of video consultations. When we compared medians, we found broadly similar trends, however a more detailed analysis is needed to pinpoint the relative importance of all factors.

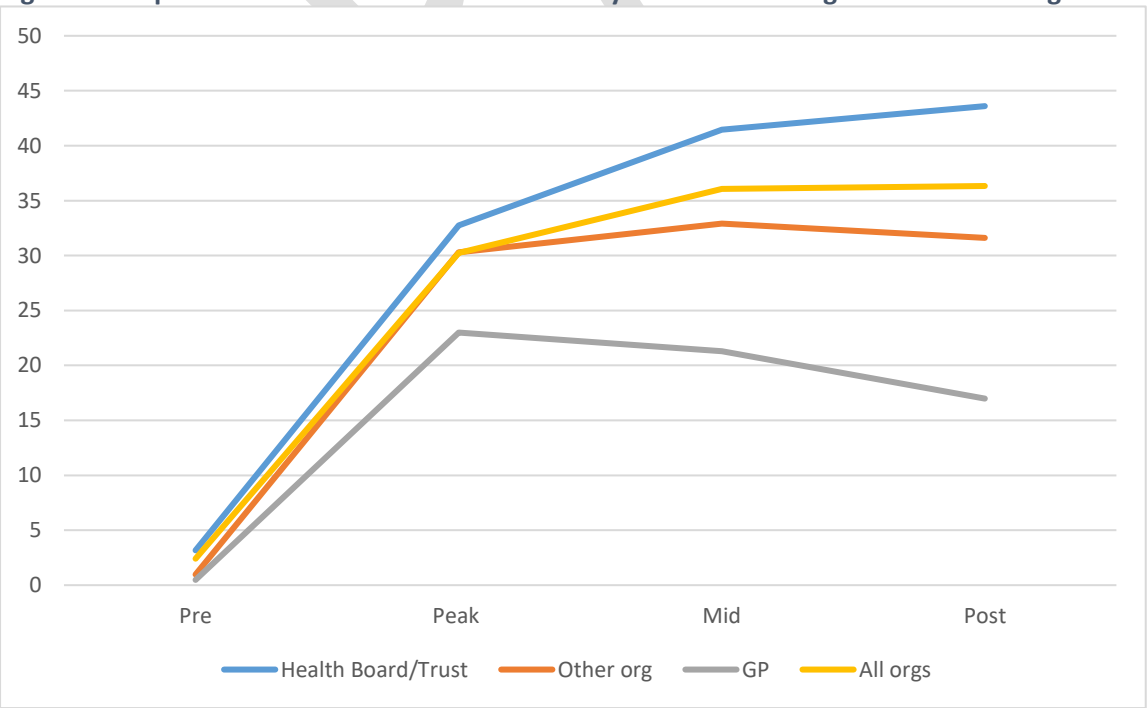
Figure 8: Proportion of consultations carried out by video in each nation*



* N of responses varied for each question between 750 and 800 (out of the 809 total responses)

There were differences in the estimated levels of activity across Health Trusts/Boards and other organisations and general practice. Health Trusts/Boards were maintaining higher proportions of consultations by video in the post-peak period (Figure 9). Other organisations, in particular general practices, reported a reduction in the proportion of video consultations.

Figure 9: Proportion of consultations carried out by video in each organisational setting*



* Number of responses varied for each question between 750 and 800 (out of the 809 total responses).

Reasons for any reported decline in video consulting

The survey sought explanations of any reported decrease in video consulting over time. Of the 140 responses received, 31 were from respondents working in NHS Trusts in England. The main reason given for decline in video consulting from these respondents was a return to face-to-face provision (in part enabled by patients ending shielding, provision of PPE and use of social distancing) and, guided by clinician and patient preference, increased use of telephone consulting.

Twenty nine respondents from NHS Boards in Scotland reported similar reasons for the reported decline in video consulting. In addition, problems with accessing equipment and experiences of technology failing were noted by clinicians. Those working with children noted that on return to school, children and young people were no longer accessible by video. One respondent working with a vulnerable group noted that they had found that things had been 'missed' over video, which were only picked up when face to face contact resumed. Another respondent noted that video had been used initially to deal with a backlog of routine/return patients but now they are having to deal with urgent returns and new patients that necessitated face-to-face consultations.

Two respondents from Wales attributed a decrease in video consulting to the lifting of restrictions on face-to-face consultations. One comment received from Northern Ireland attributed a decline in video consulting to an increase in use of telephone.

Of the 45 responses from general practice across the UK, most noted that an increase in face to face appointments post-peak had led to fewer video consultations. Respondents also noted that video was not always necessary due to 'increased competence' at telephone consultations, and that either they did not always need the visual cues provided by video, or that photos (e.g. for dermatology presentations) were at least as good as video. Respondents also noted that some patients needed physical examinations or to come in to the practice for blood tests. 'Clunky' technology and 'patchy' connectivity (particularly in rural areas) were given by some respondents as reasons for decline in video consulting, alongside concerns about accessibility of video-based services for patients with low digital skills and/or limited income.

Types of consultation that video used for

We asked respondents to indicate the types of consultation that their organisation, service or team predominantly used video for. Active management of an ongoing condition was the most commonly indicated type, with group consultations least used (Table 2). 'Other' types of consultation included use of video for end of life/palliative care, talking therapies, tertiary referrals, home 'visits' or assessments, connecting inpatients to family members, triage/assessment and staff meetings.

