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Patient & Public Engagement and Social Research: Virtual Access to Care

Report to the Joint Programme for Patient, Carer and Public Engagement in COVID Recovery

September 2022

Guy's and St Thomas' NHS Foundation Trust (including Royal Brompton and Harefield Hospitals and Evelina London Children's Healthcare) and King's College Hospital NHS Foundation Trust.

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Generously funded by Guy's & St Thomas' Charity and King's College Hospital Charity

Acknowledgments

We are so grateful for the people who have accessed virtual care, and who contributed their experience and stories in the spirit of collaboration and to secure improvements in services. People were understanding of the NHS's constraints and both health professionals and people using NHS services were supportive of each other. The group focused their attention on the issues in workshops on how virtual access can be improved.

We were struck by both people's generosity with their own stories and data, their clarity about what they needed, their frustration at the difficulty of getting the access they need, and the variation in people's experiences.

We are thankful for the professionals that stepped into unknown collaborative territory with open hearts and minds to discover how to improve virtual access, some of whom had similar frustrations to the patients and carers.

Thank you to the People's Academy citizens from London South Bank University who listened with care to people's experiences and supported those who were having difficulties.

Finally thank you to the funders of this work who had the foresight to fund a programme of work that not only contributed to advise on how to provide virtual access to care, but also built relationships to support those solutions along the way.

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Summary

This report gives a full account of a collaboration between Guy's and St Thomas' NHS Foundation Trust (GSTT) including Evelina London Children's Hospital and Royal Brompton and Harefield Hospitals (RBH) and King's College Hospital NHS Foundation Trust (KCH), and the communities they serve to improve virtual access to care.

The Inquiry Questions for the Programme are:

1. What constitutes a successful virtual appointment (whether by telephone or video), from the perspective of patients, carers/ family members and clinicians?
2. What do patients expect to get out of virtual appointments and how does this differ from face-to-face appointments?
3. How can we align the two more closely to ensure consistency in quality of service delivery? What does this mean for service delivery?

The approach included:

1. Desk Research, including reviewing previous commissioned research and intelligence from National Voices work on the pandemic and virtual access to care, provided as a report.
2. Mapping cohorts and inviting participants to the workshops with the help of a Design Team (a group of committed leaders from within the Trusts), through direct phone calls and messaging, through engaged local community organisations and representatives.
3. A series of codesign workshops bringing people accessing services virtually from a range of specialties, their carers, clinicians and allied staff from primary and secondary care together.

Overall, 53 people were engaged in the Virtual Access to Care workshops of which 3 were observers.

This work resulted in ongoing collaboration of people accessing services virtually to service development in the Apollo Programme[1], and codesign of the Charter and the dissemination materials which can be found here.

What is Virtual?

Patients were clear in the workshops – virtual means visual camera online. Telephone calls are only useful for brief follow-ups after a visual virtual consultation. Telephone calls are transactional, virtual consultations are relational. The participants noticed an increase on reliance on telephone calls which do not work for them in terms of providing a good consultation.

The Virtual Access Charter

This work demonstrated the value of learning lessons from the published evidence and best practice on virtual consultation.

The data generated from the workshops amplified the key messages from the desk research.

This is captured in this Charter and which is supported by a video some short videos from patient participants here.

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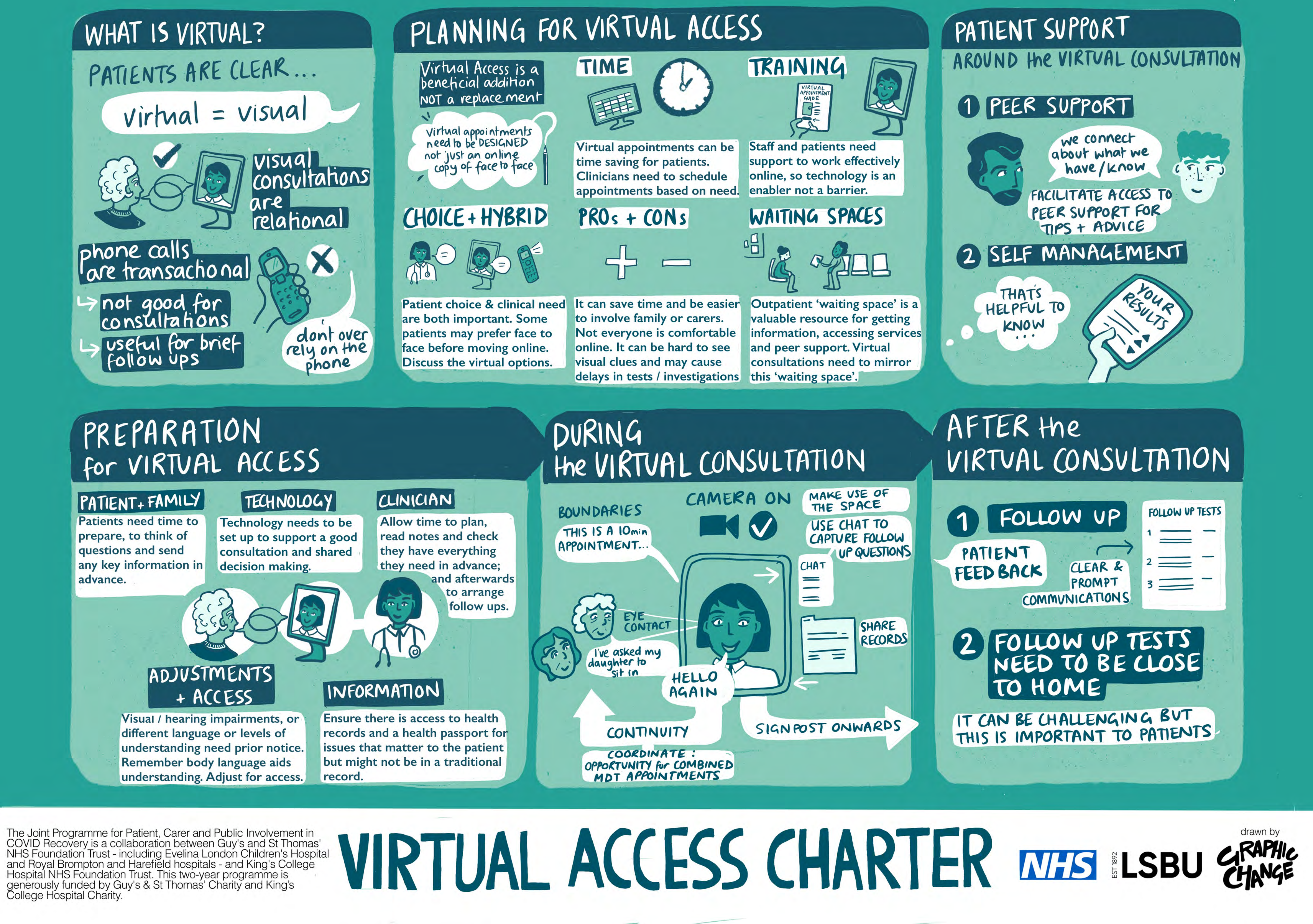
[1] The Apollo Programme is implementing a new electronic health record system at GSTT and KCH.

Fig 1 Virtual Access Charter



WHAT IS VIRTUAL?

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virtual = visual

visual consultations are relational

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↳ not good for consultations

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Virtual Access is a beneficial addition NOT a replacement

Virtual appointments need to be DESIGNED not just an online copy of face to face

TIME

Virtual appointments can be time saving for patients. Clinicians need to schedule appointments based on need.

TRAINING

Staff and patients need support to work effectively online, so technology is an enabler not a barrier.

CHOICE + HYBRID

Patient choice & clinical need are both important. Some patients may prefer face to face before moving online. Discuss the virtual options.

PROs + CONs

It can save time and be easier to involve family or carers. Not everyone is comfortable online. It can be hard to see visual clues and may cause delays in tests / investigations

WAITING SPACES

Outpatient 'waiting space' is a valuable resource for getting information, accessing services and peer support. Virtual consultations need to mirror this 'waiting space'.

PATIENT SUPPORT

AROUND the VIRTUAL CONSULTATION

1 PEER SUPPORT

we connect about what we have / know

FACILITATE ACCESS TO PEER SUPPORT FOR TIPS + ADVICE

2 SELF MANAGEMENT

THAT'S HELPFUL TO KNOW...

PREPARATION for VIRTUAL ACCESS

PATIENT + FAMILY

Patients need time to prepare, to think of questions and send any key information in advance.

TECHNOLOGY

Technology needs to be set up to support a good consultation and shared decision making.

CLINICIAN

Allow time to plan, read notes and check they have everything they need in advance; and afterwards to arrange follow ups.

ADJUSTMENTS + ACCESS

Visual / hearing impairments, or different language or levels of understanding need prior notice. Remember body language aids understanding. Adjust for access.

INFORMATION

Ensure there is access to health records and a health passport for issues that matter to the patient but might not be in a traditional record.

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THIS IS A 10min APPOINTMENT...

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IT CAN BE CHALLENGING BUT THIS IS IMPORTANT TO PATIENTS

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VIRTUAL ACCESS CHARTER

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Recommendations

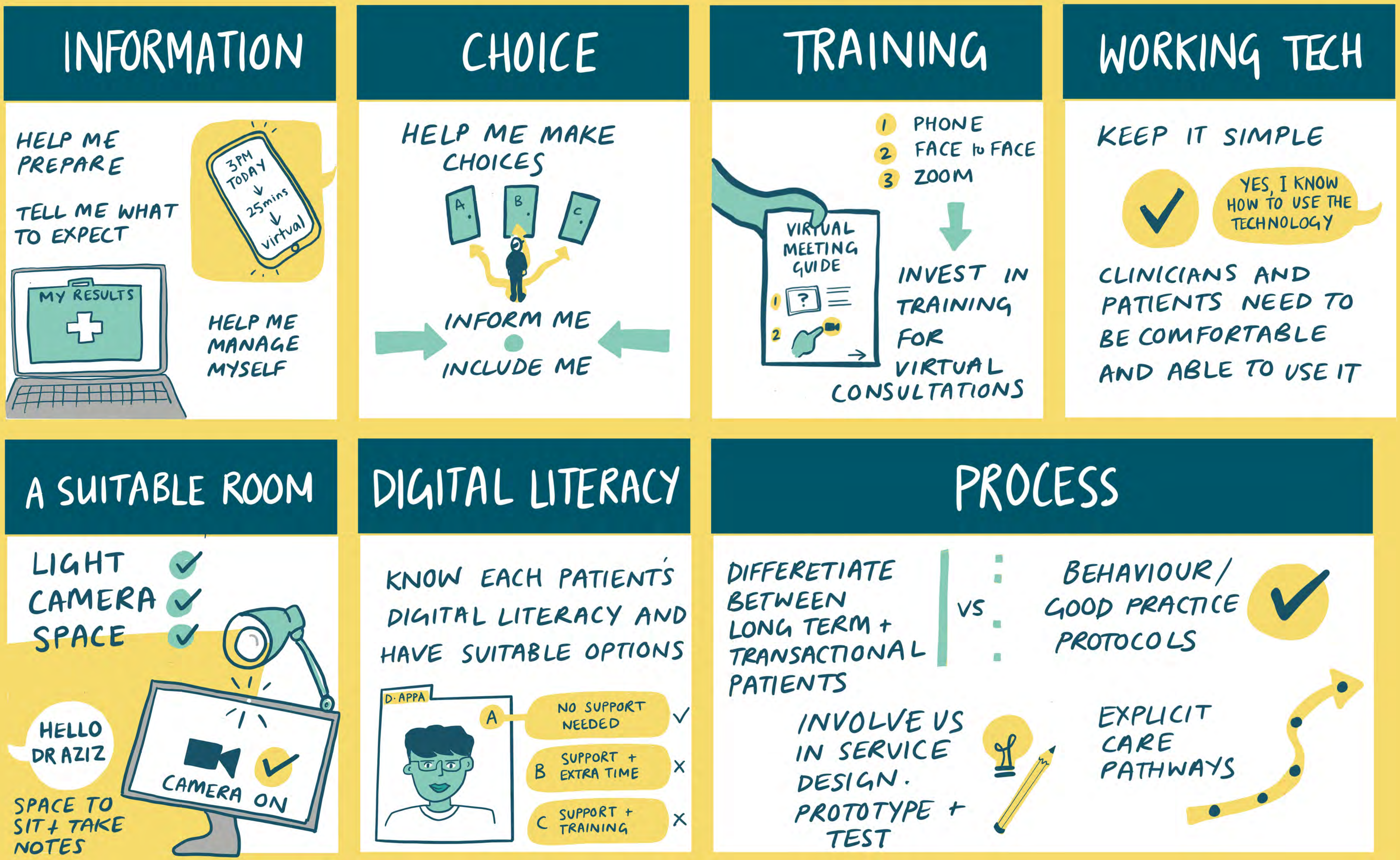
The overall recommendation is for the Trusts to engage with the evidence provided by the desk research; the additional finding in this report (detailed in the Charter) and explained in the videos and graphics; and the patient feedback metrics; and use this to design virtual access.

The Virtual Access Charter brings together all the experience of and ideas for virtual access from patients, carers and clinicians, showing the potential of virtual access to meet needs and secure effective care. The charter addresses the key issues of

(a) What is Virtual Access
(b) Planning for Virtual Access
(c) Preparing for Virtual Access for patients, carers and clinicians
(d) Undertaking the Virtual Consultation
(e) After the Virtual Consultation
(f) Patient Support

People who engaged with this work identified the following 7 top areas, within the above Charter categories that the Trusts should address as a priority:

Fig 2 The top things the Trusts must sort out



TOP THINGS THE TRUSTS MUST SORT OUT

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These results require a strategy for disseminating the evidence provided, and we recommend that the Trusts generate a Self-assessment Tool using the Virtual Access Charter, against which to assess all aspects of Virtual Access performance.

