

Recording HC03

I: And we've started, okay. So to start, can you tell me a bit about yourself and your role, please?

R: Yeah, so I'm [name], and I'm a GP with a special interest in older people, and I'm the [position] at the [NHS Trust], which means that I lead the research as well in the trust. So at the start of the pandemic, we set up quite a lot of services that were using technology to communicate with different people, who it was harder to reach face-to-face. And we saw significant problems with getting into some care homes at the start of the pandemic, because they were reluctant to have healthcare staff coming in, in case we were transmitting Covid. But also when they were having outbreaks, it was very key for us to go and do ward rounds, around the care homes to kind of assess the severity of sickness of people within the care home. So we set up a preventative admission service, and we also set up a... We looked at - we're looking after the Covid-positive care homes, so when people can't go back to their normal care home, they go to the Covid-positive care home until they become Covid-negative.

So we provide the medical support for that care home. And now as a result of that, we're now doing ward rounds around some other care homes, because of the expertise that we gave them during Covid on technology, to do ward rounds around care homes. We then used that expertise to set up other ward rounds around care homes. We continued to provide prevention of admission with video consultations in that, and one of the things that we thought was quite interesting was health very quickly adapted video consultations. And we've been doing video consultations since the start of April, and so we've got loads of experience with those. We use two different platforms, and we've kind of worked out the pros and cons of doing things, we've adapted things along the way.

I: Oh amazing!

R: And social care really struggled to kind of adopt the kind of technology, and what were the barriers and facilitators that kind of helped with that, I suppose.

I: Yeah. Oh amazing!

R: Which is why we thought the research was a good idea.

I: Yeah. Oh amazing! Well, that's like covered quite a number of questions. So you say you started in April, and were you using the technology before April at all?

R: So we weren't doing any video consulting before April, but we've rolled it out across and pretty much all of our services now have the option to do video consulting, but particularly our services that interact with the GPs in... So the GPs will sit in a central referral hub, and GPs are kind of an expensive resource and putting them with every team on the ground, we don't have enough money to do that, basically. And so if you put the GPs centrally, and you enable them to do a video consult with any team on the ground, it makes best use of that kind of scarce resource. And also they don't spend any time travelling, so they literally can jump from one call to the next call.

I: That's brilliant.

R: So it seems the most efficient way to make use of a kind of scarce resource as well, so there weren't loads of GPs either. It wasn't like I could put a GP in any place that I needed a GP. So it was to kind of make use of a scarce resource as well.

I: And are you talking with the care homes directly via this technology, or...?

R: Well, I did at the start. I don't do it as much now, because I'm actually going... And we also use it to talk to our community hospital wards as well, so I did ward rounds around all of our community hospital wards. So I did, at the start of the pandemic, and I have done up until about September probably, and then I've been back to being more of a medical director since September. So during the pandemic I was very much redeployed to be a frontline connection, while from September, I've been much more been back being a medical director.

I: Okay. And so you spoke a bit about you've - that you found some advantages and disadvantages of using the technology for consultations with care homes. Could you talk a bit about them, please?

R: Yeah. So I think the main advantage was, so it was efficient because the GPs were able to have a GP sitting centrally and they weren't wasting any time kind of driving around different care homes. We were able to get around two care homes in an afternoon, for instance. And the technology, because we had some iPads in some other care homes, we found that on a phone, that what you can see isn't quite as good for clinical examination. Whereas if you have a tablet or a bigger phone, you actually can get a much better view of the patients in a clinical perspective. So we found it was more effective with iPads than phones, although sometimes an iPad isn't available. But some of the care - lots of the care homes now have iPads, and I think some of the rollout of iPads is based on some learning that we did at the start, because we deployed iPads to two different care homes at the start, to do a trial of iPads, and we found the iPads were much better than phones.

I: That's good.