Table 2: most common types of consultation

Rank	*Type of consultation*	*No. of respondents*
1	Active management of an ongoing condition	586
2	Advice and support	516
3	Routine review of long term condition management (including medication)	485
4	Acute presentation	374
5	Follow-up after a procedure/operation/hands on care	219
6	Assessment before a procedure/operation/hands on care	198
7	Group consultations	171
8	Other	79

There were differences between Health Boards/Trusts and general practice in terms of the types of consultation using video. Active management of an ongoing condition was the most frequently indicated amongst Health Boards/Trusts, and acute presentation in general practice. The most commonly indicated consultations for Health Boards/Trust and general practices across the UK are listed below (with 1 being the most common, and 8 the least common):

Health Boards/Trusts

1. Active management of an ongoing condition
2. Advice and support
3. Routine review of long term condition management (including medication)
4. Follow-up after a procedure/ operation/hands on care
5. Assessment before a procedure/operation/hands on care
6. Acute presentation
7. Group consultations
8. Other

General practice

1. Acute presentation
2. Active management of an ongoing condition
3. Routine review of long term condition management (including medication)
4. Advice and support
5. Group consultations
6. Assessment before a procedure/operation/hands on care
7. Follow-up after a procedure/ operation/hands on care
8. Other

A total of 79 respondents indicated 'other' for type of consultation (38 from England, 31 from Scotland, 8 from Wales and 2 from Northern Ireland), most (n=67) being from Health Boards or Trusts. These were grouped into 13 types of consultation (Table 3).

Table 3: List of 'other' types of consultations ranked from most to least common

Rank	'Other' type of consultation	No of respondents
1	Assessment	27
2	Staff meetings	18
3	Talking therapy	6
=4	End of life/palliative care	5
=4	Generic interventions/treatment	5
=6	Care home reviews/ward rounds	3
=6	Triage	3
=6	Home 'visits'	3
=6	Genetic counselling	3
=10	Tertiary referrals	2
=10	Discussion with family	2
=12	Connecting inpatient with family	1
=12	Clinical research	1

Use of video consulting in different specialities

The survey asked clinicians how they were using video consulting within their particular clinical speciality. Of the 539 comments provided by respondents, 277 were from England (157 from NHS Trusts, 105 from general practice and 15 from other organisations), 189 from Scotland (174 from NHS Trusts/Boards, 14 from general practice and 1 other organisation); 43 from Wales (25 from Health Boards, 17 from general practice and 1 other organisation) and 30 from Northern Ireland (24 from Health Trusts and 6 from general practice).

Key themes from the most commonly reported specialities, primary care, mental health and children and young people, are provided below.

Primary care

Some of the responses from general practice compared video and telephone consulting. Some clinicians noted that they reverted to the telephone first, and if images were needed they then might ask for photographs rather than switch to video. This was captured in comments, for instance:

> *'I sometimes invite a patient to engage in a video consultation during a phone consultation, where I feel this would be helpful. I don't do it very often, as I am very used to telephone consulting and find this adequate for [around] 90% of encounters.'*

> *'Making it easy for patients to send a photo has helped…I would seldom switch to video simply in order to look at a rash.'*

Video was reported to be useful in situations that would usually involve face to face consultations, for dynamic (rather than 'static') examinations, and to provide elements of reassurance:

> *'Used mainly to call patients who I need a visual on – e.g. care home patient who is deteriorating, or end of life, or skin presentations. Also useful for acutely unwell children as a first line (often end up bringing those in).'*

Reported limitations of video (e.g. time taken to set up, picture quality, connectivity issues) meant that it tended to be used by respondents only when needed and when it really added value:

> *'I mostly use the telephone, sometimes use photos (better images) but use video if I want to examine more than the skin of the patient e.g. overall sick/well child, gait…. It is really difficult as the image is blurry and the consultation often benefits from someone else holding the camera. I have appalling internet at home….so picture freezes and remote consulting is tortuous.'*

Mental health

Respondents reported video consulting being used for a range of purposes in mental health services, from assessing new patients to providing therapy and offering routine and follow-up appointments.

With regard to assessment, respondents reported assistant psychologists using video consulting for adaptive cognitive assessment during memory assessments, ADHD assessments, occupational therapy assessments, triage and neuropsychological assessments. Therapies, interventions and support being delivered through video consulting included psychotherapy, employment support, cognitive behavioural therapy (CBT), ante and post-natal care (e.g. baby massage, goal settings) and memory strategies for older adults with cognitive impairment. Some respondents noted that they had low uptake of video consulting by older adults, and that support was needed from family members.

One-to-one and group work was being carried out by video consulting, although several respondents noted that they were not able to provide group work as they would have liked by video.

Video consultations were reported as a helpful consultation option for staff who were shielding. They were also being used for multidisciplinary team meetings.

Children and Young People

Some respondents reported that video consulting was being used in Children and Young People (CYP) services for assessments, reviews, provision of advice and therapy, as well as facilitating multi-professional meetings. Examples given included a paediatric oncologist using video consulting for reviews, mainly where they had a well- established relationship, and to check plans to administer chemotherapy at home. Community physiotherapists used video consulting for assessments and providing advice, for example on use of equipment (chairs, standing frames), and providing exercises.