The patient feedback metrics provided in this report should be used to generate evidence for this self-assessment process.

Background to the Programme

This programme was commissioned by the Joint Programme for Patient, Care and Public Involvement in COVID Recovery.

Established in September 2020, the Joint Programme for Patient, Carer and Public Involvement in COVID Recovery is a partnership between Guy's and St Thomas' NHS Foundation Trust (GSTT) including Evelina London Children's Hospital and Royal Brompton and Harefield Hospitals (RBH), and King's College Hospital NHS Foundation Trust (KCH). It is funded, over two years, by Guy's & St Thomas' Charity and King's College Hospital Charity to ensure the involvement of patients, carers and the public in ongoing changes and the development of services necessitated by the COVID pandemic.

The programme is working with patients, carers, and the public to understand:

- shifts in public attitudes and behaviours toward accessing care in different parts of the healthcare system and the risk that patients and the public may retract from accessing the care they need now or in the future.
- how changes made, or being made, continue to affect patients, their families, and carers'experiences of accessing care, using new or rapidly changing models of care.
- variations in experience of care between different protected characteristics.
- how we can improve and further develop services.

As part of the programme's activities, an extensive scoping, identification, and prioritisation exercise was carried out to refine the focus of the programme. This resulted in the prioritisation of the following three projects:

- Virtual access to care
- Waiting for treatment and self-management
- Long COVID

London South Bank University's Health Systems Innovation Lab and People's Academy supported the delivery of the three projects outlined above. This report is for the Virtual Access to Care Patient and Public Engagement Programme.

The Inquiry Questions for the Programme are:

1. What constitutes a successful virtual appointment (whether by telephone or video), from the perspective of patients, carers/ family members and clinicians?
2. What do patients expect to get out of virtual appointments and how does this differ from face-to-face appointments?
3. How can we align the two more closely to ensure consistency in quality of service delivery? What does this mean for service delivery?

The deliverables include:

1. Key Themes from the desk research, a summary is provided here alongside a graphic presentation and the full report was provided to the Joint Programme Steering Group
2. Virtual Access Charter for People and Professionals, provided here

3. Patient Experience Measures provided within this report
4. Video Illustrating the Charter with stories provided by patients here
5. A network of people (patients, service users and carers) who are willing to support the Joint Programme Aims. This has been provided as a database to the Joint Programme
6. An evaluation report which is provided within this report
7. Project final report as required (Report) in the specification and a set of materials to support knowledge sharing including graphics and videos available from the programme webpage here

A summary of the work and findings is provided as an animation video online here

The Context of COVID

This programme of work was commissioned in Autumn 2021 with the plan to deliver the workshops in 2021-22. The pandemic COVID surge in the winter of 2021-22, created a significant capacity issue for the clinicians contributing to this work, and a difficulty in recruiting patients and carers to the programme. The workshops were delayed, and then provided online rather than in person to ensure everyone's safety. The methodology was adjusted to ensure that the relational approach of co-design and co-production was built into the online space.

Note on the Language of Appointment and Consultation

Appointments are meetings and can refer to tests and investigations. A consultation is where a patient consults a clinician, it is a meeting between the patient (and carer) and the clinician where treatment and care is discussed and determined. This report used both terminologies. Where the substance of the findings relates to the relationship between the clinician and the patient, we use the term 'consultation'.

Methodology

Governance

Local oversight and strategic support for the project was provided to LSBU by a designated lead from GSTT as well as the Joint Programme steering group, which includes partners from South East London Clinical Commissioning Group, The Trusts' charities (GST Charity, KCH Charity RBHH Charity), patient-public stakeholders, governors, Healthwatch bodies, clinical leads, transformation leads and patient and public engagement leads from the founder partners (GSTT, RBHH Clinical Services and KCH). Throughout the project the LSBU team met with the local project lead weekly and the steering group (every 2 months on average) to review the process and ensure input and support from strategic stakeholders throughout.

Ethical Considerations

This Codesign (service improvement) project received LSBU ethics panel approval. NHS approvals were not sought as the project is not research.

Rationale

The rational for using coproduction is to help services move away from a paternalistic attitude whereby clinicians and managers 'know best' towards a culture that enables those jointly affected by the pandemic to help guide recovery (IHI, 2020). There is increasing evidence that co-producing change and improvement in healthcare leads to new approaches that are more likely to succeed and be sustained (IHI, 2020). The LSBU project team also involves lay members from the LSBU People's Academy who supported with various aspects of the project including the project design, running the workshops and writing the participant information in plain English.

Methodology Brief Overview

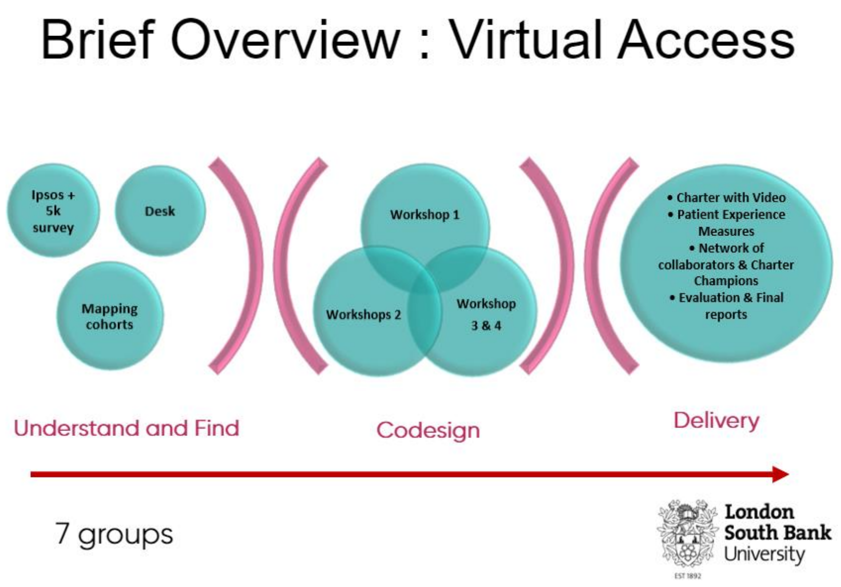


Figure 3 Overview of the Methodology

Understand and Find

This comprised of:

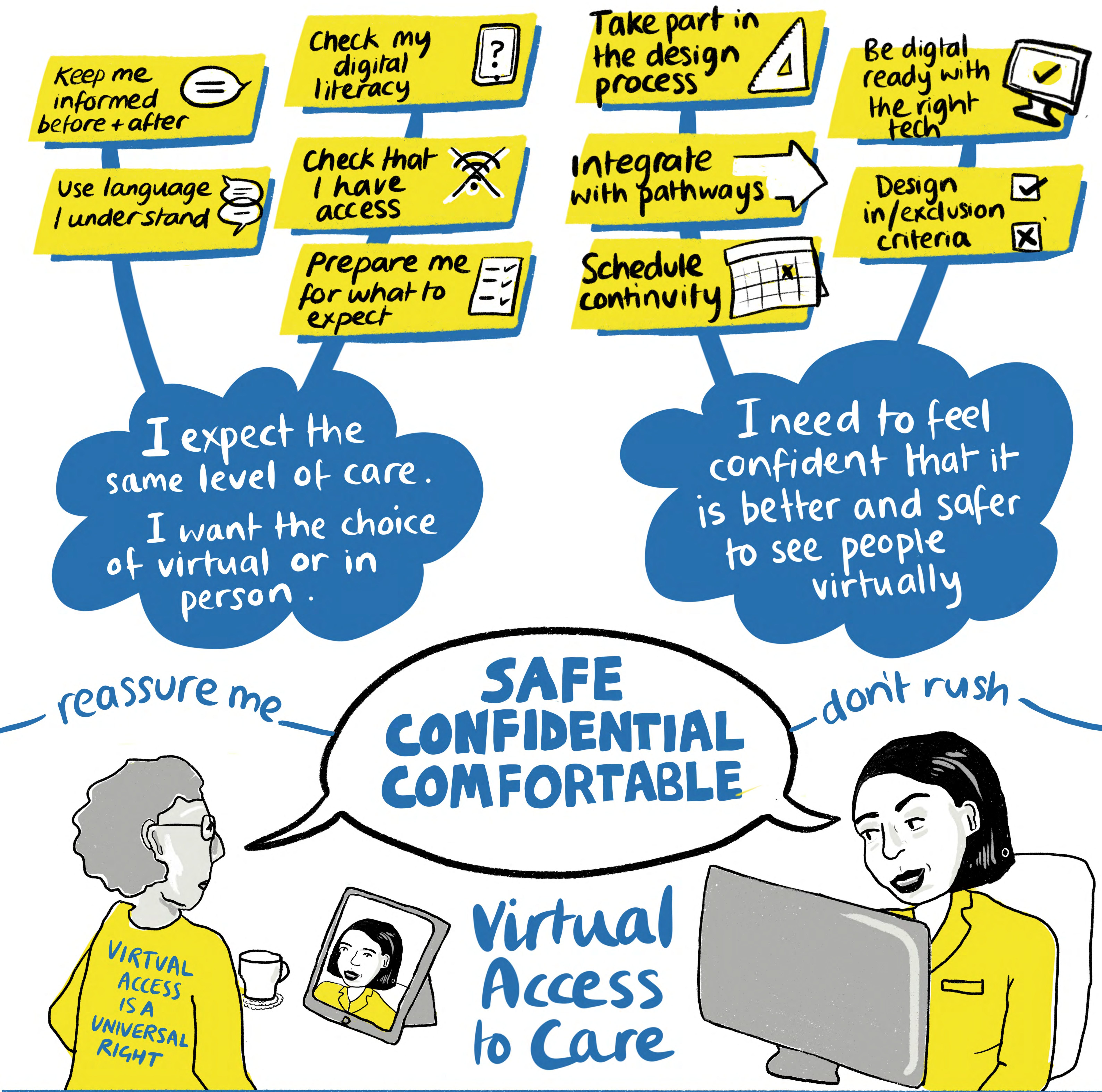
(a) Desk Research, including reviewing previous commissioned research and intelligence from National Voices work on the pandemic and virtual access to care.
(b) Mapping cohorts and inviting participants to the workshops with the help of a Design Team.

The Desk Research was delivered in both long and short form in February 2022. This provided background information and context to help shape and inform the project.

Key messages from the Desk Research are provided in the report available here and provided as Appendix 1. These are critical to the recommendations presented in this report.

A summary of the Desk Research was also provided in graphic form

Fig 4 Virtual access to care desk research



If you design and implement virtual access using available best practice, you will secure high levels of patient satisfaction and uptake.
You will also improve quality.
(equality, continuity & asset based)

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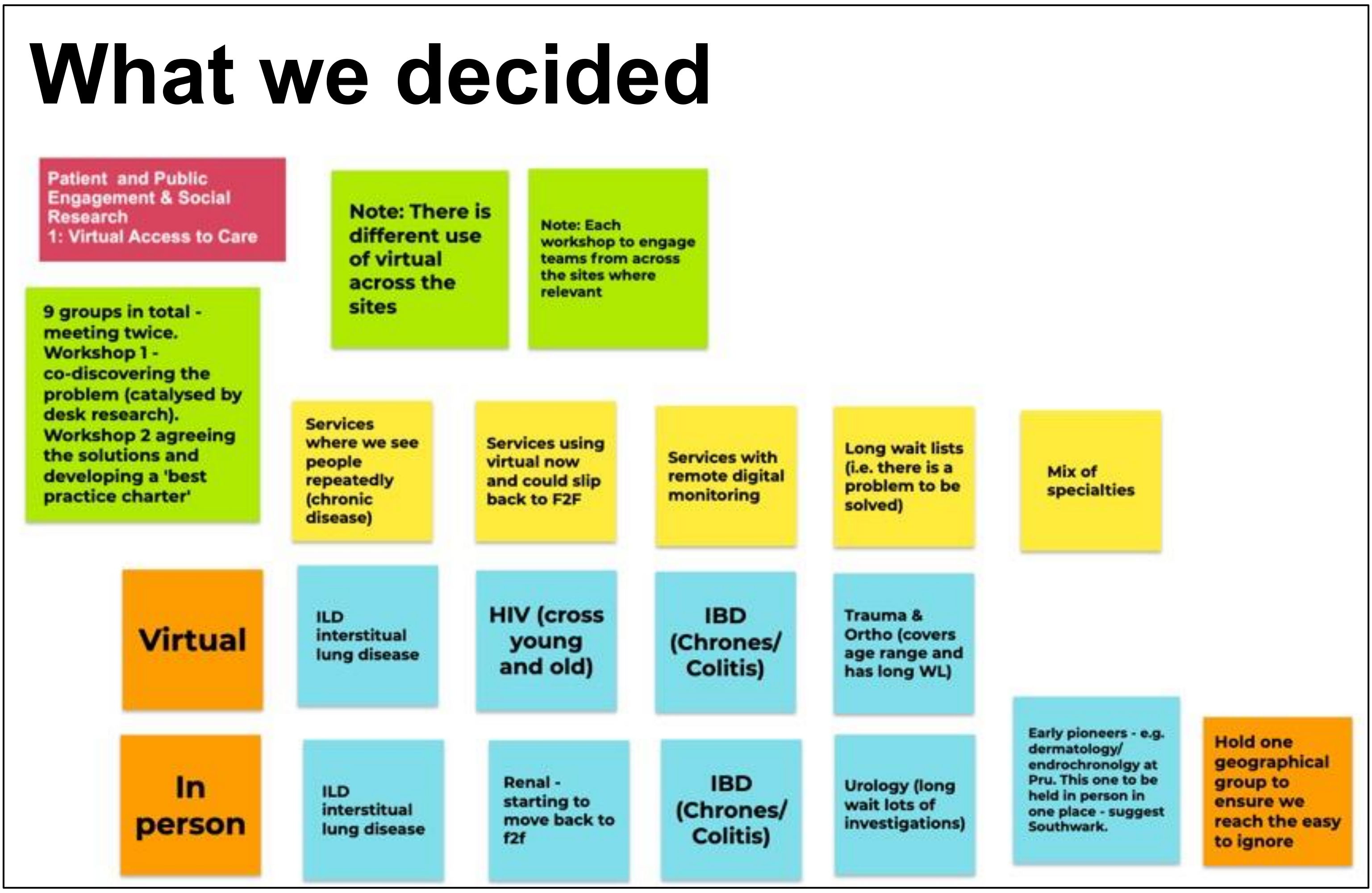
The Design Team

The Design Team was a small group of people from across GSTT and KCH who committed to helping us secure participation and to being ambassadors within the partner organisations. The group did this by helping:

- Sense-check the design in terms of how it will be understood by those we want to invite in (what are we trying to do).
- Identify the cohorts to take part in the workshops (who needs to do it) to be signed off by Steering Group.
- With the invitation process.

