

Recording HC01

- I: Before you start, I just want to check that you are happy to be interviewed and that the interview to be audio recorded?**
- R: Yeah, that's fine.
- I: Okay, brilliant! Well, the first question I just want open up quite openly, broadly and just ask you... I want to know what your experience has been using video technology like Zoom and Attend Anywhere, or WhatsApp for Consulting?**
- R: So with the pandemic I was brought into NHS TRUST to work in the prevention of admission pathway, so that was looking at preventing older people from going into hospital, and if we could care for them at home. And one of the big challenges was obviously the demand on GPs, and access to doctors. So as a GP, I was brought in to work virtually, so I was providing support for nurses who were going into people's homes. And, as part of that, there was a community - not community - it's like it was a care home that we then provided support in. So the patients that were being admitted there were from hospital with Covid, so if they were tested positive, but they were well, so couldn't go home or back to their own care home, they were being admitted to these care homes and we were providing GP support there virtually. And I've also been using it in my general practice role as well, so assessing patients at home and in care homes as well. So a few different uses, I guess.
- I: Have you ever used this technology before?**
- R: No. So it was all very new. We had to learn very quickly. And I think it's interesting, because there was always a hesitancy about using it, I think, in the past. And it was always sort of mentioned, maybe in the future we'll do it, but it was kind of, oh, we're not sure if it's safe, if we're able to, what the consequences would be? Whereas we just had to get on with it, with Covid. And, actually, we've just used it and it's worked, which is great!
- I: That's the thing.**
- R: So I can't see us going back now.
- I: Yeah, well, what are some of the - since you've had a good experience, can you tell me what the advantages of using this technology are?**
- R: So I guess, for me, as a GP, it means I can review more people, because I don't have to physically go out. So you can do quite a lot on video, which usually you would have to visit. And obviously the time taken to travel, getting there and signing in, and all of that has gone and you can just see someone really quickly. So I think speed, which increases your capacity to be able to see more people is the biggest thing. I've not personally used it, but I know some of my colleagues have done stuff like three-way consultations with families as well, which is quite nice. Whereas before it was all just over the phone, and you'd see the patient and then maybe ring them afterwards, but you can actually do it in real-time. They're the sort of main things for me, I guess, in terms of the benefits.

**I: Well, what then maybe are some of the disadvantages of using a video-conferencing type of technology?**

R: Yeah, I don't think it's ever going to replace seeing someone in person. I mean, I'm quite a hands-on person anyway and I do think... I do think there's a huge value in seeing someone face-to-face, and perhaps some of the softer elements of a consultation that you can't quite get over a video: the human touch is quite powerful. And that's one of the big things that I've noticed, is it takes a long time to build rapport over video. And, yeah, especially with the older people that we've been dealing with, there's challenges with technology. But I'm quite comfortable using it, but I've found it sometimes it's quite difficult for them. I've had some consultations where I've just seen the person's ear, because they think it's a phone and they just put it to their face, and you kind of see like this amount of them. I think particularly people with dementia have struggled a little bit with using it, so I think for those people I can imagine I will go back to going out and visiting them.

**I: Yeah.**

R: But for people who are a little bit more able to embrace the technology, I think it's going to be really beneficial.

**I: Well, so you've kind of mentioned, and you might have to do things differently, but you may be adopting it in the future. So did using this technology fit with your existing ways of consulting, and the different things that you do, such as assessment, monitoring and review?**

R: Yeah, so I suppose I can see it going to more of a blend in the future, because at the moment it's predominantly video, and we don't go out at all in my NHS TRUST role. I do still in my GP role, but in NHS TRUST it's all virtual and we're not going out and visiting. The site is really far away from where we are, so it's not really possible to be going out to see them. But I imagine as things change, it will perhaps instead of doing a... You might do a face-to-face, a ward round a couple of times a month, and then the rest virtually, or just it'll be interesting to see whether we then slip back into old habits of visiting all the time, or if we'll carry on doing it the way we're doing it at the moment.