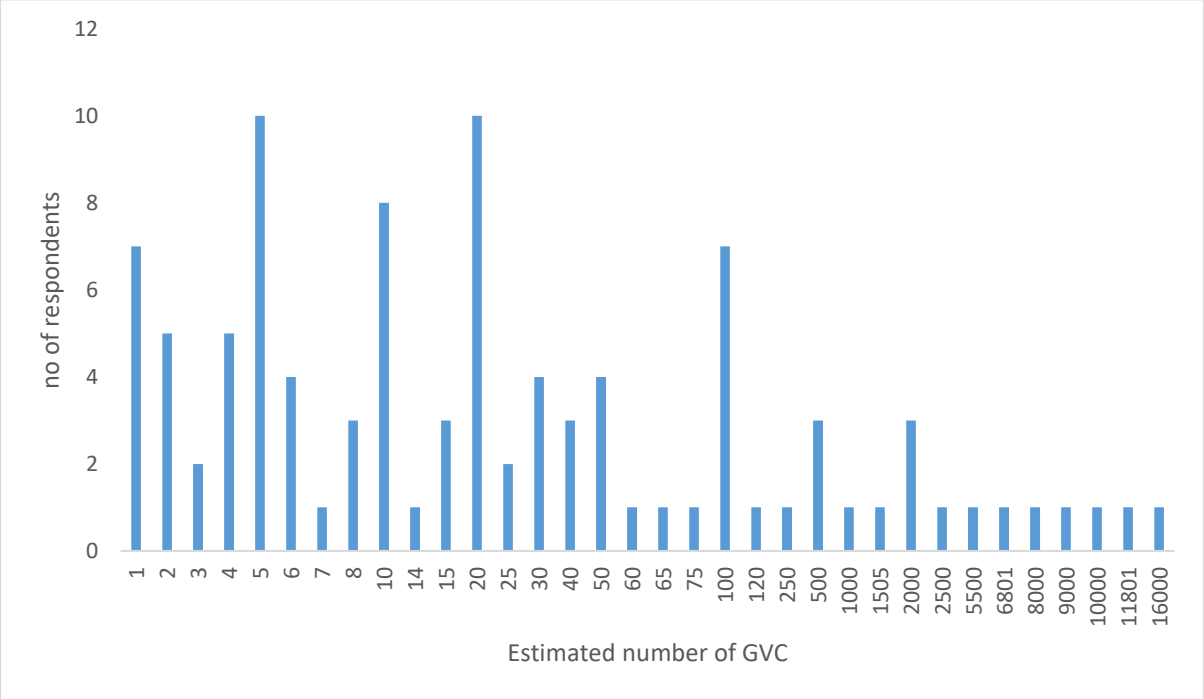
Generally, these respondents reported that video consultations were used in children and young people's services in place of home visits. A small number commented on how they used video consulting for observations, particularly good for children who might otherwise get anxious in clinic settings. Observation of live play was reported as possible, as was observation in school.

Several respondents noted that video was less effective than home visits for assessment. A few noted that families sometimes struggled to 'get on' to the video consultation.

Group video consultations

As noted above, 354 respondents (44% of all survey respondents) indicated that group video consulting had been set up in their organisation, service or team. Of these, only a third (114 or 32.2%) offered an estimate of the number of group video consultations provided by their service: however 14 of these indicated that zero consultations had taken place, with the remaining 100 respondents estimating between 1 and 16,000 group video consultations in the prior six months.[2] The distribution of responses is shown in Figure 10. Almost half the respondents (n=45) estimated between 1 and 10 group video consultations, 37 respondents between 11 and 100 and 18 respondents more than 100 and up to 16,000 (Figure 10, the estimated number of group video consultations on the x axis are cited from the survey and is not a linear scale).

Figure 40: estimated total numbers of group video consultations (since the start of the pandemic)



[2] This range reflects, in part, the different perspectives of the survey respondents, close to half of whom were answering on behalf of their team or clinic, with others answering on behalf of a whole service or organisation.

Platforms used for video consulting

The survey asked respondents to indicate which technology, or technologies, they used for video consulting, including group video consulting. The top 20 platforms are listed in Table 4.[3] Four platforms accounted for more than 80% of the responses to this question: Attend Anywhere, AccuRx, NHS Near Me and MS Teams. Attend Anywhere was the most commonly used platform across the UK (36.4% of responses), followed by AccuRx (19.9%) then NHS Near Me (16.4%) and finally MS Teams (9.1%).

Attend Anywhere was used in England, Scotland and Wales, but not in Northern Ireland. NHS Near Me (which offers a tailored service in NHS Scotland, using the Attend Anywhere platform) was only used in Scotland. AccuRx was used widely in England and Wales with only a handful of users in Northern Ireland and Scotland. MS Teams was used in all four nations.

The platforms most commonly used by respondents in England were Attend Anywhere in NHS Trusts and AccuRx in general practice. In Scotland, NHS Near Me was the predominant platform accounting for 82.8% of reported use,[4] with MS Teams used by 8.1% of respondents. Zoom was commonly used by respondents in Northern Ireland along with Pexip, MS Teams and AccuRx. In Wales, Attend Anywhere was the most commonly used platform followed by AccuRx and MS Teams.

Table 4: Main video consulting platforms reported to be in use across the UK

Rank	*Platform*	*No of responses**
1	Attend Anywhere	423
2	AccuRx	231
3	NHS Near Me	191
4	MS Teams	106
5	Zoom	37
6	WhatsApp	33
7	Cisco Webex	18
8	FaceTime	17
9	Skype	15
10	Pexip	14
11	EMIS Health	10
12	Xuper	8
13	OneConsultation	7
14	Goto	7
15	Visionable	5
16	GoodSAM	4
17	Push Dr	4
18	AskmyGP	3
19	Qhealth	3
20	Bluejeans	3

* Respondents were able to tick all responses that applied to their clinic, team or service.

[3] Other platforms mentioned by only one or two respondents included: Referro, VidyoConnect, Lifesize, star leaf, Clinic.co, National VV, IAPTUS, Whereby, Doctor link, Footfall, Adastra, Nye, Involve medio link, Sesui, Ortus, HSL/Savience, Pando.

[4] The NHS Near Me service in Scotland uses the Attend Anywhere platform. This figure therefore includes all those responses that indicated both NHS Near Me and Attend Anywhere.