The Design Team met throughout the pre-workshop phase.

The discussions in the Design Team reviewed the Desk Research report and from that, and their experience in how services were engaging with virtual access, categorised the Virtual Access Clinics as follows to provide cohorts for the workshops:



What we decided

Patient and Public Engagement & Social Research
1: Virtual Access to Care

Note: There is different use of virtual across the sites

Note: Each workshop to engage teams from across the sites where relevant

9 groups in total - meeting twice. Workshop 1 - co-discovering the problem (catalysed by desk research). Workshop 2 agreeing the solutions and developing a 'best practice charter'

	Services where we see people repeatedly (chronic disease)	Services using virtual now and could slip back to F2F	Services with remote digital monitoring	Long wait lists (i.e. there is a problem to be solved)	Mix of specialties	
Virtual	ILD interstitual lung disease	HIV (cross young and old)	IBD (Chrones/ Colitis)	Trauma & Ortho (covers age range and has long WL)		
In person	ILD interstitual lung disease	Renal - starting to move back to f2f	IBD (Chrones/ Colitis)	Urology (long wait lots of investigations)	Early pioneers - e.g. dermatology/ endrochronolgy at Pru. This one to be held in person in one place - suggest Southwark.	Hold one geographical group to ensure we reach the easy to ignore

Fig 5 The categories of virtual access clinics for the workshop cohorts.

At this stage the Design Team were working on the assumption that half the workshops would be in-person and half-online. However, as the Covid surge hit in the winter through to the spring all the workshops were reverted to being held online.

The clinical groups chosen by the Design Team were:

Services where we see people repeatedly	
Interstitial Lung Disease	
Services that are using virtual access now but could revert back to being held to face to face	
HIV	Renal
Services with remote digital monitoring	
Irritable Bowel Disease	
Services with long waiting lists	
Trauma and Orthopaedics	Urology
The virtual pioneers – those services that are pioneering virtual access	
A mix of specialties including dermatology, endocrinology and cardiovascular	

Table 1 Clinical Groups chosen by the Design Team

This provided 7 condition-specific workshops.

Mapping Cohorts

For each workshop the Design Team mapped the health and care system for providing support to people accessing virtual appointments and determined the invitation list. The Design Team then mapped the citizen participants ensuring we were able to find a diverse mix of people and referring to the specification requirements.

A full description of this process is provided at Appendix 2

The Design Team intent was to identify these cohorts of patients through the clinics, but this yielded a very short list of people. This was augmented by the GSTT/ KCH Database for the cohorts identified, and wide-ranging publicity for the workshops (see invitation process provided in Appendix 2).

Overall, we were able to engage people who met these wide range of characteristics with the exception of homelessness and people with learning disabilities (made much harder by moving this entire process online) although total participation in this programme was low.

Recruitment Issues

Overall recruitment to this workstream was the lowest of the three commissions (the other two being Waiting for Treatment and Self Management, and Long COVID). By the time the COVID surge had subsided enough for clinicians to be able to contribute, a panel of patients and carers was already working with GSTT and KCH to introduce a new electronic patient record system. In addition, clinicians felt that they had been involved in virtual access design previously.

The Workshops

The workshops ran from April 2022 – July 2022, with a feedback session in September.

The workshops were designed in terms of the process to:

1. To develop 'readiness' for utilising best practice (attitude)
2. To 'personalise' best practice to the partnership context (ownership)
3. To ensure that how virtual is implemented and provided improves health inequalities (fairness)
4. To catalyse better quality for all appointments (improve)
5. To design the measures to review the success of virtual (feedback – what counts)
6. To consider how to spread equably across the partnership (share)

The workshops were designed, in terms of outcomes, to develop a Virtual Access Charter and to provide patient experience measures to support the development of the Virtual Access approach across GSTT and KCH.

Participants

A maximum of 30 people (per online workshop) was decided as the group size for each workshop to allow for discussions within the group; to give everyone time to interact; as well as having sufficient people in any virtual breakout discussions. Each workshop aimed to have an equal number of members of the public and staff. Both staff and the public were invited to attend one initial workshop and following this they could opt to attend the following workshops. We were also joined by observers from the Joint Programme Steering Group. Overall participation at the workshops was as follows:

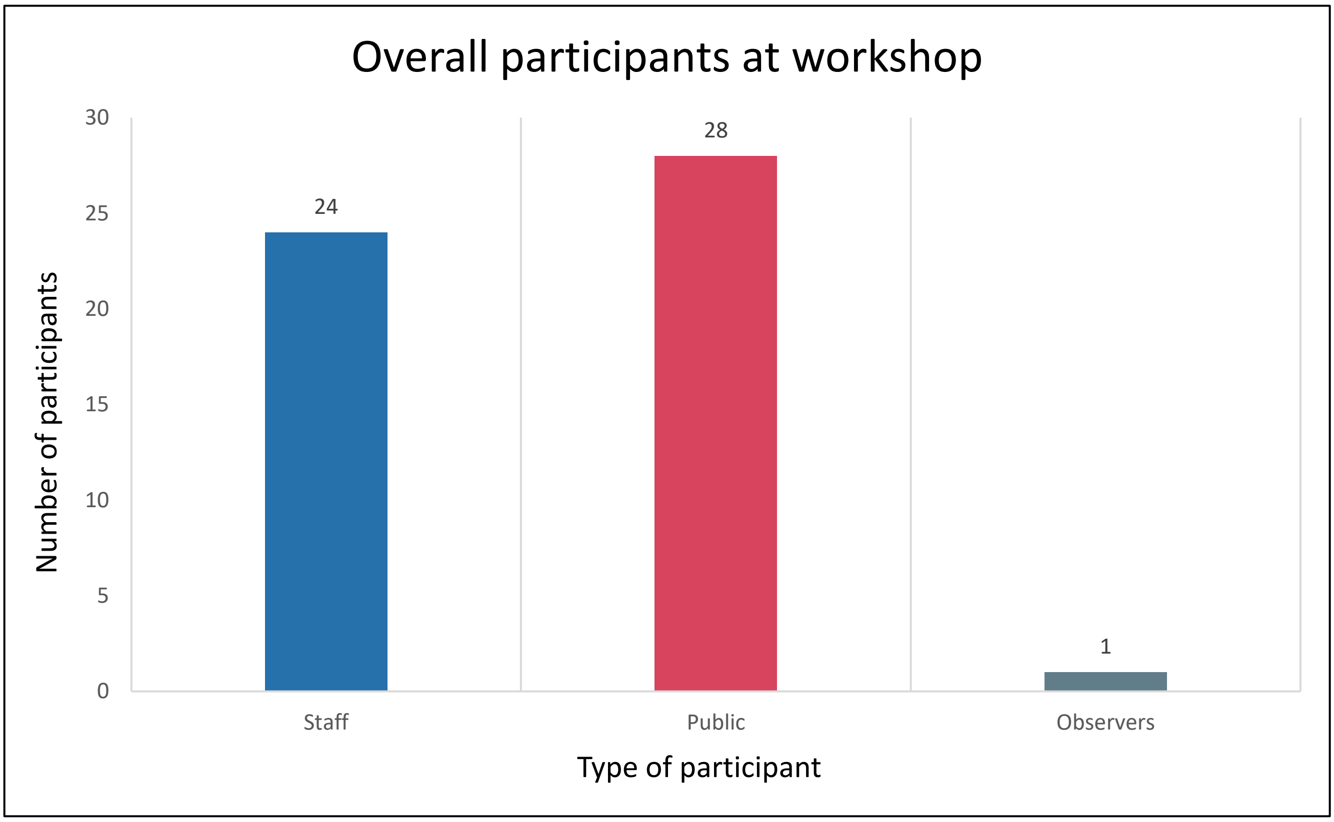


Fig 6 Overall participation in the workshops

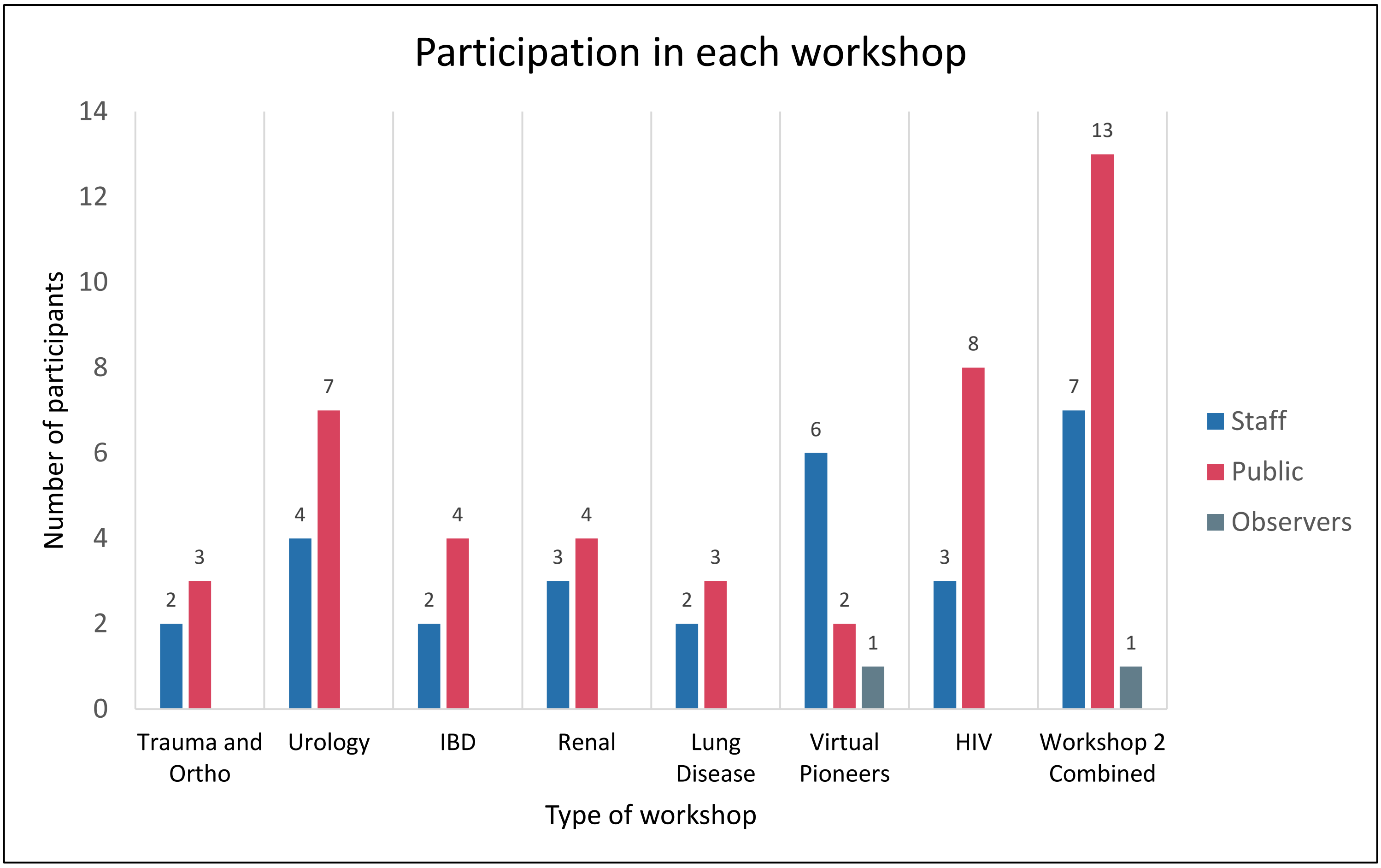


Fig 7 Participation in each of the workshops

Overall, 53 people were engaged in the Virtual Access to Care workshops of which 3 were observers.