R: So we do - so the advantage was that you could... I mean, you can actually assess quite a lot clinically via video. You can get a feel about how alert a patient is. You can have a look at how much they're breathing, if they're breathing too fast. How many - much they're accessing muscles they're having to use when they're breathing. You can have a look at skin rashes really effectively over the phone, over a video as well. You can have a look at a wound on the leg, and things like that. So there's lots of advantages from that point of view, so what you can look at is actually quite extensive. And we combined that with - we gave all the care homes temperature gauges, saturation probes and blood pressure machines as well. And we trained the care home staff to be able to use those, and so they were also able to give us a set of basic observations on the patient as well, which really helped us with the kind of diagnosis going forward. So it wasn't just the video, it was the fact that they could tell us those clinical signs as well. And so you can get a lot more video, and you can get a lot more from a video than you can from a phone call as well.

I: Yeah.

R: So the advantage of video over phone, is you can actually eyeball the patient. You can look at their wounds, you can look at whether the patient is in distress, those kinds of things. And you can also pick up problems with infection control from the care home staff as well. So if the care home staff are going from patient-to-patient, they're not cleaning the iPad, they're not taking off their PPE, and all of those things. We were able to pick that up on the video as well, and say you need to wipe the iPad down, you need to make sure... Because with - the iPads all came with plastic covers, so they could be properly wiped down and clean them in between. And also they could remove the - you could remove the... You could ask them to remove their PPE and change their PPE, so it was an opportunity for kind of education as well.

I: Oh, that's good.

R: So that was another advantage of it as well, [unclear 07:20] doing a phone call. And [?basic 07:23] disadvantages, is that some older people, I think, found it a bit bewildering talking to the doctor through an iPad. Although with some of them, even with very advanced dementia, that we were really surprised about, really thought it was brilliant because the doctor talked to them through a screen, they thought it was... So we thought that was going to be more of a problem than it actually turned out to be, so we anticipated that was more of a problem than it actually turned out to be. And then the other thing that was quite difficult about it, is you obviously can't listen to a chest, or listen to somebody's heart, or something like that. So there are limitations in terms of the amount of examination you can do, and you can't feel somebody's tummy and those kinds of things. And sometimes if we were looking at something very specific, like a mole or something like that, the picture quality wasn't good enough to assess the mole and so it still required a face-to-face visit.

I: Right, yeah.

R: And if people needed things like a gynaecological examination or something like that, obviously you can't do that over video, so you have to go and do those kinds of things in person. And so they were the kind of major disadvantages, as I saw it.

I: Thank you. And did this - did using this technology fit with the existing ways of consultation that you had before? And like you say you were using them for ward rounds and assessments, and...?

R: Yeah, so they did fit with the existing ways, so we were able to... With AttendAnywhere, we were able to go from patient-to-patient in the care home on the same log in, and we didn't have to keep logging in and logging out, and...

I: Oh, that's good.

R: ...those kinds of things. So we were able to go around all of the patients in the care home, all of the ones the care home wanted us to see, so to speak, on one log in. And the technology has now advanced, so that you can actually have more than one person on the ward round as well.

I: Oh wow!

R: So you can have the doctor, the care home resident, maybe the pharmacist who is there logging in as well; and then sometimes we've actually had the patient's family logging in as well to do a family meeting.

I: Oh wow! That's good. No, that's good. So when you - would you schedule particular times for these calls, or is...? Yeah.

R: Yeah. So we tended - so there were two different types, so the type where they were having an outbreak and it was all dreadful in the care home, they were done on a kind of emergency basis. So there's lots of sick people, please, can you do a ward around? And then we just went around, say, 14 patients who they were worried about and that wasn't scheduled at a specific time, it was just reactive to a situation that had developed. But then the Covid-positive care home that we took on, and the subsequent care homes, we now have ward round times that we have to go and do a ward round around the care homes, that everybody knows to dial in at that time.

I: Okay, so it's a similar question to the advantages and disadvantages, but sort of what factors do you think helps using this technology, and what hindered it?