Comments (n=575) about why specific platforms had been chosen frequently related to AccuRx, which respondents told us was already known to some general practices (who were using it for texting patients), was readily available, free and easy to use (for staff and patients), and recommended by CCGs (and PCNs and NHSE). The integration of the AccuRx platform with the clinical system was important to the ease of use.

Reasons for use of platforms other than the most popular four (Attend Anywhere, AccuRx, NHS Near Me and MS Teams) included availability (including legacy procurement decisions), security and ease of use. Skype, Zoom, FaceTime, WhatsApp and Starleaf were considered to be easy for patients to use, as they could be used on phones rather than needing laptops.

Requirements of group video consulting affected the choice of platforms. The limitations of Attend Anywhere, and delays in installing MS Teams, led to a number of people using alternatives. With Attend Anywhere unable to host sufficiently large groups, people turned to Zoom, Goto, Skype for Business and Bluejeans. Skype for Business was understood to be more secure than Zoom and did not require installation of Microsoft Office 365, which not all organisations had available initially.

4. Scale-up and spread of video consulting

To understand the extent of scale-up and spread of video consulting, the survey asked about factors affecting the extent of video consulting, organisational changes and support for scale-up and spread during the Covid-19 pandemic.

Respondents were asked to indicate where they considered their organisation, service or team to be in terms of the spread and scale-up of video consulting services on a scale from 0 (indicating minimal and/or ad hoc use of video consulting) to 100 (indicating widespread and routine use). The average (median) response for the UK was about mid-way between 0 and 100. Within the UK, on average spread and scale-up of video consulting was considered to be most widespread in Scotland, then England, then Northern Ireland and finally Wales where it was considered to be least widespread.

Respondents selected from a pre-defined list the factors that they felt had had a high impact on the extent of video consulting and group video consulting (Table 5) in their clinic, team or service.

Table 5: Factors having a high impact on the extent of video consulting and group video consulting*

Video consulting	**Group video consulting**
1. The cancellation of non-essential face to face appointments	1. The cancellation of non-essential face to face appointments
2. Change in staff attitude due to Covid-19	2. Change in staff attitude due to Covid-19
3. Change in patient attitude due to COVID-19	3. Change in patient attitude due to COVID-19
4. Arrival of webcams or other hardware	4. Availability of IT support
5. Staff/peer-to-peer support AND Availability of IT support	5. Arrival of webcams or other hardware
6. Increase executive/senior leadership support	6. Staff/peer-to-peer support
7. Staff training	7. Increase executive/senior leadership support
8. local Standard Operating Procedures	8. Staff training
9. Introduction of automated letters of text reminders	9. local Standard Operating Procedures
10. Other	10. Introduction of automated letters of text reminders
	11. Other

* As ranked by survey respondents (Highest rank = 1)

Other factors identified by respondents that had an impact on group video consulting included the pandemic necessitating the use of groups for patient education, specific issues caused by COVID-19 (e.g. not being able to have a second parent in the consultation meaning that families living in more than one household can only have group video consultations), and a push related to productivity targets.

Some respondents commented on difficulties that had had an impact on their ability to provide group video consulting, including governance and privacy issues and patients' language and IT skills.

Organisational changes relevant to video consulting services

Respondents were asked if a series of statements (listed below) were true of their organisations, service or team before or during the pandemic (Table 7).

Pre-COVID, the first statement below (A) was said to be true by most respondents (n=295), with statement G being true for least respondents (n=88).

A. My organisation has a digital strategy that includes developing video consulting services
B. There is a dedicated individual or team leading on implementing video consultations
C. Clinical colleagues are keen to make use of video consulting
D. Having adequate ICT support for video consulting
E. Any concerns about privacy and security related to video consulting have been largely addressed.
F. Essential hardware (e.g. computers or webcams) has been updated to support video consultations
G. We are able to log appointments on our booking system as 'video'

There was a general increase in the numbers of respondents who said these statements were true during, compared to before, the crisis. This increase was consistent across all countries and all organisational settings with the exception of statement A (my organisation has a digital strategy that included developing video consulting), which saw an increase across all settings except for in NHS Boards in Scotland where fewer people said there was a digital strategy post- than pre-Covid.

Statement C (Clinical colleagues are keen to make use of video consulting) was chosen by the highest number of respondents during the crisis followed by Statement F (essential hardware has been updated).

Essential hardware being updated was the statement that received the biggest increase in respondents saying it was true, followed by 'clinical colleagues being keen to make use of video consulting'.

Table 7: Responses to statements comparing pre and during the pandemic, and most change

Statement	*Pre covid*		*During covid*		*Order of most change (absolute change)*
	True	*Rank*	*True*	*Rank*	
Essential hardware (e.g. computers or webcams) has been updated to support video consultations	103	6	586	2	1
Clinical colleagues are keen to make use of video consulting	134	3	616	1	2
Any concerns about privacy and security related to video consulting have been largely addressed	105	5	544	3	3
Having adequate ICT support for video consulting	109	4	511	4	4
We are able to log appointments on our booking system as 'video'	88	7	466	5	5
There is a dedicated individual or team leading on implementing video consultations	207	2	317	7	6
My organisation has a digital strategy that includes developing video consulting services	295	1	366	6	7

Working from home

The majority of respondents (76.1%, n=614) reported that their organisation, service or team did permit clinicians to work from home during the pandemic, 13.1% (n=106) reported that working from home was not permitted and 10.8% (n=87) did not know.

A slightly higher proportion of respondents from England (82.6%) said clinicians were permitted to work from home than in the other countries (76.2% in Wales, 69% in Scotland, 61% in Northern Ireland).

Comments on arrangements put in place to enable consulting from home were received from 490 respondents. The majority of responses were from NHS Trusts in England and Scotland (164 and 159 respectively). There were also responses from general practices in England (n=87), Scotland (n=3), Wales (n=11) and Northern Ireland (n=4). Other organisations from across the UK provided 21 responses.