The characteristics of the public participants (28) was as follows:

Male	Female	Employed	Unemployed	Ethnic minority	Child/ Teen	Adult (19-65)	Adult (65+)	Cognitive decline	Co-morbidities	Digital Poverty	Carer	Disability
15	12	7	2	6	0	10	8	1	10	0	2	3
54%	43%	25%	22%	21%	0	36%	29%	4%	36%	0	7%	11%

Table 2: Characteristics of the public participants

The characteristics of the Professional participants (24) was as follows:

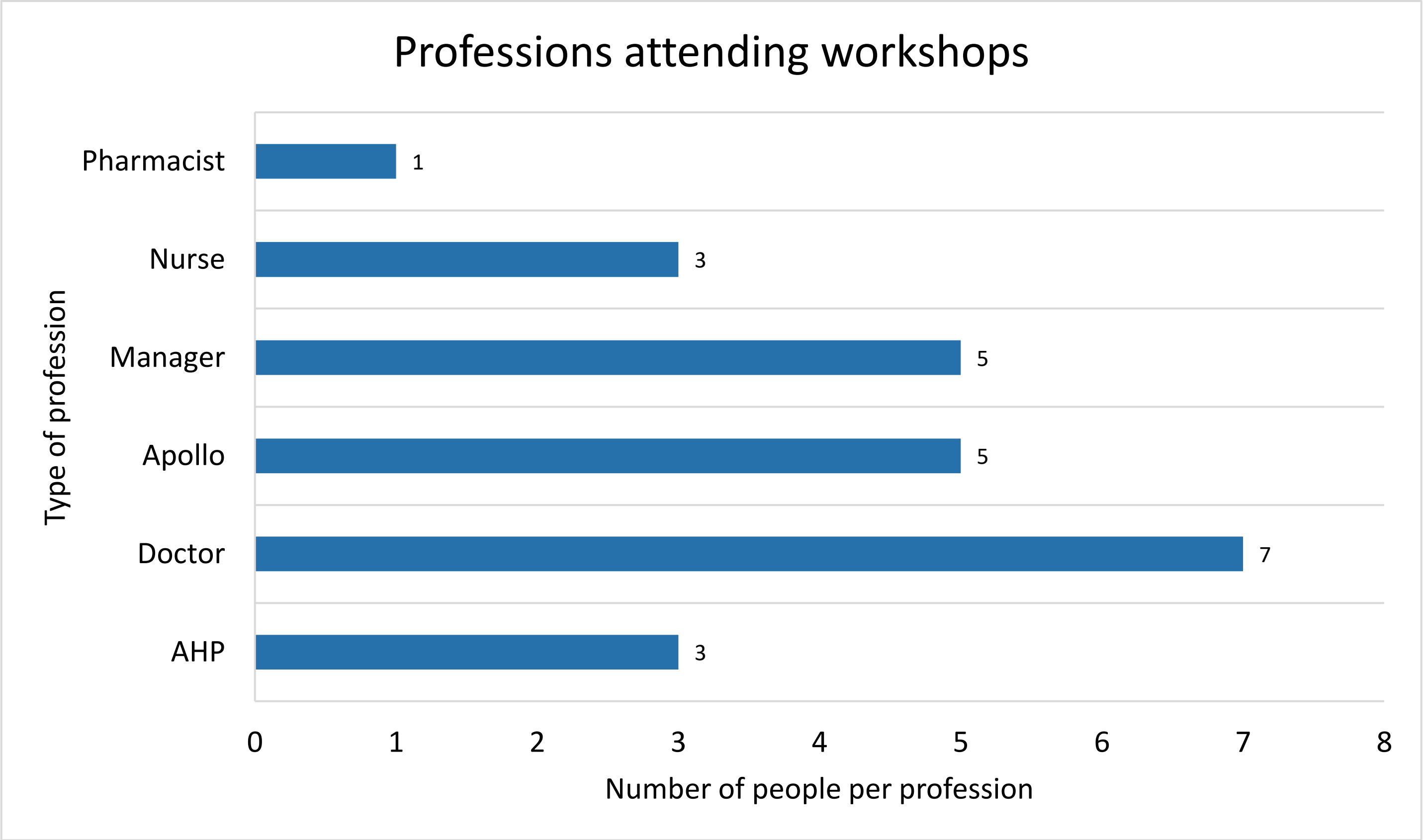


Fig 8 Professions participating

Who came from these organisations:

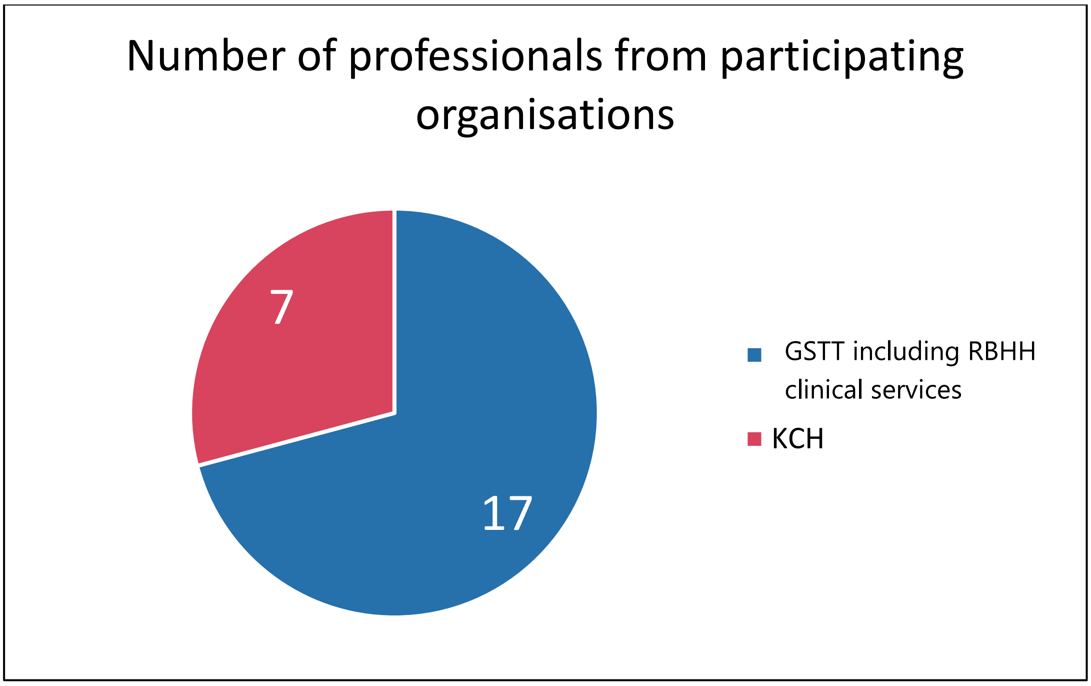


Fig 9 Number of professionals from participating organisations

GSTT including RBHH clinical services	17
KCH	7

A full breakdown of participation by workshop is provided at Appendix 3 along with the feedback from participants.

Results of the Work

What is Virtual?

Patients were clear in the workshops – virtual means visual – the camera should be on online. Telephone calls are only useful for brief follow-ups after a visual virtual consultation. Telephone calls are transactional, virtual consultations are relational. The participants noticed an increase on reliance on telephone calls which do not work for them in terms of providing a good consultation.

Make the Most of Best Practice

The desk research set out the 'Best of the Best Guidance'. This is where any service development should start – taking this best practice and using it as the framework for developing Virtual Access. The issues raised here replicate much of the advice provided and learning shared in the Top 4 that we identified in the desk research:

1. Top Tips for Patients and Clinicians for 'Getting the most out of the virtual health and care experience' (Healthwatch, 2020):

   https://www.healthwatch.co.uk/advice-and-information/2020-07-28/getting-most-out-virtual-health-and-care-experience

2. 'Video consulting in the NHS' (Nuffield Dept of Primary Health Sciences, 2021). Guidance and resources for NHS patients and clinicians to support online consultations, including quick guides for staff and patients: https://www.phc.ox.ac.uk/research/resources/video-consulting-in-the-nhs
3. 'Video consultations for secondary care' (NHSE, 2021): https://www.england.nhs.uk/coronavirus/publication/video-consultations-for-secondary-care/
4. Everything you need to know about the practice of virtual appointments in a Paediatric setting, but relevant and transferable to adult settings. 'Principles for conducting virtual consultations with children and young people' (RCPCH, 2021): https://www.rcpch.ac.uk/resources/principles-conducting-virtual-consultations- children-young-people

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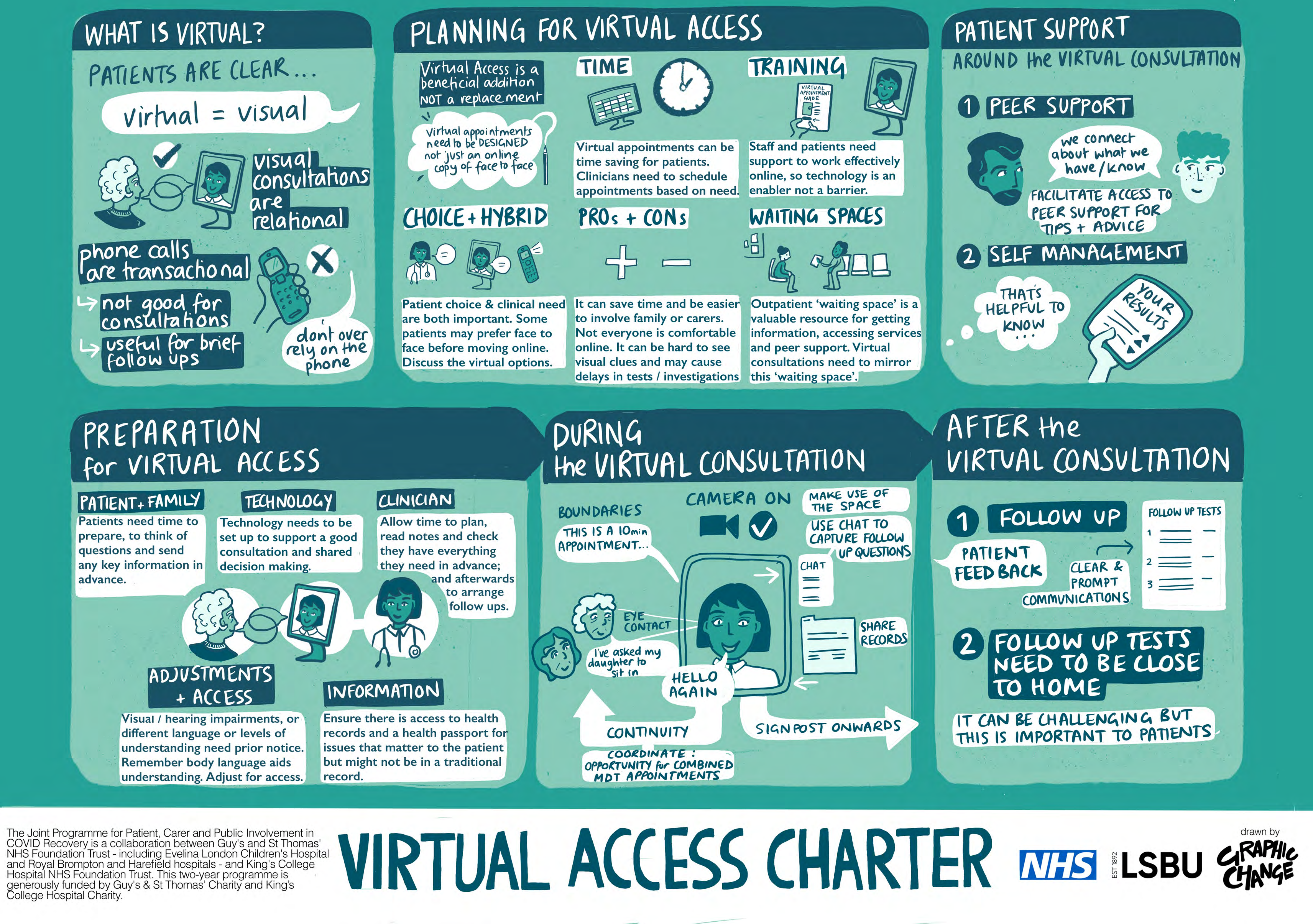

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Planning for Virtual Access

Virtual access should be a beneficial addition to face-to-face appointments, helping those work better. It is not a replacement for all face-to-face appointments. With that in mind, virtual appointments need to be 'designed' rather than just an online version of a face-to-face appointment.

Here are some issues raised by participants in the workshops that need to be considered in how virtual access is designed:

(a) Time

This could be timesaving for the patient if the technology works and the clinics run to time, as it avoids the transport time; but it is not timesaving for the clinician. Appointments need to be scheduled based on need – those patients who are more complex need longer, much like how general practice organises appointments.

(b) Training

Staff and patients need support to work effectively online, so that the technology is an enabler not a barrier.

(c) Choice and Hybrid Approaches

The approach needs to fit both the patient's choice and clinical need. It is easier to move online once a relationship has been formed. So newly diagnosed/ first time patients may do better with a face-to-face appointment initially. At this point there should be a discussion with the patient about the option of virtual appointments as follow-up, but this should be the patient's choice. Patients shouldn't be pressurized into virtual appointments because you don't have to wait as long, it should be fair for all.

The best model is one where the appointment matches the patients need, for instance a face-to face appointment at the outset and at points where needs indicate; virtual visual checkup appointments; with phone calls for any follow-through transactional issues. People were also concerned for those who are less articulate and confident online who should always be offered a face-to-face appointment.

(d) The Benefits and Challenges

The benefits outside of the obvious time saving for patients, is that it is easier to call in family members or carers into the appointment if needed.

The challenges are that it can be harder for visual clues in terms of the patient's health to be visible, and any tests can't be done there and then in the same way as a face to face appointment.

There are also problems with virtual in terms of how the technology can interrupt thinking and make it difficult to say what you want to say. Not everyone is at ease online.

Virtual can also cause delay, where patients need follow-up tests and investigations that, if there were in the hospital, would have been done whilst they attended for the appointment.

(e) Replicating Outpatients

In designing virtual appointments, the 'waiting space' needs to mirror the patients waiting space, with the opportunity to get information, to check in with peer support workers (available for instance in the HIV clinics but not the online clinics), and to meet other people who are waiting. Many patients talked about the value of this for them to help themselves, how outpatients connected them to resources and groups, which has been lost in the virtual space.