R: Yeah, so I think the training was really important. So we deployed a lot of people to do training with all the professionals who were going to use it, and being able to roll the iPads out to the care homes really helped; because you could see a lot more on the iPad than on people's phones. And I think the other things that - the fact that we were already using technology in terms of all of our [unclear 10:54] medical records are on one system, and I think that really helped us. And also the fact that with one of the systems, AccuRx, we were able to send texts out to the care homes to photograph skin lesions, or to photograph something. And then that photograph would come directly back into the medical record, so it would then...

I: That's clever.

R: ...sit in the medical record, and you could see the photograph that related to that individual patient. So those kinds of technology things were really useful, and the fact that for most of the time, the technology worked really quite well. So I think they were all the kind of enabling things. The disadvantage things that made it more difficult, was certainly at the start, and AttendAnywhere wasn't very reliable and it kept going down. So we'd lose all AttendAnywhere opportunities, but then we got a second system, so that became less of a problem. Because if AttendAnywhere went down, we were able to use the AccuRx system that we had. And the other problem was that in some parts of some care homes, the wi-fi connection was really poor. And so we would lose the ability to do a video with the patient in some rooms in the care homes, which was really important when people were kind of isolating. So then we'd - then the next [unclear 12:23] that we deployed had chip and pin in them, so they were able to... So on those circumstances, we were then able to... It didn't matter if the wi-fi went down, so to speak.

I: Yeah, so they had like GPS in them, and yeah. Oh, that's good. So when you spoke to older people, were the care home staff in on the conversations too, and did they sit down in...?

R: Yeah. So what normally happens, is they kind of held the iPad so that we could see the older person, but then we could kind of fix the iPad then to ask them questions as well, or they would be standing next to them if they were kind of sitting in a chair or in the bed.

I: And was that - is that normal, and you did that before Covid as well, or...?

R: Yes. So before Covid, when we went to do a ward round around the care home, the care home staff would tend to... If we did it in person, they would come into the room with us, and they would give us the update on the patient, all of those kinds of things.

I: Yeah, that's good. Did you find with the patient - I mean, I guess and with the staff as well - did you have any communication issues over the video technology?

R: So a lot less than you would think, actually. So we didn't have lots of problems, even with people not being able to hear us, I would say. So because it was busier, people who lip-read, could lip-read on the video, and you can actually come up really close to the camera, so that people can see your lips quite close-up, and so that worked for people. And there are obviously some people that were just extremely deaf, and then the care home staff member was then writing down what we would say. But that, I suppose, it's the same in non-...and if you were there in person, sometimes you have to write it down if anybody is extremely deaf as well. We didn't ever have the facility where we needed to get an interpreter in, and I think at the start that would have been quite tricky, because at the start you couldn't have... It was just a two-way conversation that was facilitated, but now I think it would be absolutely fine, because the interpreter could join as a third person on the call. And, actually, that would be fine now, and at the start, but at the start it would have been an issue for us.

I: Yeah, that's a good point. Do you have any specific situations - well, you've just given one, actually, about the interpreter - but of where it worked well, and where it didn't work well?

R: Yes, so fairly early on in the pandemic, we had a care home phone us, in a kind of a state of distress, I suppose, that they had 14 people who they were worried who all had Covid. And they were really worried about all the residents, and, actually, we then went around and did a ward round around all of those patients really rapidly. And that gave them a lot of reassurance that they had been seen...

I: Oh, that's good.

R: ...by a doctor, even if it was virtual. And then we actually deployed some face-to-face staff to go into that care home as well for the patients who were most sick, but I think the staff in the home really valued that face-to-face ward round fairly early on. So that worked really well. An example of where it didn't work very well - we had a mental health patient in one of our care homes who was really severely depressed, and just wouldn't engage with us at all via video, and we had to go face-to-face to see that person. I have to say, they didn't really

engage very much when we went face-to-face either, but they just were not prepared to engage at all with the video.

I: Okay. Yeah, that must have been difficult.

R: Yeah.

I: So another question I've got is - sorry, so only because you've brought something up there I wanted to ask a specific question, but I can't find it now. Oh, I'll keep going down the list. So do you record any of the videos that you do? No. No, you don't share them?