A key part of arrangements to support home working was around ensuring appropriate information governance, confidentiality and data security. This included provision of appropriate hardware, remote and secure access to patient records and Trust systems, reminding staff of information governance protocols and assessing/ensuring appropriate working spaces. Additional IT support and training was also important. Some respondents reported limited support for working from home, with insufficient or delayed provision of equipment.

A large number of respondents commented on being provided with laptops, as well as headsets/microphones and webcams. A small number of these respondents reported provision of mobile phones and/or tablets/ipads. Several respondents mentioned that they used their own device (ensuring secure log in), and rely on their own broadband/wi-fi.

Software was provided, notably for video consulting specifically but also to enable secure remote access to patient records and organisational systems. Remote access from home to Trust systems (clinical systems, patient records, shared drives) was an important part of the arrangements to enable working from home.

Privacy and confidentiality was an important theme: staff were reminded of their obligations to maintain confidentiality and that existing policies and protocols (and professional duties) applied at home, as well as new protocols and guidance made available to support working from home (e.g. standard operating procedures, working from home agreements, safeguarding and security guidance). The provision of secure equipment (laptops and headsets) and software was reported as relevant to ensuring patient confidentiality.

A small number of staff reported that they were advised to blur their backgrounds to ensure confidentiality. A larger number reported that they were given guidance to ensure their working space at home was private, confidential and free of disruptions. Some staff commented that they were told to inform patients that they were consulting from home and to ensure patients consented to their consultation on that basis. A small number of staff were asked to dress appropriately/wear their uniform whilst consulting from home.

A small number of respondents reported some consideration about staff safety including workplace and work station assessments and provision of ergonomic office equipment/furniture. Some mentioned extra administrative and IT support being made available.

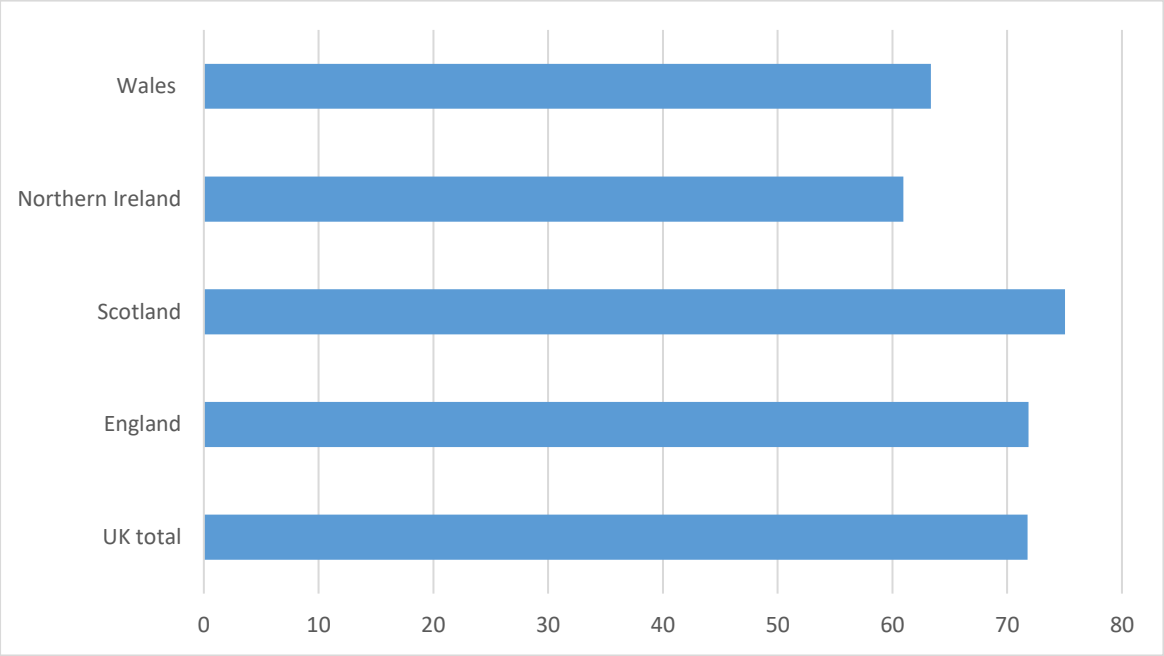
A small number of respondents noted that working from home was generally limited, and/or that video consulting was not supported from home; with comments that working from home was limited to staff who were shielding. Others noted that availability of devices were limited or that there was delay in providing equipment and support, thereby limiting potential for home working.

Executive team support

Respondents generally felt that the executive team (or equivalent) in their service, team or organisation had encouraged the take up of video consultations (Figure 11). On a sliding scale from 0 (not at all) to 100 (significantly), the average response for the UK was 71.77, with highest levels of executive support felt in Scotland (75.04) and lowest in Northern Ireland (60.95).

Examples of specific kinds of encouragement from executives in NHS Trusts/Boards included: sharing positive examples of video consulting, providing weekly/monthly data on use of video consulting, 'celebrating successes' on social media and other communication formats, sharing positive outcomes from national data, providing reassurance on the clinical evidence-base, and conveying a 'can do' stance. Prioritising resources to support implementation of video consulting was also noted, particularly designation of dedicated specific roles/teams to support roll-out.

Figure 5: perceived executive support for VC as a %



Across the UK, respondents reported highest levels of support in Health Boards or Trusts, with lower levels of support in general practice and other organisations.

Respondents provided comments about what one their executive team (or equivalent) had done that had helped the uptake of video consulting, citing the provision of resources (equipment, funding for equipment, training, policies).