Preparation for Virtual Access

(a) The Patient and Family

In order to be prepared and contribute fully, people need to know what to expect and how to prepare. They need to think through the key issues they want to cover and questions they want to ask. There should be an opportunity for the patient to send through key things they want the clinician to know before the consultation so that the clinician can be prepared. There are excellent examples from general practice of patients being notified by text that their appointment is coming up, telling them what to expect and asking them some preparatory questions to get ready. Simple information, such as how long the appointment will be, would have a very positive impact on patients.

There should be the opportunity to practice with the technology before the appointment.

(b) The Clinician

Clinicians need time to prepare for the appointment, reading the background notes in advance, checking they have the information they need. They also need time at the end of the appointment to arrange any follow-up.

(c) The Technology

The technology needs to be set up to support a good consultation (see the section on consultations) i.e., it must function to enable the clinician to do their work and the patient to be heard and consulted, and it has to enable shared decision-making.

This means the clinician must have functioning technology including a camera.

There needs to be a way for both the clinician and the patient to share information during the consultation. All information being addressed during the consultation needs to be visible to both parties so that both are confident in the discussion and decisions.

There must be signposting as the patient moves through the virtual appointment from registering, to waiting, to the consultation, to the follow-up. This must include how long each step takes.

Without the right equipment, the quality of the consultation is severely impaired, and it is likely to not meet patients' need, and to create further demand.

(d) Information

Ensuring there is access to health records, and a health passport for issues that matter to the patient but might not be held in a traditional record.

(e) Adjustments and Access

There needs to be prior notification of visual or hearing impairments or difficulties, or different levels of language understanding need to be taken into account when using virtual appointment options, as quite often body language cannot be picked up as easily virtually and can be key to patient/consultant understanding discussions. The virtual appointment process needs to be adjusted for people with access issues.

(f) Supervising Juniors

Clinicians described how supervising and training juniors is harder in virtual consultations, with less opportunity for shadowing. This needs to be built into the design of virtual consultations.

During the Virtual Consultation

(a) Camera on.

This is vital to building the relationship and being able to understand the patient and their needs. People need eye contact to be sure they are being listened to. "The clinician gave me his full attention virtually, was engaged to what I was saying. Positive feeling overall".

(b) Making the most of the whole virtual space for information sharing.

This includes using a chat box and capturing patient questions for follow-up, and access to records for all.

(c) Boundaries.

It needs to be clear how long the appointment is for.

(d) Continuity and coordination

Seeing the same person is vital where people's needs are complex. It is a more efficient use of time and builds trust. There is also the opportunity to have combined appointments where the patient sees more than one clinician at the same appointment, where two specialists need to work together. This is one of the advantages of virtual appointments- they can be scheduled to secure continuity and coordination.

(e) Making the most of the context

If patients have thought through what they need from the consultation, then they will also have thought who else they want to be there, which gives the clinician and patient the benefit of the carer and family perspective.

(f) Signposting

As with face-to-face consultations, virtual consultations still need to signpost patients to other sources of support and help.

After the Virtual Consultation

(a) Follow-up.

It must be clear what follow-up has been arranged and that this is communicated quickly. Patients noted that after your clinic appointment you saw someone pick up and move your notes, a sign that something was happening. This is missing in the virtual system and creates anxiety – patients said even automated messages would be better than nothing.

There is a survey or follow-up interview to secure feedback on the virtual appointment experience.

(b) Follow-up tests need to be close to home

Whilst we recognise the demand in general practice, and the difficulties of the payment system, patients want follow-up tests as close to home as possible, otherwise the virtual appointment actually ends up requiring more time than the face-to-face appointment.

Community pharmacists were keen to play a more active role in supporting tests close to patients' home.

Around the Virtual Appointment (patient support)

(a) Peer support

The virtual appointment needs to be able to facilitate access to peer support which "enables us to draw out tips and advice - connecting on what we have/ know".

(b) Self-management

Having access to results to allow people to manage their condition themselves.

Ensuring Virtual Consultations Do Everything a Good Consultation Should Do

1. A preparatory call to check you are prepared for the consultation.
2. Consistency of relationship – see the same person where they have complex needs.
3. Be prepared – read the notes before you meet the patient.
4. Introduce yourselves.
5. Build the relationship – start with listening to what the patient and carers need/ are concerned about. Make eye contact and stay present. Repeat what you have heard to check your understanding and so that the patient feels heard. Check how the patient feels about the issue.
6. Bring in other expertise if needed – be able to call on other members of the multi-disciplinary team if needed in the consultation
7. When making agreements double check the patient understands – ask them to repeat back what they think has been agreed. Use good shared decision-making practice.
8. Make space for the patient to ask questions. Recognise that some people have had difficult experiences and may need more reassurance about the next steps.
9. Ask for feedback at the end and clarify what next.

Fig 11 Consultations Checklist

Ensuring virtual consultations do everything a good consultation should do

1. Be prepared - *A preparatory call to the patient to check they are prepared for the consultation; Clinicians read the notes before you meet the patient*

2. Consistency of relationship - *see the same person where the patient has complex needs*

3. Introduce yourself

4. Build the relationship - *start with listening to the patient / carers needs are concerned about. Make eye contact and stay present. Repeat what you've heard to check your understanding and so the patient feels heard. Check how the patient feels about the issue.*

5. Bring in other expertise if needed - *be able to call on other members of the multi-disciplinary team if needed in the consultation.*

6. When making agreements double check the patient understands - *ask them to repeat back what they think has been agreed. Use good shared decision-making practice.*

7. Make space for the patient to ask questions. *Recognise that some people may need more reassurance about the next steps.*

8. Ask for feedback *at the end and clarify what next.*

The Joint Programme for Patient, Carer and Public Involvement in COVID Recovery is a collaboration between Guy's and St Thomas' NHS Foundation Trust - including Evelina London Children's Hospital and Royal Brompton and Harefield hospitals - and King's College Hospital NHS Foundation Trust. This two-year programme is generously funded by Guy's & St Thomas' Charity and King's College Hospital Charity.

drawn by GRAPHIC CHANGE

Fig 13 Top things the trusts must sort out

INFORMATION

HELP ME PREPARE

TELL ME WHAT TO EXPECT

HELP ME MANAGE MYSELF

CHOICE

HELP ME MAKE CHOICES

INFORM ME

INCLUDE ME

TRAINING

1. PHONE
2. FACE to FACE
3. ZOOM

INVEST IN TRAINING FOR VIRTUAL CONSULTATIONS

WORKING TECH

KEEP IT SIMPLE

YES, I KNOW HOW TO USE THE TECHNOLOGY

CLINICIANS AND PATIENTS NEED TO BE COMFORTABLE AND ABLE TO USE IT

A SUITABLE ROOM

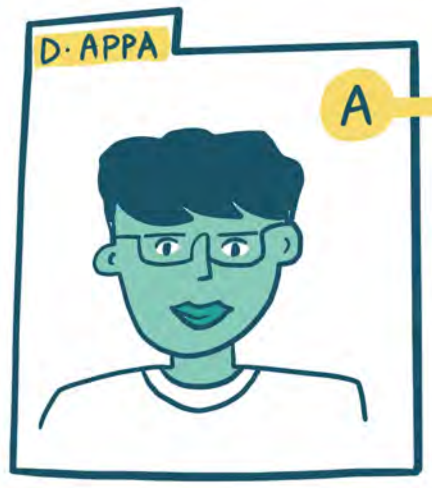
LIGHT ✓
CAMERA ✓
SPACE ✓

HELLO DR AZIZ

SPACE TO SIT + TAKE NOTES

DIGITAL LITERACY

KNOW EACH PATIENT'S DIGITAL LITERACY AND HAVE SUITABLE OPTIONS



A NO SUPPORT NEEDED ✓
B SUPPORT + EXTRA TIME ✗
C SUPPORT + TRAINING ✗

PROCESS

DIFFERETIATE BETWEEN LONG TERM + TRANSACTIONAL PATIENTS VS BEHAVIOUR / GOOD PRACTICE PROTOCOLS

INVOLVE US IN SERVICE DESIGN. PROTOTYPE + TEST

EXPLICIT CARE PATHWAYS

TOP THINGS THE TRUSTS MUST SORT OUT

The Joint Programme for Patient, Carer and Public Involvement in COVID Recovery is a collaboration between Guy's and St Thomas' NHS Foundation Trust - including Evelina London Children's Hospital and Royal Brompton and Harefield hospitals - and King's College Hospital NHS Foundation Trust. This two-year programme is generously funded by Guy's & St Thomas' Charity and King's College Hospital Charity.

drawn by GRAPHIC CHANGE

Measures that Matter

The participants were asked to identify what measures should be used for patients to provide feedback on the quality and experience of virtual access to care.

There are a set of measures that are known to matter to patients accessing services (The Picker Principles of Person Centred Care, Picker Institute[2]), and these resonated with the participants in the workshop.

Fig 12 Picker Institute. About us: [Principles of Person Centred care.](https://picker.org/who-we-are/the-picker-principles-of-person-centred-care/)

Workshop participants were clear that measures should be coproduced, and that patients and carers should be involved in evaluation (including reviewing the results). They also recommended qualitative measures and follow-up with people (patients and clinicians) after their virtual appointment for open feedback, asking questions such as

- What can be done to better engage with the patient?
- What can be done to make the appointment more beneficial for patient and clinician?

The workshop participants recommended that evaluation includes recording the appointment type and asking related experience questions to understand what works well in particular appointments.

The methods for securing feedback from patients should be varied to ensure all can access e.g. text, email, and phone call.

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[2] The Picker Principles of Person Centred Care. Picker Institute Europe. Available at https://picker.org/who-we-are/the-picker-principles-of-person-centred-care/ Accessed 25th September 2022

The suggestions against the Picker Institute categories are provided here

1. Fast access to reliable healthcare advice

   Were patients seen on time?
   Measure waiting times for virtual and within the virtual appointment process. Measure the "delays" *(e.g., minutes or days) to virtual meetings; is the consultant delayed 20 mins, 1hr? AND, how many times one patient is deferred.
   Did the technology work?
   Did the doctor have the results needed ready for the appointment?

2. Effective treatment delivered by trusted professionals

   Were all the patients' issues addressed in the appointment?
   Track a cohort of patients with complex needs over time to get their feedback on the appointments impact.

3. Continuity of care and smooth transitions

   Did the patient see the same clinician at each appointment?
   Did the patient still have to go to the hospital after the virtual appointment for tests?
   Was the patient successfully re-booked after a cancellation?

4. Involvement of and support for families and carers

   Did the virtual appointment meet the patient expectations?
   Was the patient offered a choice of appointment types (Virtual or face-to-face)?

5. Clear information, communication, and support for self-care

   Measure the "latency" of the video link. Set thresholds. If poor, ensure a follow up question is asked… in case the patient felt hard done by… or was unable to get across what needed.
   Are extra information and resources provided and accessible around the appointment?

6. Involvement in decisions and respect for people's preferences

   Would the patient choose to have another virtual appointment?

7. **Emotional support, empathy, and respect**

   Did the patient feel they were listened to and understood?

8. Attention to physical and environmental needs

   Did the patient think there was understanding of their physical & environmental needs in the virtual space (adjustments)?

Impact of the Workshops – Catalysing Change

Alongside the development of the improvement ideas, some of the people who were waiting were able to secure answers to their individual questions. Some of the participants have volunteered to help in the testing of the improvements to virtual access.

Recommendations

The overall recommendation is for the Trusts to engage with the evidence provided by the desk research; the additional finding in this report (detailed in the Charter) and explained in the videos and graphics; and the patient feedback metrics; and use this to design virtual access.

The Virtual Access Charter brings together all the experience of and ideas for virtual access from patients, carers and clinicians, showing the potential of virtual access to meet needs and secure effective care. The charter addresses the key issues of

(a) What is Virtual Access.
(b) Planning for Virtual Access.
(c) Preparing for Virtual Access for patients, carers and clinicians.
(d) Undertaking the Virtual Consultation.
(e) After the Virtual Consultation.
(f) Patient Support.

People who engaged with this work identified the following 7 top areas, within the above Charter categories that the Trusts should address as a priority:

1. Information.
2. Choice.
3. Training.
4. Working technology.
5. A suitable room.
6. Digital literacy.
7. The process of the virtual appointment.

These results require a strategy for disseminating the evidence provided, and we recommend that the Trusts generate a Self-assessment Tool using the Virtual Access Charter, against which to assess all aspects of Virtual Access performance.

The patient feedback metrics provided in this report should be used to generate evidence for this self-assessment process.

Appendix 1: Key Messages from the Desk Research

Ahmed, K., Shamah, S., Malby, B. (2021) Virtual Access to Care: Summary of the Desk Research. Report for Health Systems Innovation Lab, London South Bank University December

A report for the Joint Programme for Patient, Carer and Public Involvement in COVID Recovery generously funded by GSTT Charity and supported by KCH Charity

Key Messages: The Approach

1. What to do to provide excellent virtual consultations is known within the NHS. There is a lot of excellent guidance available that should be used to design and implement virtual appointments. The 'best of the best' is provided in this document.
2. This best practice is not known by people (and carers) and needs to be shared.
3. Best practice can be better used in the process and design of virtual appointments across the Trusts involved in the project.
4. Where virtual care is well designed, patients using virtual appointments report high levels of satisfaction, are less likely to cancel or miss appointments, find it easier to access as they don't have to travel, and feel safer (less risk of infection).
5. 'You own what you create' is a simple way of understanding why best practice is not adopted or spread. Test, learn together, and improve the remote experience with people and carers.
6. The design and implementation process should pay particular attention to unconscious bias and inequalities. Local survey feedback from ethnic minority communities reflects a poorer experience of virtual care (survey findings in section 3) and demonstrates the need to pay attention to the context in which best practice is implemented. It is important to consider that the challenges experienced by ethnic minorities can be found across NHS care and can't just be resolved by a virtual plan alone but following best practice in virtual consultations can help improve the quality of virtual care[1].
7. Ensure that virtual care is inclusive, that choice is offered, and that no one is left out or left behind due to problems such as digital poverty or literacy. Treat virtual access as a universal right (Healthwatch, 2021).
8. There are real opportunities for improving quality of care that should be explored, such as ensuring continuity of care and the use of existing service-user groups to provide local support networks to increase confidence and access.