**I: And will you use it for all of your monitoring and review and assessment, or do you think some things it might not be appropriate for?**

R: Interesting. I think whether - because sometimes if somebody is acutely unwell, I think that's tricky, because I do like to see them; and I feel sometimes it's a little bit more difficult over video. What we've been doing at NHS TRUST is that we've had a nurse who has been able to go out, who can do the examination part, so you can talk them through. Because that's the biggest challenge, is being able to examine someone. But if you've got somebody who's appropriately trained at the other end of the video, you can kind of talk it through with them and what they're finding. But it's not ideal, but it's the kind of making the best of the situation. I suppose it depends on each person, I think I'm quite a risk-averse clinician anyway, so I would always want to have that control. Whereas some people would feel happier, I think and say, oh, actually, no, I don't need to see them. Whereas I'm of the kind

of - the way that I work is that I like to have the responsibility, and I like to do the assessment myself. But, again, it's a balance of what you feel comfortable with, I guess. Does that answer your question?

**I: No, I think it does, because some things where you feel like you may need to make a clinical decision, you may not feel confident to do that using... Without seeing it yourself, or maybe something you might want to do in person, rather than using a video call. That does make sense, that you might not feel as confident from what you see during the video call, or relying on someone else to feed back to you. You might want to actually see it for yourself.**

R: Yeah, I think the biggest thing I've found is actually having sensitive conversations, so end-of-life discussions, escalation planning, I just find that I don't feel that comfortable doing it by video. I think probably, again, it's that kind of personal touch. I think video still feels quite cold and clinical, because you're removed. But, again, is that because we're not used to it? I'm not sure, but I definitely prefer to have those conversations in person. And I think in those situations I would rather go out and see somebody, and have that conversation. But maybe we'll learn all about how to use soft skills via video when we can have the training on it, but, for me, it just doesn't feel appropriate.

**I: Yeah, something like that you feel like you need to have those soft skills or touch, or something to help with those difficult conversations. Well, do you have any concerns about privacy with some of your conversations, by using this type of technology?**

R: Not so much, especially because in the homes I've been working with, it's all sort of separate rooms, so that's okay. I think as long as you know who is in the room, because sometimes it's quite difficult. [But saying 09:44] at the beginning, who is there, that's quite important. Sometimes I found the staff sort of wander down the corridor and talk, and I think, oh no, I don't know who is around there. I don't know who is listening, and they could be relatives, they could be anybody. So there is always a concern, but I don't think it's a huge concern for me, personally.

**I: Well, with your video calls and conferencing, did you schedule particular times for the calls with the care homes, and did this work, or...?**

R: Yeah, so we were using Attend Anywhere, so you have to sort of log in, I guess. So we'd agree a time, either on the phone or by email, and then log in to the Attend Anywhere software at like an agreed time, rather than just having direct access.

**I: And that was - that worked for you guys?**

R: Yeah, I guess it is one extra step though, thinking about it and it probably would be better if you could just dial in. But for our workload it worked better being able to schedule it in, because we were quite busy, so having an agreed time was quite helpful.

**I: Yeah, because then you can manage your time a little bit better. Yeah, I understand. Was there - were there any communication issues?**

- R: Yeah. So I think sometimes the video quality is not great. So if the call dropped out, we did have one care home where there was a particular black spot where every time they went, we'd lose them. So just things like infrastructure-wise, and, yeah, some of the patients, particularly if they were hard of hearing, really struggled with it. So you ended up sort of going through the nurse, or the carer, whoever was there as like a three-way, which isn't ideal. They did try using the text-to-speech, but, again, that didn't work too well either. So I think I did question whether it would be better if they had a headphone, and they could give the patients the headphones, but then I don't know if that would work if they've got hearing aids, or whether there must be some sort of technology that you can use to amplify the sound. I imagine it must be quite distorted if it's coming through a little tinny speaker for them, especially if they've got aids in.
- I: **Yeah, if they have any hearing impairments, it's going to be much more difficult. Yeah, that's a good point, definitely. Well, you've kind of mentioned the hearing aids or anything, or the use of like earbuds or something like that. But was there anything that you - that helped you to use this technology? Because it sounds like the text speaking - the direct with the text didn't work, but is there anything else that may have worked, that may have helped you?**
- R: We didn't use anything, it was more just using a third person, I guess, to help. I don't think there was anything else that we tried. No, nothing that springs to mind.
- I: **Well, was there anything that hindered using it?**
- R: I guess, yeah, the infrastructure, so having a wi-fi signal. I think some of the - so I've been using AccuRx for some things as well, so that's more with in people's own homes. And I don't if that's outside of the scope of what your work has been doing, and this is more sort of the care homes.
- I: **Yeah, we're more focused on our care homes, but if there's something that kind of translates to care homes as well, that's feel free to talk about it.**
- R: Yeah. So with the AccuRx, we could bypass things, so we could, I could send it directly to a relative or something, and they've been able to open it on their phone if there was a connection issue. So I guess having multiple ways, so if one way doesn't work then having an extra way of using. But with the AccuRx, I find it's quite a lot of steps and people find it quite difficult, because you have to give it permission to access your camera, and things like that, so having those additional security steps. Whereas if you - because we had the iPad that was set up ready to go with the Attend Anywhere, it was very simple. But I found that the technologies, there's just a few extra steps which can make it a little bit more tricky.
- I: **Yeah. And, yeah, but you see the benefit of having multiple ways to talk to the homes and their residents, but some things may not be appropriate because there's a lot of extra steps and things, and stuff you may have to also install and give access. Well, were there any specific situations, residents, or like events in which it worked really well, video-conferencing?**