We conducted more detailed analysis on responses from those respondents who felt most and least encouraged by their executive team, compared comments made by the bottom quartile (who felt they had the least executive support for video consulting) to comments made by the top quartile.

Of the 175 comments provided by the bottom quartile: 96 were from England, 47 from Scotland, 18 from Wales and 14 from Northern Ireland. The provision of equipment (laptops, webcams, phones, headsets) was the single biggest factor that these respondents felt helped, however some people noted that they did not have access (or timely access) to the right equipment for video consulting. Connectivity was a concern for some, particularly respondents in rural areas. Lack of support for staff access to data/wi-fi at home was also a concern. General support and encouragement was available, and some noted that there was dedicated project support and resources; however in some areas a 'directive' was given to use video consulting with little support. In some cases, the process of setting up video consulting was thought to be unnecessarily complicated.

Some respondents in the bottom quartile commented positively on the decision to video consulting being devolved to clinicians, enabling them to choose when to use video consulting. This was associated by some respondents with rapid roll out. However, others noted limited take up. Some noted a lack of support for patients, as some didn't have appropriate devices, or the technological know-how. Patient preferences were also a concern:

> *'Patients want to be seen face to face, I don't think they consider a video/telephone consultation as a proper consultation'.*

Of the 165 comments from respondents in the top quartile (who reported most executive support) 94 were from England, 62 from Scotland, 6 from Wales and 3 from Northern Ireland. Respondents covered similar topics to those in the bottom quartile, but added specific examples of executive encouragement as well as planning and implementation support. The rapid availability of hardware, software and IT support were all cited as helpful, with some respondents noting that they were

already well-equipped due to initiatives that pre-dated the pandemic – this included general provision of equipment and (in Scotland and Northern Ireland) specific initiatives that had already established video consulting. One respondent from Scotland described how the pre-existing video consulting initiative continued to evolve during the pandemic with full support from the organisation and from the Scottish government.

Respondents in the top quartile noted that appropriate space was made available for video consulting, either by facilitating home working or ensuring appropriate rooms were available in services. Learning how to use software for video consulting was facilitated through formal training (including flexibly scheduled online training) and through informal peer support. Online meetings and training was identified as helping to build confidence:

> *'…participating in meetings and other non-clinical discussions with colleagues/managers has helped build confidence with IT generally, and with video consultations particularly.'*

Clear expectations about the use of video consulting was considered important in NHS Boards and Trusts. Allowing flexibility for clinicians to decide when to use video consulting was felt to be helpful by those working in general practice.

Training to support use of video consulting

The most common type of training reported as being available to staff was guidance via email/direction to online resources (Table 8). Then came in-house training, standard training provided as part of the video consultation platform and cascaded training. Training from an external provider was the least common type of training available.

Table 8: Type of training available ranked from most to least common

Rank	*Type of training*	*No. of respondents**
1	Provided guidance via email and/or directed staff to online resources and online training	545
2	Provided in-house training to staff	332
3	Used standard training as part of a video consultation platform	250
4	Cascaded training e.g. training users in house who then train their teams	207
5	No training is currently available	78
6	Secured staff training from an external provider	30

* Respondents were able to select as all responses that were applicable for their service, team or organisation

There were no differences in the ranking of most to least common types of training provision between the four nations.

Potential for increasing the spread of video consulting

Increased support for patients to use video consulting was the most important single thing that all respondents across the UK identified that would enable further spread of video consulting. Increased support for patients was also the single most important thing for each nation, with the exception of Northern Ireland where it was the second most important thing after resources.

Combined with the high ranking of increased awareness of the service by patients and the public and increased information for patients of the benefits of video consulting, a focus on patients was of high priority to the survey respondents.

Appendix 1: Survey questions

Video Consultations in the NHS

SURVEY: VIDEO CONSULTATIONS IN THE NHS

This survey is for NHS providers in England, Scotland, Wales and Northern Ireland - whether you have set up and provided video consulting or not, we want to hear your views.

BACKGROUND

We are a team of researchers and NHS staff who have been supporting the development of video consulting in the NHS for 10 years. We are working with NHS England, NHS Wales, NHS Scotland and Health & Social Care Northern Ireland to learn about the impact of COVID-19 on the use of video consulting and to support future planning and development of video consultation services.

With funding from the Health Foundation, we are conducting a survey across the UK. We are seeking responses from across primary, community, secondary and tertiary care. We are asking clinicians, managers and administrators about their experiences of setting up or running video consulting (either before or during COVID-19).

PLEASE NOTE: The survey is specifically about VIDEO consultations only **(using Skype, Attend Anywhere or similar media), and not other forms of virtual consultations, such as telephone or e-consult. It focuses primarily on clinician-patient video consulting, and also asks about group video consulting (involving two or more patients and one or more health professionals).**

Your views from this survey will help to inform plans for video consulting services. The survey will close on Friday 25th September 2020.

The survey has 20 questions and should take about 20 minutes (or less) to complete. All of your responses will be anonymous and confidential. We will not know who said what. We will publish the results at www.phc.ox.ac.uk by the end of October.

Many thanks for your help.

Video Consultations in the NHS

Please fill in the survey as fully as you can.