R: No, because of information governance, so we don't record or anything like that, and they're literally in time and people write notes about the consultation. The only thing that we would record is if we sent out an email to... So, say, on AccuRx, we're able to send out a text to somebody's mobile phone to say please send us a photo of the skin region, or something like that. We would store that photo in the records, but we wouldn't store a video.

I: Okay, yeah. Yeah, I understand. So you said about how the ringing up - sorry, doing video technology with the care homes really, really assured them during that time. Have you found that the relationship between practitioner and care home has been influenced by this use of video technology?

R: Yeah. So we've carried on, and not me personally, but the... Some of our team who you're probably going to interviewing, have started doing... They do now weekly ward rounds around the care homes, and I think they've really valued the video.

I: That's so good. Yeah.

R: And also it's meant that we can do these multidisciplinary team meetings within the care home. So the GP joins, the pharmacist joins, the nurse joins and the care home staff join. And so it allows, in effect, a virtual MDT, whereas it's actually quite difficult to get all of those people on-site at the same time.

I: That's so good. That is good. What are outcomes of the call, and some of the calls? So like to what extent might these have been altered by the use of this technology?

R: So, for instance, we were able to prescribe antibiotics for infections remotely, which probably keeps people at home and prevents them being admitted to hospital. We were able to assess end-of-life patients for comfort and things, to make sure that they were dying peacefully, as opposed to being in pain or those kinds of things, which you can't necessarily assess over the phone in quite the same way. We were able to look at rashes and prescribe medication for those, so that people were more comfortable. We were able to reassure the pa-...the care homes that we weren't sending staff in unnecessarily, and potentially increasing the risk of infection. And we were able to reassure care home staff who have just had a query about something that they just wanted reassurance on, I suppose.

I: Yeah. No, that's good. And how confident are you that you and your staff were able to pick up on any potential safeguarding issues when using the technology?

R: Yes. So I think you don't do as thorough an examination on video, so potentially you're not going to see bruises in unusual places. So, potentially, if you were looking for bruises, you might not see them on a video, whereas you might see them face-to-face, so I think that's a potential weakness of the system. I don't want you to think that we never went into care homes...

I: **No, I know.**

R: ...[over speaking 20:24], because we did and we went and did some face-to-face stuff. And we also - but we could certainly pick up some things about infection control. We were able to pick up things about how the staff were interacting with the patients. So we didn't have any concerns, but I think we... But we would have been able to pick up how the staff were interacting with the patients, and if the patient seemed upset or those kinds of things, we obviously explored why they were upset. So it's quite difficult, I would say...

I: **I know.**

R: ...to be completely sure that you didn't miss anything, but certainly if we were able to assess wounds and pressure areas and stuff like that over video, so we were able to pick up pressure ulcers that were developing...

I: **That's good.**

R: ...so from a safeguarding point of view. We were able to look at people, and when we took their clothes off, if there had been any bruises on their chest and things, we would have been able to pick those up, which we definitely wouldn't have been able to do via phone. And, obviously, I mean, we did see somebody with quite bad kind of nappy rash type symptoms from incontinence pads, and so we obviously gave advice to the care home about changing the pad more frequently, and all of those kinds of things. So we were able to pick up some things. Whether we would pick up more subtle things over video, I can't say.

I: **Yeah, because that's kind of similar to my next question, because obviously when you're videoing a person, you're seeing them and perhaps not the people who are around them as well. Could you see any other people in the care home, while you were on video? Do you know what I mean?**

R: Yeah, so we didn't tend to see more than the resident who we were interacting with, but that may have been because of Covid, because people were pretty much confined to their bedrooms, weren't they?

I: **Yeah.**

R: And so even if we had gone into the care home, I'm not sure... We wouldn't have been walking into a lounge area where lots of people were sitting. Everybody was pretty much in their bedrooms a lot of the time.

I: **Yeah, that's - yeah, that was the case, wasn't it?**

R: Yeah.

I: How did - okay, so I've got three more questions. How did using the technology, so video consultation, feel compared to a face-to-face or a phone call? You've kind of touched on this already, but...