R: Yeah, so we did a lot, which we would never have been able to have done, so I guess novel ways in which we never intended, but assessing someone with abdominal pain. So usually you'd want to examine them, and there wasn't a nurse or anyone qualified, but you could just say, oh, could you just press on your own tummy? Where is it sore, and they could show you and you could do a little bit of an assessment that way. And we had some quite sick patients that we were able to see, and you could do a fair examination, I guess, without being there. But I don't think it replaces by actually listening to the chest, or having a feel yourself, but we did the best we could. And it meant that we could see them quickly, whereas before they'd have to call 111, they'd have to wait for somebody to come out, whereas we could be there instantly to assess them. I'm trying to think of any specific examples.

So, I mean, we had a chap who had - they were concerned about his toe, and they thought his toe had gone purple. So I said, well, let me have a little look, and so you could see very quickly that there was nothing to worry about, whereas before I probably would have panicked and rushed over. But you can see in two seconds, oh, it's just a rash, you don't need to worry, and you could get them to hold it up, and you could get them to press and do a sort of capillary refill. So just like simple things, which I guess I wouldn't have had to have gone out, but I would have felt that it would have felt necessary to have gone, and then it would have been a little bit of a waste of a visit, I suppose. Yeah, maybe I should have thought of some specific case examples I could have brought. So if I think of anything I can send some.

I: **Yeah, feel free to send me if you can think of particular situations. Well, I know you mentioned - like you mentioned a few things about situations, or specific situations, or residents or events where it didn't work well, where you definitely weren't confident and felt like you needed to attend. So can you give more information about that, and what kind of situations or residents, or specific events that happened that you felt video-conferencing doesn't work well for this?**

R: Yeah, so I felt particularly patients with memory impairment, and specifically sort of severe dementia, so quite sort of advanced dementia. I don't think they've really understood; they couldn't quite... I don't know whether it's something to do with the way information is processed, but they couldn't quite understand that I was kind of behind the screen. And there must be something about the way the brain interprets this, that it meant it was more difficult, because it was certainly that sort of section of patients. They were sort of looking around trying to figure out was I there, or not, and I think it might have been a bit disorientating for them. And, as I say, some of them, they sort of hold the iPad to their face, just to like talk to me. Or they'd - yeah, not quite understand where the camera was, and...

I: **Yeah, and you'd only see a part of their face and not like...? Yeah.**

R: Yeah. Or you'd get a view of their feet, something like that. So I think for those patients who may be confused, disorientated, it didn't work quite so well in terms of talking to them. And it worked very well using a carer to - I could say if they held the iPad, they could show me things, which was useful, but not so much communicating with that person. Whereas I think

if you were there, it would have been fine and you could have had a chat with them. But because they couldn't quite understand it, it was more tricky.

**I: Yeah, that not quite understanding that you're there, but your screen and making the connection that you are talking to them. And, yeah, that's interesting actually that they're not quite making the understanding that you're actually having a conversation, and thinking that it's a phone.**

R: Bless them, and they're very sweet. But I was really surprised, actually, a lot of people who I thought this is going to be a no-go - absolutely fine.

**I: Oh really?**

R: So it just - there are a lot of surprises where... Especially you kind of had this perception that maybe if someone is a hundred, they're not... They're going to really struggle, but some of them were brilliant, and they had never used an iPad before, but they were absolutely fine. So, yeah, it was really good to see that, actually, you can't make that assumption.