*** Questions with asterisks must be completed for the survey to move onto the next page.**

* **Q1. Which of the following best describe the <u>main organisation</u> you work with or for?** (Please select only ONE)

- ◯ Acute non-specialist provider
- ◯ Acute specialist provider
- ◯ Mental health provider
- ◯ Community provider
- ◯ Other (please specify):
- ◯ Community and mental health provider
- ◯ Acute and community provider
- ◯ GP practice
- ◯ Ambulance service

* **Q2a. In which country is this organisation based?**

- ◯ England
- ◯ Northern Ireland and Isles
- ◯ Scotland
- ◯ Wales

* **Q2b. In which organisation do you work?**

- ◯ Health Board or Trust (please specify, below)
- ◯ GP practice (please give name and/or CCG or region, below)
- ◯ ·Other organisation (please specify, below)

* **Please TYPE** in the name of your organisation/region:

Q3. How rural or urban would you describe the area this organisation serves? (Please choose the closest description)

- ◯ Major urban area
- ◯ Predominantly urban
- ◯ Mixed urban and rural
- ◯ Predominantly rural
- ◯ Very rural

* **Q4a. Has your involvement with video consultations primarily been as a clinician, manager, or support staff (e.g. ICT)? (please select ONE)**

- ◯ Clinician
- ◯ Manager
- ◯ Support staff

Video Consultations in the NHS

For Clinicians

Q4b. if you are a clinician, which of the following best describes your professional group? (please select ONE)

- ◯ Doctor
- ◯ Nurse
- ◯ Physiotherapist
- ◯ Speech & Language therapist
- ◯ Pharmacist
- ◯ Psychologist
- ◯ Occupational therapist
- ◯ Dietitian
- ◯ Midwife
- ◯ Dentist
- ◯ Ophthalmologist / optometrist
- ◯ Other (please specify)

* **Q4c. Which of the following specialities do you primarily work in?**

Please select ONE from the dropdown list:

Video Consultations in the NHS

For Managers and Support Staff

Q4d. If you are a <u>manager or support staff</u>, which of the following best describes your current position ? (Please select ONE):

- ◯ Senior executive/Board level or Associate Director
- ◯ Middle management/Service Manager
- ◯ Administration
- ◯ IT and/or technical support
- ◯ Other (please specify)

Video Consultations in the NHS

Setting up video consultation services

The remainder of the survey includes questions about your organisation, service or team. Please answer these based on whichever category you select in Q5.

Q5. Are you answering this survey on behalf of :

- ◯ Your organisation or practice
- ◯ Your service
- ◯ Your team/clinic

*** Q6. When did your organisation, service or team first set up video consulting?**

	Not set up	Set up before COVID-19 (i.e. February 2020 and before)	Set up in response to Covid-19 (i.e. March 2020 onwards)
Clinician-patient video consultations	◯	◯	◯
Group video consultations	◯	◯	◯

Q7. What types of consultation does your organisation, service or team predominantly use video for? (Please tick all that apply).

- [ ] Acute presentations
- [ ] Active management of an on-going condition
- [ ] Routine review of long-term condition management (including medication)
- [ ] Assessment before a procedure / operation / hands-on care
- [ ] Follow up after a procedure / operation / hands-on care
- [ ] Group consultations
- [ ] Advice and support
- [ ] Other (please specify)

* **Q8. Was increased video consulting part of your organisation, service or team's emergency planning in response to COVID-19?**

- ( ) Yes
- ( ) No
- ( ) Don't know

* **Q9. Which of the following statements are true for your organisation, service or team before and during the COVID-19 crisis?** (Please answer for all items)

	Prior to COVID (February 2020 & before)	During COVID (March 2020 onwards)	Don't know/ Unsure	N/A
My organisation has a digital strategy that includes developing video consulting services	☐	☐	☐	☐
There is a dedicated individual or team leading on implementing video consultations	☐	☐	☐	☐
Clinical colleagues are keen to make use of video consulting	☐	☐	☐	☐
Having adequate ICT support for video consulting	☐	☐	☐	☐
Essential hardware (e.g. computers or webcams) has been updated to support video consultations	☐	☐	☐	☐
We are able to log appointments on our booking system as 'video'	☐	☐	☐	☐
Any concerns about privacy and security related to video consulting have largely been addressed	☐	☐	☐	☐

Q10. Has your organisation, service, or team allowed video consultations with clinicians to be conducted from the staff's own homes during the COVID crisis?

- ◯ Yes
- ◯ No
- ◯ Don't know

If YES, what arrangements, if any, were put in place to enable consulting from home?

Q11a. On the scale below (where zero is 'not at all' and 100 is 'significantly'), how far has the executive team (or equivalent) encouraged the uptake of video consultations in your organisation? (Please click the button on the slider, even if you don't wish to move it from the mid-point, or enter a number in the box).

0: Not at all Moderately Significantly: 100

Q11b. Please tell us ONE thing the executive team (or equivalent) has done that has either helped or hindered the uptake of video consultations:

Q12. Which of the following best describes your organisation, service or team's approach to staff training and support? (Please tick all that apply)

- [ ] Provided guidance via email and / or directed staff to online resources and online training
- [ ] Used standard training provided as part of a video consultation platform
- [ ] Provided in house training to staff
- [ ] Secured staff training from an external provider
- [ ] Cascaded training e.g. by training users in the house who then train their teams
- [ ] No training is currently available

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Video Consultations in the NHS

* **Q13a. What platform or technology does your organisation, service or team currently use for video consulting?** (Please tick all that apply).

	Clinician-patient video consulting	Group video consulting (two or more patients)
AccuRx	☐	☐
AskmyGP	☐	☐
Attend Anywhere	☐	☐
Cisco Webex	☐	☐
EMIS Health	☐	☐
FaceTime	☐	☐
GoodSAM	☐	☐
Microsoft Teams	☐	☐
NHS Near Me	☐	☐
OneConsultation	☐	☐
Pexip	☐	☐
Push Dr	☐	☐
Referro	☐	☐
Visionable	☐	☐
WhatsApp	☐	☐
Xuper	☐	☐
Zoom	☐	☐
Other (please specify below)	☐	☐

If answered 'other' above, please specify:

Q13b. Please tell us why your organisation, service or team elected to use this platform/these platforms?