"You are wasting your time and money if you implement an online consultation tool without significant process change." STP Clinical Lead NHSE (2020)

Key Messages from people and health professionals

1. People expect the same quality of care from virtual as they get from face-to-face appointments.
2. People's preferences in relation to virtual appointments are shaped by convenience of access, transportation, work, concerns about infection, ability to access and confidently use digital tools, whether they think they need a physical examination, privacy and confidentiality and physical space at home.
3. Local people from ethnic minority groups had a poorer experience with virtual appointments.
4. Clinicians need the following to provide a good virtual appointment:

- A confidential space to conduct virtual appointments.
- To be digitally 'ready' - have had training and have working technology and support to hand.
- To be involved in the design of the virtual process.
- That virtual care and processes are clearly integrated into the care pathway.
- Sufficient confidence in the efficacy and safety of seeing people virtually.

Key messages on best practice pre-consultation

1. Design the inclusion / exclusion criteria before inviting people for virtual (e.g.,those that are likely to need a physical exam, and have digital literacy) which should include:
    a. clinical factors such as need for physical examination
    b. safeguarding or social concerns
    c. interpersonal factors such as language difficulties or emotive and sensitive conversations
    d. factors relating to digital access and choice
2. Choice: Offer choice of appointment type - in person or virtual (then video or phone) - it has to be what's right for the person and their needs.
3. Video not telephone if possible (ask the person); people need to be seen as well as heard. This can help manage anxiety about lack of a physical examination.
4. Scheduling: Design in continuity. Use the ease of virtual to provide continuity for complex care needs.
5. Information: Help people prepare. Explain how the appointment works, provide prompt questions to help people prepare, do they need someone to be there with them (or is a translator required?), can they access WIFI? Clarify what to expect.

Key messages on best practice for the consultation:

1. Information: Communicate using best practice techniques across all platforms.
2. Consider the virtual 'space'. Healthwatch (2020): "It's important for people to feel safe, comfortable and that they have a confidential space in which to talk about their medical concerns. Most of those we spoke to hadn't received any information in advance about how the appointment would work or what they could do to help. It would be useful for patients to be alerted to this fact beforehand so that they can prepare for their appointment."
3. Scheduling: Stick to the time. Make the appointment at a time the person can attend and stick to it.
4. Consultation: Don't rush (or appear in a hurry). Take time for people to respond fully and come back to questions if they are anxious to check the response. Reassure or advise if there are concerns relating to lack of a physical examination. Be kind and compassionate.
5. Consultation: Interact - support the discussion through chat and shared screens.
6. Consultation: Share the record of what was said and agreed.
7. Consultation: Make it clear what happens next and provide written information.

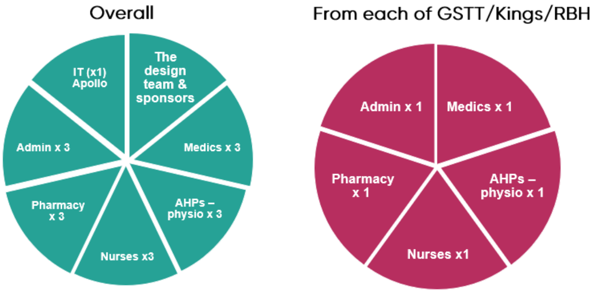
Appendix 2: The Methodology in Detail

Mapping Health and Care System

For each workshop the Design Team mapped the health and care system for providing support to people accessing virtual appointments, and determined the invitation list as follows:

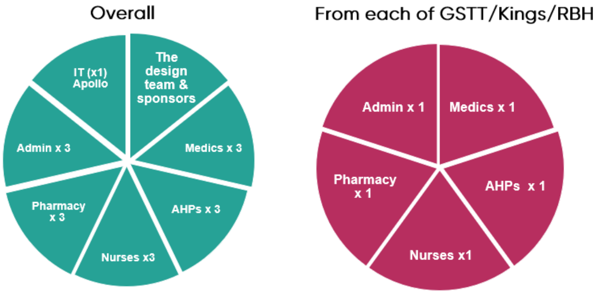
Interstitial Lung Disease

2 workshop groups
For each group we are inviting following mix from across the partners (where is says x 3 that's one from each Trust team – GSTT/Kings/RBH



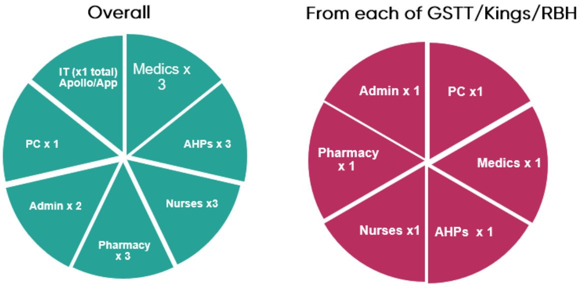
Renal

1 workshop group – in person
For each group we are inviting following mix from across the partners (where is says x 3 that's one from each Trust team – GSTT/Kings/RBH



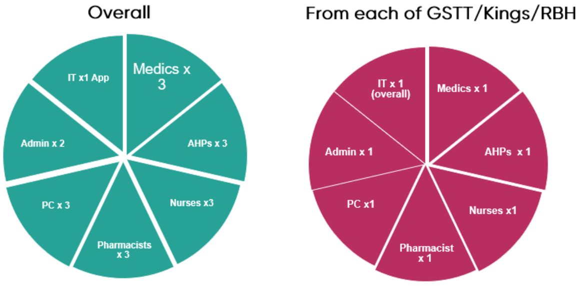
HIV

1 workshop group – Virtual
For each group we are inviting following mix from across the partners (where is says x 3 that's one from each Trust team – GSTT/Kings/RBH



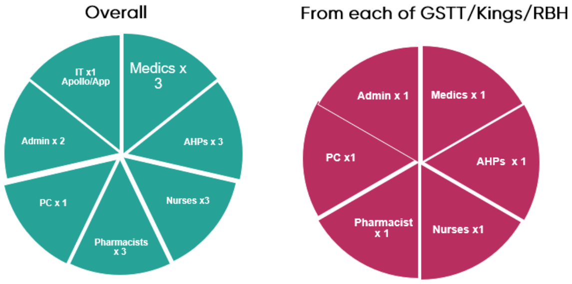
IBD

2 workshop groups – 1 x in person and 1 x Virtual
For each group we are inviting following mix from across the partners (where is says x 3 that's one from each Trust team – GSTT/Kings/RBH)



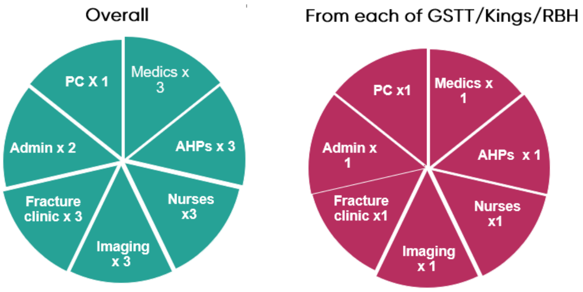
Urology

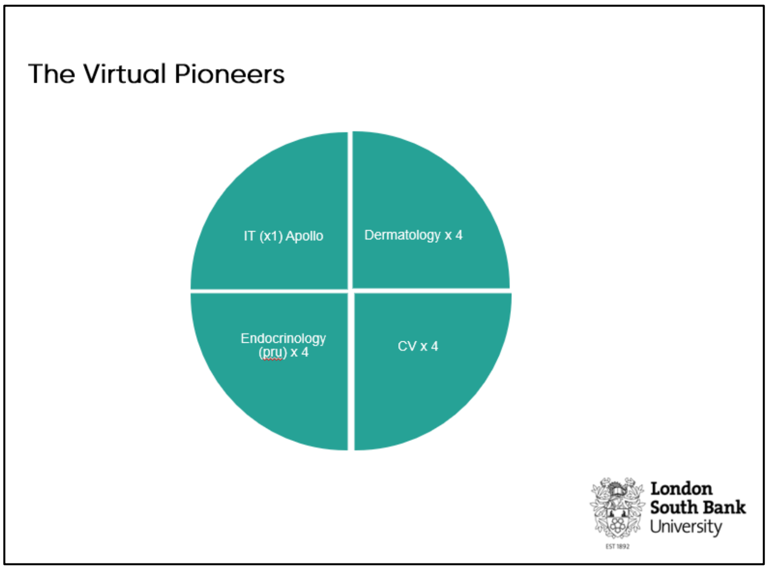
1 workshop group – in person
For each group we are inviting following mix from across the partners (where is says x 3 that's one from each Trust team – GSTT/Kings/RBH)



Trauma and Ortho

1 workshop group – 1 x virtual
For each group we are inviting following mix from across the partners (where is says x 3 that's one from each Trust team – GSTT/Kings/RBH)





The Virtual Pioneers

This was then translated to a spreadsheet where the Design Team and their colleagues identified names and contact details for the invitations. The Design Team then invited the professionals, and these invitations were all follow-up by the LSBU team to secure participation at the events.

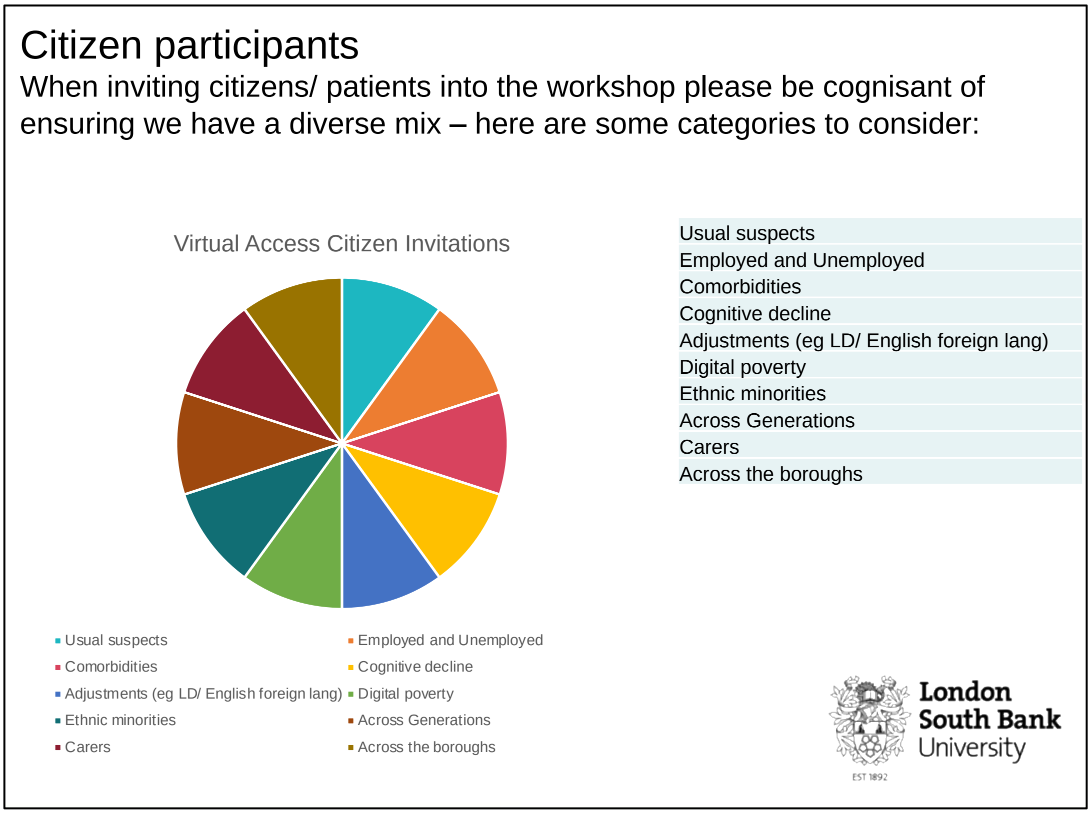
Mapping Citizen Participation

The Design Team then mapped the citizen participants ensuring we were able to find a diverse mix of people, and referring to the specification requirements of:

- "Those who are already using and delivering virtual services. This should cover a broad spectrum of patients and carers from both medical and surgical specialties and include adults, children, young people and their families, as well as patients with one or more long term conditions who would benefit from receiving virtual care due to reduced numbers of in-person appointments. Clinicians who are delivering these services to patients virtually should also be involved.
- Those who cannot or who are not willing to access services virtually, to explore how best to support their use of digital tools and what the alternatives to virtual services are. This includes people who have previously had limited or no experience using digital technologies as well as people that may be excluded from digital services or for whom virtual services are not appropriate. We have prioritised the following groups and communities to work with as they are highly likely to include people who experience digital exclusion:
    - people who do not speak English as their first language
    - people with learning disabilities
    - people from Black, Asian and minority ethnic communities
    - people aged 65+ who don't use the internet at home and/or use a smartphone

The populations in scope from the specification should cover Bromley, Lambeth and Southwark (i.e., the local populations GSTT and KCH predominantly serve) as well as non-local patients who access specialist care from across Southern and South East

England, as well as other parts of the country (i.e., national or regional specialist services) provided by the founder partners." (Project Specification 2021, unpublished)



Citizen participants

When inviting citizens/ patients into the workshop please be cognisant of ensuring we have a diverse mix – here are some categories to consider:

Usual suspects
Employed and Unemployed
Comorbidities
Cognitive decline
Adjustments (eg LD/ English foreign lang)
Digital poverty
Ethnic minorities
Across Generations
Carers
Across the boroughs

London South Bank University
EST 1892

The Design Team's intent was to identify these cohorts of patients through the clinics, but this yielded a very short list of people. This was augmented by the GSTT/ KCH Database for the cohorts identified, and wide-ranging publicity for the workshops (see invitation process).