**I: Yeah. You don't know who's going to do - be okay with using this kind of technology with regard to the residents.**

R: Yeah, because in general practice, I've had patients who were in their nineties who have a phone. They've got a smart phone, and they don't know how to use it. But I've been able to say, let's give it a try, send the link and they click it, and then they're like, wow! Because it's so simple to use, so you think... I usually say, let's give it a go and then if it doesn't, you've got back up. But I've been really impressed with they've got this technology at home and they don't know how to use it, but because it's so easy, it's a support.

**I: That's really interesting, yeah, the fact that you can sometimes give it a go and they've never tried it before, but they actually are able to use it.**

R: Yeah. They say, oh, I don't think I've got a camera on my phone. And I've said, well, if not, that's fine and I won't be able to see you, but then their face pops up. So they must have a camera, and they just don't know.

**I: Well, you did mention that sometimes care home staff would join the calls when somebody maybe was, had some cognitive impairments or maybe some hearing issues. Can you expand on any other situations where maybe a care home staff might be present when you're having conversations with a resident?**

R: To be honest, they were there the majority of the time we assessed them, I think just maybe for technical reasons. How it worked is we'd a ward round, so they'd sort of walk around with the iPad. So rather than having like a set ten-minute consultation, we were there as long as you needed. So you kind of needed someone there to be able to then going to next person, rather than them dialling in and out. I'm trying to think of any of other specific examples when they'd be there. It was mostly - I mean, it was all of them pretty much that they would be there for. But they weren't always involved in the actual consultation

sometimes, and they were just sort of in the background waiting for us to have a chat, and then finish, so yeah.

**I: So they were always there, and there was never a situation when they weren't really there?**

R: Not really, no.

**I: Okay. Well, how did the consultation feel compared to your face-to-face encounters, or over the phone?**

R: I definitely prefer face-to-face still, even with video. I think, as I've said before, it's just those sort of softer skills, being able to see someone in their environment. You can get a bit of that on video, but not so much. Building that rapport with someone often, there'll be a photo and I'll I always say, oh, who is that in the photo? And just those little things that you don't even realise you do, until it's taken away from you. It felt very much as though you're there, you speak to them and then you go. Whereas you might sort of have a little bit more of a chat, or especially if someone was confused or distressed; and that's what I miss. And just like picking up on emotions, I think is a little bit more tricky, especially when you can't really... If the connection is not so good, or they're not holding it right you can't tell what the sort of body language is. I mean, you can, but not as well as if you were in person, so I think that's where it has its limitations.

**I: Yeah, you can't quite get the whole picture maybe of how they're feeling?**

R: Mm.

**I: Whether - or what exactly they're expressing in their body language.**

R: Yeah

**I: And did you - I know you mentioned this a little bit with people with cognitive issues, but was the person's understanding and participation in the conversation impacted by using this technology?**

R: Can you repeat that?

**I: Was the person's understanding and participation in the conversation impacted using this video technology?**

R: Yeah, and I think sometimes there's sort of misinterpretation, miscommunication. Sometimes it sounds really silly, but they didn't actually realise I was a doctor. And I think sometimes when you're in person, you obviously give off this presence of being a doctor, but especially as being female and young, you know, 'Who are you?'. If I maybe - I should have worn my stethoscope maybe around my neck or something to make it obvious, but I think sometimes they were a bit confused as to who I was, because I wasn't a normal doctor. I think, yeah, sometimes mishearing what I'm saying, little things, and I guess that's to do with the audio quality, not quite understanding the gist of things, but that can happen even if you're in person with sort of accents and things. But, overall, it was okay.

**I: And were they able to participate in the conversation as well?**

R: Yeah, to an extent. Obviously, some people find it more difficult than others, but the majority of people could, even if they did convert to phone, using it as a phone at least and you could get some conversation out of them.

**I: Well, how was the information from the consultation recorded and shared?**

R: In terms of documentation and things?

**I: Yeah, so whatever was said or disclosed, or decisions that were made during the consultation, how was that recorded and shared?**

R: Yeah, so we didn't record any consultations, and I don't know if there is a way of doing it on AccuRx, but we didn't do any sort of recording, but it was all documented in System One. So you can kind of do it as you went along, and especially where we are in the hub, we have sort of three screens, so it's quite easy to just flip between and sort of document as you go, like you would in a normal GP consultation, I guess. Which is different from if you're visiting, because if you're visiting you might not be able to do that. So it did speed up the process, because you could document and see somebody at the same time. Whereas if you're visiting someone at home, you've usually got your laptop, but you might not always have access to that information immediately. So, I guess, thinking about it from that way, having more... Having access to more information, so you could look at blood results in real-time and look up scan results in real-time, and which you don't usually do in GP. Usually you take a printout with you to the patient, so then you can't then look things up. If you think, oh, they say I was seen in clinic six months ago, and I wouldn't have taken that information with me, whereas I could access it instantly.