Q13c. If you indicated your CLINICAL SPECIALITY earlier, please tell us how you're using this platform, or platforms, within your speciality.

Video Consultations in the NHS

Video consulting throughout the pandemic

The next questions look at how video consultations have been used throughout the pandemic period.

We are interested in four time-frames:
(i) Pre-COVID (prior to 1st March);
(ii) Peak (March and April);
(iii) Middle (May & June), and,
(iv) Post-peak (July & August).

NB: Please move the slider to enter number in the box or enter manually.

14a. PRE-COVID (before 1st March): What percentage of clinician-patient consultations were via VIDEO in your organisation, service or team, prior to the COVID period? (Move the slider to enter number in the box or enter manually).

0: None Half All: 100

Q14b. PEAK-COVID (March & April): What percentage of clinician-patient consultations were via VIDEO in your organisation, service or team, during the PEAK-COVID period? (Move the slider to enter number in the box or enter manually).

0: None Half All: 100

Q14c. MID-COVID (May & June): What percentage of clinician-patient consultations were via VIDEO in your organisation, service or team, during the MID-COVID period? (Move the slider to enter number in the box or enter manually).

0: None Half All: 100

Q14d. POST-PEAK (July & August): What percentage of clinician-patient consultations were via VIDEO in your organisation, service or team, during the POST-PEAK COVID period? (Move the slider to enter number in the box or enter manually).

0: None Half All: 100

* **Q14e. To what extent have the following impacted on any increase in clinician-patient video consulting?** (Please select level of impact for each item, or N/A)

	No impact	Slight impact	Moderate impact	High impact	Don't know	N/A
Cancellation of non-essential face to face appointments	○	○	○	○	○	○
Introduction of automated letters or text reminders	○	○	○	○	○	○
Arrival of webcams or other hardware	○	○	○	○	○	○
Staff training	○	○	○	○	○	○
Staff/peer-to-peer support	○	○	○	○	○	○
Local Standard Operating Procedure	○	○	○	○	○	○
Availability of IT support	○	○	○	○	○	○
Change in patient attitude due to COVID-19	○	○	○	○	○	○
Change in staff attitude due to COVID-19	○	○	○	○	○	○
Increased executive/senior leadership support	○	○	○	○	○	○
Other (please specify below)	○	○	○	○	○	○

If 'other', please specify:

Q14f. If clinician-patient video consulting DECREASED please use this space to tell us why:

* **Q14g. Did you indicate above (Q6) that your organisation has set up GROUP video consultations?**

- ◯ Yes
- ◯ No

Video Consultations in the NHS

Group video consultations

Question 15 focuses on GROUP video consultations, involving two or more patients and one or more health professionals

* **Q15a. Please estimate the TOTAL number of video group consultations with patients that have taken place in your organisation, service or team since the Covid-19 pandemic began?** (March to August 2020).

* **Q15b. To what extent have the following impacted on any increase in GROUP video consulting?**
(Please select impact for each item, or N/A)

	No impact	Slight impact	Moderate impact	High impact	Don't know	N/A
Cancellation of non-essential face to face appointments	○	○	○	○	○	○
Introduction of automated letters or text reminders	○	○	○	○	○	○
Arrival of webcams or other hardware	○	○	○	○	○	○
Staff training	○	○	○	○	○	○
Staff/peer-to-peer support	○	○	○	○	○	○
Local Standard Operating Procedure	○	○	○	○	○	○
Availability of IT support	○	○	○	○	○	○
Change in patient attitude due to COVID-19	○	○	○	○	○	○
Change in staff attitude due to COVID-19	○	○	○	○	○	○
Increased executive/senior leadership support	○	○	○	○	○	○
Other (please specify below)	○	○	○	○	○	○

If 'other', please specify:

Q15c. If group video consulting DECREASED please use this space to tell us why:

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* **Q16. Which of the following, if any, pose issues for patients (not clinicians) who want to access services from your organisation, service or team by video?** (Please select **up to THREE** that are the most relevant)

- [ ] Infrastructure, e.g. access to a computer, broadband and mobile coverage
- [ ] Digital skills and experience
- [ ] Level of comfort using the technology
- [ ] Income and cost of accessing data
- [ ] Health literacy
- [ ] Concerns about privacy and security
- [ ] Lack of support from family member/carer
- [ ] Lack of access to a private/confidential space for a consultation
- [ ] Other (please specify)

Q17. Please use the scale below to indicate where you consider your organisation, service or team is in terms of the spread and scale-up of video consulting services (where 0 indicates minimal and/or ad hoc use of video consulting and 100 indicates widespread and routine use')

0: Minimal Moderate Optimal: 100

* **Q18. What ONE thing do you think would enable your organisation, service or team to increase the spread of video consulting?**

- [ ] Resources, financial or human
- [ ] Advice and support about platforms/technology
- [ ] Senior management/leadership support
- [ ] Support from clinical team members
- [ ] Support from support staff (e.g. ICT)
- [ ] External support and learning for staff
- [ ] Increased awareness of the service by patients and the public
- [ ] Increased support for patient to use video consulting
- [ ] Increased information for patients on the benefits of video consulting
- [ ] Other (please specify):

Q19. Please use the space below to share any further thoughts you have on video consulting in the NHS:

Q20. Thanks for taking part in the survey. We want to find out more about how video consulting is working in the NHS. Would you be willing to take part in a short phone or video interview, at a time that is convenient for you?

- ◯ Yes
- ◯ No

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Video Consultations in the NHS

Follow-up interview

Thank you for agreeing to help further. The details you provided are solely for the purpose of arranging a follow-up interview, and will not be kept with the main data.

Your details

Name:	
Email address:	
Telephone number:	
Best days and times to contact you:	
Any other comments:	