R: Yeah, so I actually really like video, and I thought I would hate it, but, actually, I really like it. And, actually, you can see a lot more than you think you can see, and you can actually do quite a detailed examination on a video. And certainly enough combined with the observations, to be able to make a diagnosis in a lot of cases. And the fact that the care homes have the technology now to [unclear 23:23] do video, it means that there's no kind of digital poverty exclusion. So sometimes with people living in their own homes, for instance, we worry about the fact that they don't know how to use the technology, or, indeed, they just don't have a smartphone, so it's more difficult to do that kind of thing. Whereas with the care homes there wasn't really that concern, because of having, them having the iPads that NHS England bought for them. So I think that the advantage of video over a phone, is you can see a lot more, and you can do more of an examination. And you can really - and you can see a lot more how the patient is. A lot of it is kind of based on gut feeling as to how they how they are that day, as opposed to anything truly that you pick up just by examining them, and it's more about the kind of thought about how they look, and those kinds of things.

And I suppose the disadvantages on face-to-face is the things I've touched on, video is not suitable for a medical condition and some things you actually do have to see face-to-face. And we've probably missed out some of the more subtle safeguarding issues, by doing video as well.

I: Yeah. And is there anything you'd change, going forward?

R: So we have changed quite a lot, and we've brought in the second system, because the first system was sometimes unreliable and it didn't have the ability to upload photographs. The next thing that we've changed is the ability to have more than one person on the video consultation, which has been really effective. And I think the other things that we would change, if we would try and... And then, obviously, moving from iPhones, smartphones to iPads or tablets, while we changed that as we went along. Other things that I would change now, I think trying to set up more leeway kind of things with families as well, because I know it's been really difficult for families during the pandemic, and they've felt quite excluded from things.

I: Well, do you know what? We've covered all the questions on my list.

R: Oh! Really?

I: Thank you so much. Is there anything else you think that would be useful for us to know about this, that we haven't covered?

R: So I think one of the things we've found is that one of our iPads got stolen from one of the care homes.

I: Oh dear.

R: Which is obviously really disappointing, because NHS obviously bought all those iPads for the care home. And so we've been scratting around, and we don't have any money to buy more iPads, but we've been scratting around trying to find an iPad for this care home. So I think the care home is really understanding the kind of investment that's been made in them, to try. And there isn't just going to be another one coming if they lose, or have stolen the iPad. So I suppose it's a kind of - and I don't know how clear we made that to them at the start, that the iPad. The NHS spent a lot of money on buying the iPads for them, and actually they should have been really careful with them, and making sure they were locked away and everything like that.

I: **Was it one iPad per care home then?**

R: So it was one iPad per car home, yeah.

I: **Oh dear! Gosh.**

R: Yeah. So I'm not saying it was the care home's fault or anything like that...

I: **No, no. Yeah.**

R: ...I'm just saying that it's kind of... They then said we want another iPad, and we were like, well, we don't have another one and we've kind of spent the money buying your one; it's not like this is an endless pit of money.

I: **Yeah. So that's something to consider then, is like the security of the technology, really, isn't it?**

R: Yeah, exactly. Yeah.

I: **Anything else you want to add?**

R: I suppose the only other thing is the kind of information governance around it. So you've got to get all of that set up at the start, so we had our IT and information governance teams very much looking at the technology, making sure it was safe, making sure that there was no evidence, no way that it could be kind of hacked into, so that other people could view the consultation between the clinician and the doctor. And then the other thing is about making it more private, so we're all sitting in a referral hub now, but we have kind of plastic screens around us and that's partly to protect us from Covid, but also to give a bit of privacy. But we also position people who are doing patient video calls somewhere where there's nobody sitting behind them, so they can't actually be observed.

I: **Yeah, and that's a really good point, thank you.**

R: Yeah. So you've just got to think about all those kinds of things when you're setting it up.

I: **Yeah. Well, thank you so much for talking with me today.**

R: No, no problem.

I: **And you've been really helpful. Let me just stop there.**

End of Transcription