**I: Yeah, that's a really - yeah, you had, instantly had access to all of their records during your conversation, whereas normally you'd have, like you said, if you went to a visit, you would have to print it out. And you'd maybe not print out the ones that they're referencing, or they're talking, or you're having a conversation about maybe. Okay. And what were some of the outcomes of your calls?**

R: Outcomes in terms of?

**I: Well, did they result in changes in care, or did they kind of...? Were just to update or to check and monitor things, and make sure that there were no issues that needed to be addressed, or anything that came out of the calls that you had?**

R: Yeah. So I guess the same as any consultation, so we could make management plans. So prescriptions, and we could send them electronically. We could arrange for hospital admissions, and we did that on a few occasions. Discharge planning; so discharging patients from the homes back to their own home. What else? I suppose exactly the same as what you'd achieve from a normal consultation.



**I: Yeah, so to the extent... Yeah, so the extent that - so was there any extent that - it sounds like no - but was there any extent that these may have been altered by the use of a video-conferencing?**

R: No, I guess the only thing is that I was a little bit more hesitant in having those sorts of end-of-life treatment planning discussions. We did have them if it was appropriate, but perhaps it would be earlier if it was face-to-face. So, usually, if you were expecting to get to know someone over a period of a couple of weeks, you'd maybe address that on maybe the second visit. You'd build that rapport and then see on the second, but because you didn't quite get that rapport through video, I think it was maybe left a little bit later just to give you time to build that up with the patient.

**I: Okay, yeah. So it sounds like sometimes things might have might have taken longer than they would have if you were in person, because you weren't able to build up trust and rapport with that individual.**

R: Yeah.

**I: So we've kind of talked about this a little bit with trust and rapport, but in what way - with the residents - but what about your relationships with the care home staff, were these influenced by using video technology?**

R: I suppose it depends whether it's compared to being face-to-face, or whether it's compared to telephone, because it was nice to be able to see them because I would dial in, have a chat with the care home staff in their office. It was quite nice to have that little conversation, and then go and see the resident. So I felt like I got to know the staff quite well. Yeah, it was interesting how they saw it from the other side, I guess, not having the doctor in person. But I found it was it was fine using the video, and I think you could still build that rapport with them. And they were very good at being able to sort of follow directions, sort of, oh, can I look at the legs? And I felt it was quite easy, and they embraced the technology amazingly, because I think there's always a concern that having a doctor in person, people feel quite reassured by that. And I did wonder whether maybe the video wouldn't be quite the same, but it seemed to work; it seemed to work well, I think.

**I: Okay, so even though you weren't in person, your relationships with the staff did seem to be fine and maybe didn't quite change; and you felt confident in what they were doing?**

R: Yeah.

**I: Well, I know you said that you think that going forward you'll probably use the video-conferencing technology more in your practice, so what would you change going forward?**

R: I think, as I've already said, it would be more of a blend. So at the moment it's very black and white, and we're either... We're not seeing people at all, whereas I think in the future it would maybe be more of a triage. So you can see - use it as a do an assessment to make a decision whether you need to visit in person. [Often then 32:58] purely just using it instead of visiting, or always visiting, so more of a triage, I think. A lot of things that you can probably do on a video that we wouldn't have thought before, but now, having used it, I think it will

be used more as, yeah, as a triage, I guess. So then you can still visit if you need to, but you could have already done a lot of the assessment beforehand.

**I: Yeah. So certain things, like you mentioned the toe, you realised that before you would have gone and realised it was a wasted visit because it was just a rash. But this - but if it was a triage, you could check, you could have the video conference to check that the toe was not a problem, and it was just a rash and it didn't need to be a visit. Something like that would be an example.**

R: Yeah, or like somebody saying, I'm really worried about this resident and they're really drowsy. I would have gone straight away, but without question, but actually just being able to see them on video, and then they're sat up in bed drinking a cup of tea saying, 'Oh, hello doctor,' and it's like, well, I'm fine. So because things change quite quickly, but it just... I suppose it's that sort of layer of is a visit really necessary, and it can save quite a lot of time.