Overall, we were able to engage people who met these wide range of characteristics with the exception of homelessness and people with learning disabilities (made much harder by moving this entire process online) although total participation in this programme was low.

The Invitation Process

The invitation process comprised of the following.

(a) Inviting Professionals.

Design Team members from each organisation approached the teams to invite to the workshops. They were provided with an invitation to use (Example at Appendix 2), but this is a personal process, and so the Design Team members were asked to invite people personally (by phone or in person) and follow-up with emails. All invitations had FAQs and all patients/ citizens/ carers were free to withdraw at any point.

(b) Inviting People/ Citizens and Carers

Having mapped the range of people to invite we asked that Professionals participating also invite patients/ carers that they had contact with. We provided both invitations and easy read versions (Appendix 2). Where professionals invited patients/ carers we had a good uptake with people quickly identified and recruited and this was the best way of securing participation.

However, as not all professionals took this approach, we had to recruit patients through other means. The reasons for not inviting patients were related to (a) time in the consultation to do the invitation and answer any questions, (b) the difficulty of asking people when working remotely, (c) uncertainty about what they were inviting patients to. In addition, the postponement of the workshops due to the Covid surges means the Design Team and the invited clinicians lost momentum. In addition, during the workshops, we heard from clinicians about the capacity issues in their areas making participation difficult and reducing their capacity to think about inviting patients/carers.

Therefore, we invited people through more transactional means in addition. This was much less effective in turning contacts into someone coming to a workshop. We found that thousands of touchpoints (newsletters/ social media/ flyers/ asking patient groups/ direct text messaging and phone calls) converted a few contacts into participation.

This approach included:

- Healthwatch in the Boroughs were provided with social media posts, newsletter text, the easy read invitation and flyers with for their community.
- 98 VCS organisations working in and with people in communities were provided with short text information for newsletters and the flyers for each of the topic groups (Long Covid, Waiting, Virtual Access) separately with 2 weekly gaps.
- Prof Malby joined the South East London Primary Care Leaders meetings twice to invite them to the workshops and to ask them to invite their patients.
- We wrote to all Social Prescribing leads asking them to invite patients and carers (provided with flyers and Easy Read invitations).
- Foundation Trust Members for KCH and GSTT were sent short text and flyers.
- Southwark & Lambeth Councils Community Engagement Leads were sent text invitations, and flyers to share.
- National Voices shared all workshop flyers through their network.
- Social Media – posts to Facebook pages and posts on Twitter from GSTT, LSBU.
- Foundation for Learning Disabilities shared the Easy Reads with all their contacts; and we asked SEL community Learning Disabilities nursing teams were asked to identify people and recruit, as was the SEL patient carer network for LD. We also asked 5 specific LD charities to support workshop recruitment.
- Finally, we also approached 180 people from the GSTT and KCH database by text (119), and phone (61). This generated 6 participants.
- Calls lasted up to 20 mins each, recruiting between 10 and 20 people who were 'interested' and that lead to a few recruited to each workshop.
- Some calls people wanted to talk about the issue when we rang. Maximum possible calls per person per day 20.

All communication was GDPR compliant, and all patient information was held securely at LSBU. Recruiting public participants was made more difficult by the COVID surge and the lack of face-to-face contact with patients and communities.

(c) Confirming Attendance

All invited staff and citizens recruited received a written invitation (printed or electronic), a PIS and a consent form to decide if they wanted to take part. Those agreeing to take part and share their details were contacted by LSBU with pre-workshop information.

All participants were provided with:

1. Invitation email and letter with patient information.
2. The PIS and Consent forms.
3. Programme Flyer and Easy Read.
4. Workshop reminder with the desk research graphic illustration.
5. Calendar invites at 1-2 weeks prior.
6. Joining information 5 days prior.
7. Reminder and consent form 2 days prior.

Consent (paper, electronic or verbal) was requested before the workshops for all participants, and a 1-hour session was built into the workshop timings to allow for real-time consent for those that had not consented prior to joining.

(d) Recruiting to the follow-on workshops

At the end of each workshop, we provided the date for the next workshop, and invited all participants to join and to invite others. After taking part in the workshop, we sent an email thank you and provided the follow up workshop date and again asked all participants to invite colleagues, friends, family where they fit the criteria for the workshop.

(e) Citizen reimbursement

In line with NHS and the Trusts' policies, patients and carers were provided with a voucher and information on how to claim expenses.

(f) Recruitment Issues

Overall recruitment to this workstream was the lowest of the three. By the time the Covid Surge had subsided enough for clinicians to be able to contribute, the Virtual Access team in Apollo were already working with citizens advising them in the design of virtual clinics. In addition, clinicians felt that they had been involved in virtual access design previously.

Workshop Design

The design was to:

1. To develop 'readiness' for utilising best practice (attitude).

2. To 'personalise' best practice to the partnership context (ownership).

3. To ensure that how virtual is implemented and provided improves health inequalities (fairness).

4. To catalyse better quality for all appointments (improve).
5. To design the measures to review the success of virtual (feedback – what counts).
6. To consider how to spread equably across the partnership (share).

The objectives for the workshop design were:

A. To explore people's (citizens and staff) experiences of services.
B. To understand what best practice looks like when delivering services. This will involve working with patients, carers and clinicians to agree best practice requirements.
C. To develop a set of patient experience measures which capture 'what matters' to patients, carers and families.
D. To explore how to align the patient experience measures with service delivery i.e. - What does this mean for service delivery?
E. To investigate barriers to service improvements and how to overcome these, by understanding the views and needs of patients, carers, families and staff.
F. To facilitate conversations within the organisation(s) to explore and test solutions and improvements.

Creating Readiness

As coproduction is a relational process, we designed the workshops to mirror the relational experience of face-to-face events. Key to this was a 1-hour entry session at the beginning of the first workshop where participants mingled online, met the facilitators, shared any concerns, had a cuppa, and undertook consent. As people joined the session, we checked their technology was working, checked they were consented (and if not popped them into a consent room 1:1 with LSBU staff), chatted to them about how they got to be here, and provided a breakout room for groups of 3 to get to know each other. The LSBU team includes our Peoples Academy and so all our rooms were supported by people on our team with lived experience. We came back together for 15 minutes prior to the start to informally share, chat and this also helped us identify anyone with any level of distress that needed 1:1 support.

This was an invaluable introduction and created a level of camaraderie and sharing before we started the work.

Workshop Process

Pace and Engagement. The workshops were paced to enable people who may have conditions that would limit their energy levels to participate. The sessions were designed in 45 minutes discussion followed by 10-15 minutes break. We made it clear that we didn't expect people who were struggling to stay, anyone could take a break at any time and re-join when able. We had very little of this throughout all the workshops. All participants took part throughout. Professionals tended to be later joining, and we had more of these participants dropping out/ coming back because of other commitments.

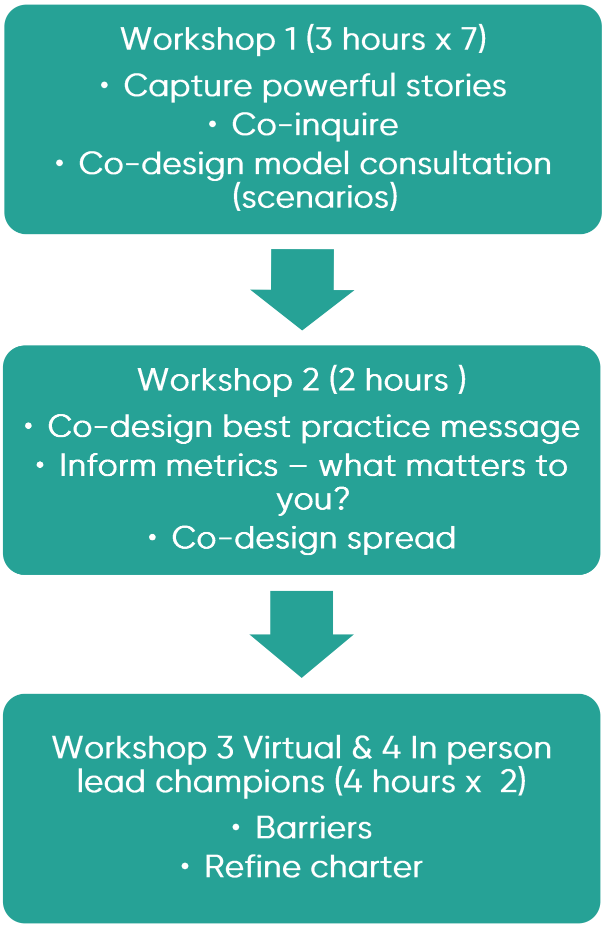
The workshops overall process included seeking narratives from different perspectives through listening to what participants choose to tell, rather than pre-determining all the topics or areas for improvement. An example of the workshop outline, discussion prompts, and questions can be found in Appendix 3. This offers a way of exploring the ‘patient's’ and the health professional’s experiences, reflecting on current practices, and exploring the response from the system (Gregory, 2010). Qualitative data was collected through narrative enquiry at the workshops for each of the 3 projects. This inquiry covered the following (from the project objectives):

Areas of inquiry specific to the Virtual Access project:

- What constitutes a successful virtual appointment, whether by telephone or video, from the perspective of patients, carers, and family members? And also, from the perspective of clinicians?
- What do patients expect to get out of virtual appointments and how does this differ from face-to-face appointments?
- How can we align the two more closely to ensure consistency in quality of service delivery? What does this mean for service delivery?
- Other considerations: That virtual services do not make it unintentionally harder for people to access care, creating new or further inequalities

One of the outcomes of these workshops will be to produce a Best Practice Charter.

The workshops were intended to follow this overall process:



However, with low participation it was possible to achieve the outcomes in a series of 2 workshops rather than 3.

Design Principles

The design of the workshops was based on these principles in response to the Joint Programme requirements:

1. Diverse community of participants, wide participation.
2. COVID restrictions/ guidance is observed.
3. Build trusting relationships through transparency, responsiveness, accountability, inclusiveness and being consensus oriented.
4. Recognise time limitations.
5. Act equitably.
6. Clear governance (ethics, direction, data protection).
7. Take time to act.
8. Maintaining pace, morale, energy.

And these principles for the design of the sessions in the Coproduction workshops developed by LSBU:

1. Build longer term relationships between communities and NHS services.
2. Start with listening.
3. Respect all views.
4. Plain English and check understanding (don't assume what you said is what others have heard).
5. What is said in the room stays in the room – agree together what is shared externally.
6. We ask that people do not audio or video record or take pictures during the workshops.
7. Equal voice.
8. You own what you create.
9. Do what matters to people where it matters to people.
10. Foster relationships as a core capability so that new capacity emerges (everyone has met everyone).
11. Stay humble.
12. Starting points really matter.
13. We each participate as ourselves – no-one speaks for all patients, or 'the hospital', etc.
14. Power: the workshops are built around discussions/ debates, rather than a professional-led presentation, for example. Each participant will be given the opportunity for equal contribution (power) and will be an active part of the co-production process.

In addition, these were the themes in terms of the design for all workshops

- We focus on relational work, not 'research', trigger discussion rather than a presentation.
- Create additional time for people to arrive and be welcomed (1 hour for tech set up for online sessions).
- Do more of what works.
- Online tools will be as accessible as possible, we will use Zoom and plan sessions assuming people will join from a variety of devices, including phones.

- Sessions will be designed with flexibility. We will invite and reinforce that people work at the pace and length that is comfortable for them. People will be encouraged to drop in and out of sessions as they need to.
- Documentation will be captured online using tools such as Jamboards that can be seen and added to by all participants. Jamboards will be left open with links shared so that people can review and contribute during/ after/ between sessions when the time is right for them.
- Make time for brief review after each session to ensure any actions to thank people, follow up, etc. are assigned. The LSBU team members will de-brief after each session to take notes and check observations/messages have been documented.
- Each workshop will have 2 facilitators, and a minimum of 1 observer to take notes plus one person leading on the technical aspects.
- We will ask that any commissioning staff attending but not participating play an active role in the sessions or take an 'observer' role, rather than act as a passive bystander. This is important so that participants and facilitators do not feel 'watched' during the sessions.
- All online participants have their names only (not role/ positions).
- There will be no recordings of the session. Notes will be taken by an observer and the facilitator and any written work from the participants will also be used to gather themes and messages as per the project objectives above.
- Offer individual check-outs for people (for all sessions) to debrief, etc. and invite feedback directly on the length and format to ensure we adapt to suit the group as much as possible.
- Online sessions will be prioritised for the group with hope to work towards a face-to-face launch session with aim to co-design a final session that all participants feel confident about in terms of accessibility and safety.

Set up (online)

- These will be held on the platform Zoom.
- We have provided information for participants on joining online and accessing IT/WIFI if this is needed.
- Participants will receive copies/ online link to the Virtual Access Poster with their invitation and encouraged to review ahead of the workshop.
- Online workshops will not be audio or video recorded but Observers will be allocated to support each breakout group to capture notes on the Jamboard.
- Online breakout groups will be designed to ensure a max mix of experiences and perspectives in each conversation.
- One facilitator will always remain in the 'main room' online to support any participants who struggle to be allocated to a breakout or who find themselves returning to the session due to connectivity issues. Facilitators can 'visit' breakout rooms or remain in main room.
- Tech lead will do screen share whenever we are working on virtual post-its so that everyone can see what is being discussed. If people are not able to add their own

post-it to the Jamboard then they can add the comment in chat as facilitators will add as a post-it.
- People will be able to drop in and out of sessions as they need, taking additional breaks as required.