**I: What could you see about the person - or let me say that again. What could you see about the person concerning other people living in the home? I know you kind of mentioned that you could sometimes hear things a little bit in the background, but could you see other things going on and other people in the home?**

R: Sometimes, so if they were sort of walking down the corridor, you might see people in the dining room, or... But not really - didn't really get much of that, I guess. Yeah, the majority of it is in the patient's bedroom. So I'm quite private and didn't have anybody sat in at a communal area, having a conversation. So they were quite good - the staff - in terms of the confidentiality, and the privacy side of things. But part of that might have been because they were all Covid, so they were supposed to stay in their rooms anyway.

**I: Yeah, if they're supposed to be social distancing anyway, so there's not going to be another person in the room.**

R: Yeah, and I guess that's also another benefit, is that we were not putting patients at risk. And people going in and out is going to be more risky with Covid, thinking about the future, about flu. And the more people that are visiting these areas, the more, the higher the risk of bringing things in. Thinking about norovirus and, actually, if you can do it over the video it's safer for them.

**I: Could you see anything about - with regarding the care home staff, and things going on in the home as well?**

R: Not as much. I guess that's another thing that you get; you get sort of a feeling when you go into a care home of is it chaotic? Is it - are people running around? Are there people visible? And so from, I guess, a safeguarding point of view, you can pick up little things. You might witness staff talking to residents, and you kind of, you can make a judgment about - and not full judgment - but you can get a feel of what's going on, which you don't get on the video. There are a few things that I would think, ooh, somebody is not wearing a mask or PPE. And I'd say, ooh, can you tell them to put their mask on? So you did get a little bit of that, but I suppose that is one of the drawbacks, is that you don't... Smell - some care homes smell really awful, and you can't tell over a video what the smell is. And lighting, and all those little

things that perhaps help you make an assessment of somewhere, whether that's good or bad.

Sometimes you can walk through and you could see - I've been to homes where you see all the residents sitting and enjoying like a therapy or art session or something. And I guess you don't see that, because you're just confined to that little video. And that's just me being nosy, and maybe being like, oh!

**I: Yeah, you're not seeing the other activities and other things that are going on in the home, and it's very much just the conversation or consultation you're having, yeah. Well, you did mention safeguarding issues, and I wanted to ask you how confident you are that you are able to pick up on any potential safeguarding issues in the homes now, that you're having to do it during video-conferencing?**

R: I think it would be harder. I mean, I didn't have any concerns about - from what I saw. It's a home that I've not been to before; there wasn't anything that I thought was a concern. But now that you've mentioned it, and I'm thinking, oh, what was it I didn't see? I'm sure it'll be fine, but I guess that's what you don't pick up on, are those whilst you're there moments. Because you still get those, oh, whilst I've got you here, can you see X, Y, Z? I think you've still got that side of things, which is a bit of a safety net. I think if you're visiting somewhere, often you'll end up seeing other people, but that was still, you are still able to do that. But...

**I: So that was still happening, even though it was over the video-conferencing, you were still, well, while I've got you on the line or while I've still got your attention, do you mind seeing this other resident and other things?**

R: Yeah, which is fine, and it's what you want, so you want to make sure that everyone's okay. And I suppose that I only ever came into contact with a limited group of staff, so often it was the more senior carer who was on that I would... There were two main carers that I would do the ward round, and they were designated as doing the ward rounds. So that meant I didn't have as much interaction with other members of the team, perhaps.

**I: Well, were you able to discuss and share any safeguarding concerns or issues, even though you said you didn't think you saw any, but were you...? Did you feel like you were able to discuss and share them?**

R: Yeah. So, I mean, there weren't anything - there wasn't anything major safeguarding-wise, or anything. But if there were - I felt confident to say, oh, would you mind giving them a cup of tea, or can you bring that over, or just like little things that maybe you would do, or have you put gloves on, and just like little, little things. Yeah, I thought it was - it was didn't impact on that at all.

**I: Okay, yeah. And you mentioned asking them to put a face mask on and stuff, so you didn't have concerns about talking about, and bringing it up and asking them to do things?**

R: Mm.

- I: Well, those are all of my questions. The only other question I have, really, is there any other information regarding your opinions or your experience that you think would be useful for me to know?**
- R: I don't think so. I hope I've sort of given a bit of a flavour, and I don't know if there was anything else that you wanted to know about? I hope that gives you a general view of what...?
- I: Yeah, it sounds like you have many different roles, so you were doing... You were being a GP and contacting care homes who normally are your visits, as part of your practice. But then also, you were also specifically supporting a very particular care home which had Covid patients, and that were being cared for as well. So you were kind of - had quite varied experiences of the different types of care homes, it sounds like?**
- R: Yeah, we were - we did a little bit as well of going into care homes who were struggling. Right at the very beginning of the pandemic, we did do a few. There was one day where I think when the real peak, and there was an outbreak in a care home and they were really struggling to contact their usual GP. So from a NHS TRUST point of view they said, can you just do a virtual ward round, and I think I saw about 20 patients. It was an epic...
- I: Oh wow!**
- R: And I suppose that was slightly different, because it was very much a quick triage, almost taking a step back. The care home staff were in a complete panic, and they thought that they had 20 people with possible Covid, and they were just not sure what to do. So actually having me on a line, although it wasn't as good as me being there in person, we could say, okay, let's calm down, let's take a step back, let's just triage. Who are you worried about? Okay, let's go and see them first. Okay, I'm not worried about them, I'm not worried about them, I'm not worried about them. Okay, yeah, they look quite sick, I'm going to get someone to come out. And being able to do that quite quickly, so the response we could step up where perhaps capacity was struggling elsewhere. So that - I should have said that as a good example of how we used it.
- I: Yeah, that's a great example of it possibly working really well, when you're kind of having to not only see lots of patients at the same time, but then also be really accessible to the care homes and kind of calm them with their concerns.**
- R: Yeah, because I imagine if someone from 111 had turned up to see one patient, and they... Because they wouldn't have been able to have seen everybody, so they might have just said I can't do it. Whereas we had the capacity to be able to just sort it out, I guess, in a time of crisis.
- I: Yeah. So, yeah, a time of crisis it sounds like is it worked really well, and was something that was actually really helpful to have, because then you could see lots of people and not being at risk yourself. But see lots of different people, and calm those staff down and address their concerns.**

- R: Yeah, I wouldn't have been able to have done that on the phone, because they were worried about everybody, which is understandable. But you get a - as soon as you see somebody on a video, you know if they're sick or not sick; you get that kind of GP gut feeling. If they're sat up eating their dinner, that's fine, and we don't need to worry about them too much. Let's see the ones who aren't sitting up eating their dinner, and just being able to provide that clinical reassurance.
- I: **Yeah. Oh, yeah, that's what it sounds like, is like sometimes it's just reassuring the staff that things are going okay and that, yeah, the person isn't critically ill. Well, if there's nothing else that you want to share, that's the end of the interview. Feel free to - if... I know you mentioned earlier things - you were kind of like, oh, I should have thought of this, but if anything does pop into your head, feel free to email me and send me any other things that you think, oh, I didn't mention this, or feel free to send that, feel free to email me and send me anything else. If I remember correctly, you did agree to be contacted about the results and for us to hold on to your contact information. So I will do that, so that when we have conducted all of our interviews and analysed them, I can send you some of the results so you can see what we do find.**
- R: Yeah, that'll be really interesting to see, because I always wonder whether my experience is common, or whether have we embraced it, or have we been really anti? I feel like I'm sitting somewhere in the middle; I'm just sitting on the fence.
- I: **No, no, it's fine. I mean, I think, yeah, it's interesting to see, especially because we are interviewing healthcare staff and social care staff, and how their experiences will be similar, as well as how they'll differ is something that might come out, and to see how they're... And even though they may be talking to similar residents or similar people, but their experiences have been really different, or using the same technology, but it's been really different.**
- R: Well, thank you. It was really interesting to reflect on the last six months, and how far we've come. And, yeah, so it's good to have that as well.
- I: **Oh, that's great to hear. Yeah, but I'll send you the results when we have a bit better idea, since we've only had a few interviews so far, but we've got some in the diary, so hopefully we can get them done quickly and then can analyse them, and I'll send you some of the results. And do feel free to contact me if you have any further questions about the study, or anything else that you would want to share with me?**
- R: Okay, brilliant! But, yeah, it's a really good piece of work, so I'll be really interested to see the outcome, so good luck!

**End of Transcription**