Workshop Programmes

Workshop 1 Co-discovery: Brief Summary of the Programme

Session 1: Brief introduction

Session 2: What Brought Me Here Today?

Session 3: Sharing stories of virtual access

Tell us a time when you have been part of a virtual consultation and it went well

Session 4: Mapping themes from the stories

Reviewing the Virtual Access Poster

Session 5: Generating potential solutions. What would help?

What ideas do we have for what is needed?

Session 6: Review and Close

Between Workshop 1 and 2 we grouped the themes from the first workshop to present at the second workshop.

Workshop 2 Co-design: Brief Summary of the Programme

Aim: To develop the charter

Session 1: Brief introduction

Session 2: Why did you come back today? What do you most remember from last time?

Session 3: Reviewing the themes from Workshop 1 and checking for gaps.

Session 4: How can the virtual access teams improve services? We worked in these groups (the themes from Workshop 1)

- Planning for virtual appointments
- What to do before a virtual appointment
- What to do During a virtual appointment
- What to do After a virtual appointment
- Thigs that need to be in place around virtual appointments

Session 5: Patient Experience Measures

Session 6: What more can we do to help? Close and thanks.

Workshop Data was collaboratively collected using Jamboards. In each session of the whole group, and in each breakout small group discussion our facilitators supported the group to populate the Jamboard with their discussions, and the data was then reviewed by the whole group during the workshop to ensure it was complete. Each workshop had a new Jamboard with a summary of the findings from the previous workshop pre-populated. Each workshop had pre-populated Jamboard pages with the questions for each session in that workshop. A summary Jamboard was populated concurrently by the facilitators to share with the Steering Group. All data was provided anonymously.

Example Workshop Design

ONLINE Workshop 1: Inquiry and Co-design (3 hrs)

Time	Topic	Lead	Process	Key design issues	Logistics	Key focus areas for observers	Objectives covered
13.00	Joining		Consent and welcoming				
14.45	Welcoming	ALL	Ensure everyone who arrives is welcomed in, asked to ensure their name is showing next to their picture, put at ease and encouraged to keep their camera on if possible Very brief intro to Zoom - How to make yourself heard – chat/ virtual hands up/ wave at the screen. Introduce talking stick and notion of managing equal voice. How to get into breakout rooms. How to change the size of slides to see more people.	Ensure people sign consent forms Explain what information we are capturing, how and why	Multiple breakout rooms for online 1-2-1 consent Ensure space feels relaxed and friendly		
15.00	Logistics & Principles (short intro) LSBU	Becky/ Sandie	All adults. Comfort breaks when needed. There is time to talk and listen. Explain the process. Life happens – children/ pets/ deliveries in the background. Introduce notion of managing equal voice	Move quickly into citizen voice rather than Prof voice. A means to manage airtime and listening Everyone's voice in the room.	Design principles visible		

15.05 – 15.10	What Brought me here today? (introduction)	Lucie	Introduce exercise - 3 pop up/ example (stand up) short responses (set up in advance – 1 citizen, 1 clinician, 1 manager) 2 mins each	Model equal voice, and collaboration from the start Model airtime and listening. Run this session in the main room but explain everyone will be in breakouts for their conversation	Prime the 3 being examples in advance	Key themes	A
15.10 – 15.25	What Brought me here today? (exercise)	Lucie	In your breakout room share what brought you here today – why do you care about this? Make sure everyone has time to speak without interruption. When you have all spoken identify and write max 3 post-its on the common themes you have heard	Importance of ensuring everyone has time to contribute – set up a warning for meeting rooms every 5 mins so group swaps plus one that reminds them to write 3 virtual post-its Nominate one person in each group to do virtual post-its (don't all have to do it)	3 people per breakout Ensure mix of people in each breakout room. Post questions in chat and link to jam board Ask each group to have one person to add virtual post-its to jam board	Key themes – any contrast between citizens/ clinicians, etc	A B
15.25	Our Purpose today	GSTT – intro by Becky/ Sandie	Welcome more than presentation Short introduction on what we are wanting to achieve through this process and what part today plays	Welcome from Joint Programme Brief presentation by LSBU Introduction to observers (get people to wave on screen)	PowerPoint presentation with shared screen	People's body language in response to the presentation	A B D E F
15.30	Sharing stories of	Becky/ Sandie	3 min - Introduction to Appreciative Inquiry approach	Listening for what works so we can build on that in our Charter	Post questions in the chat and show 1 slide		A B D F

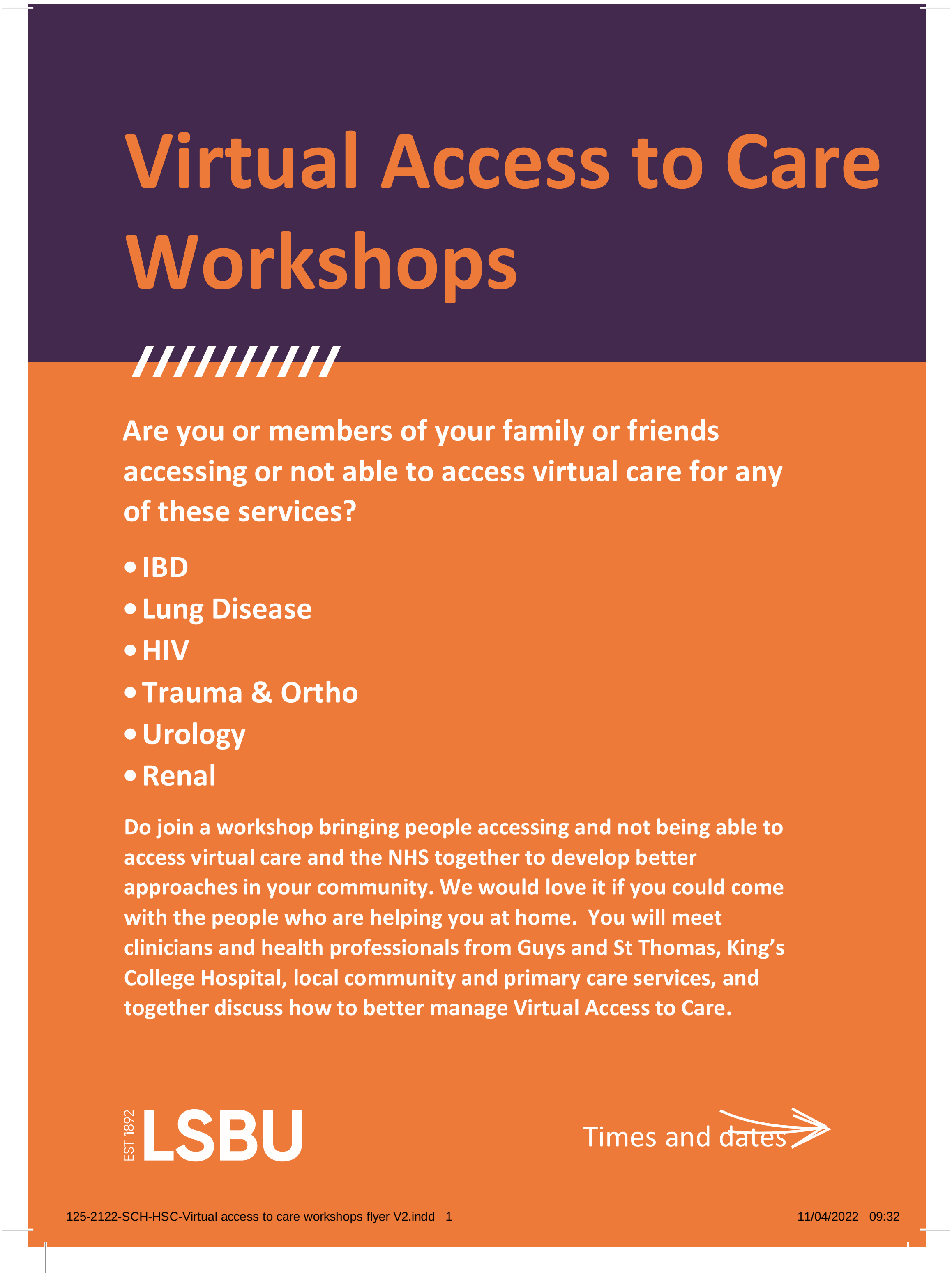
	Virtual Access (introduction)		(storytelling to find out what works) We want stories both from citizens and from health staff Citizen and member of design group demonstrate (2 mins each) – focus on being personal/ human	Run this session in the main room but explain everyone will be in breakouts for their conversation	explaining what we want them to do		
15.35 – 15.55	Sharing stories of Virtual Access Tell us a time when you have been part of a virtual consultation and it went well (Round 1)	Christine	There will be 4 people in each breakout groups (make sure 2 citizens in each group). 2 x observer, 1 x storyteller, 1 x questioner. 12 mins per story. 3 mins to tell 3 mins for questions 3 mins feedback from observers about what was heard. THEN – 3 mins capturing the themes one per post it	Looking for the 'what works' – set up a warning every 3 mins in meeting rooms so group moves through the exercise Brief observers to ensure there is space/ time to have a deeper/ longer conversation with someone if needed to be able to talk something out – people can return to the 'main room' to chat to a facilitator/ observer with aim that they are able to leave with a named contact	4 people per breakout Post questions in chat and link to jam board Add virtual post-its to jam board	Key themes from stories	B C D E F
15.55 – 16.05	Comfort Break		Have some music queued up if people want to stay in the main room		Ensure a couple of breakout rooms available if people want to talk in detail to solve an issue		A B

16.05 – 16.20	Sharing stories of Virtual Access Tell us a time when you have been part of a virtual consultation and it went well (Round 2)	Christine	Work in breakout groups of 4 (make sure 2 citizens in each group). 2 x observer, 1 x storyteller, 1 x questioner. 12 mins per story. 3 mins to tell 3 mins for questions 3 mins feedback from observers about what was heard. THEN – 3 mins capturing the themes one per post it	Rotate roles to ensure a new voice Post questions in the chat – set up a warning in meeting rooms every 3 mins so group moves through the exercise	4 people per breakout Post questions in chat and link to jam board Add virtual post-its to jam board	Key themes from stories	A B
16.20 – 16.30	Mapping Themes	Lucie	Affinity Map of the themes Working with whole group in the main room	Putting the post-its on the jam board and clustering. Whole group review	Big post-its to write 'key theme'/ summary on	Key themes from discussion – any tensions	C E
16.30 – 16.50	How does this relate to what we have found?	Becky/ Sandie	In breakout groups of 2 look at the graphic we have provided – what are we adding? (10 mins) Each group has a couple of minutes to feed back one or two thoughts – either something missing or amplifying something that is there. Feedback verbally if you are comfortable or in the chat if you'd rather. *Virtual consultations will be better when…..* Whole Group also able to add notes/ stars/ questions to the graphic in the jamboard	Building out from the desk research – bringing the new information we have together to contribute Principle: You Own what you create What did you see/ hear/ what resonates? What surprises you?	2 people per breakout Put graphic on jamboard slide and share in the chat Post question in the chat, *Virtual consultations will be better when…..* And send a reminder to all groups towards the end of the session.	Key themes from discussion – any tensions	D

					Send time reminders to breakout groups		
16.50 – 17.00	Wrap up and what Next	Becky/ Sandie	Thank people for their time today. Outline of future process/ timeframe. Ask people to come again and bring others – highlight that we are looking for diverse groups at the sessions	Ask people to come again and bring others – highlight that we are looking for diverse groups at the sessions	Slide showing dates and invitations to share with people, plus an email address to confirm someone is coming		F

Invitations to the Workshops

Flyer



Virtual Access to Care Workshops

Are you or members of your family or friends accessing or not able to access virtual care for any of these services?

- IBD
- Lung Disease
- HIV
- Trauma & Ortho
- Urology
- Renal

Do join a workshop bringing people accessing and not being able to access virtual care and the NHS together to develop better approaches in your community. We would love it if you could come with the people who are helping you at home. You will meet clinicians and health professionals from Guys and St Thomas, King’s College Hospital, local community and primary care services, and together discuss how to better manage Virtual Access to Care.

EST 1892 LSBU

Times and dates

125-2122-SCH-HSC-Virtual access to care workshops flyer V2.indd 1 11/04/2022 09:32

Invitation from Guy's and St Thomas' and Kings College Hospital to help improve Virtual Access to Care

	**Virtual Access to Care** We want to hear from people with a learning disability or their parents who have experienced **Virtual Access to Care**. This is when you have an appointment delivered by phone or online.
	London South Bank University is working with the NHS to bring together local people and health professionals.
	We want to hear from you if you had virtual access to care for any of these services: ☐ IBD ☐ Lung Disease ☐ HIV ☐ Trauma and Ortho ☐ Urology ☐ Renal
	We want to hear from lots of different people, including people with learning disabilities, about their experience with Virtual Access to Care.
	We want to talk to you about how we can improve **Virtual Access to Care** for patients.

Example Invitation IBD – Virtual Access to Care

Invitation to help Guy's and St Thomas' and Kings College Hospital improve virtual access to care

Cover letter for health professionals

We are inviting you to a workshop to improve virtual access to care (delivered by telephone or online). We will be sharing some key messages from our background research and working together with local people (who access your services) to make improvements.

This is a personal invitation, coming from a colleague in the Trust who really values you and your work, and thinks you would make a valuable contribution.

Below is the first workshop date. Please do confirm with them OR email us at healthlab@lsbu.ac.uk to let us know if you can take part.

	IN PERSON
IBD	5th May 2022, 11:30 – 15:00 Health Systems Innovation Lab, School of Health & Social Care, London South Bank University, 56 Tabard St, London, SE1 4LG

Inviting people who use your services, and members of the public.

If you are a clinician and you can come to the relevant workshop, we would really like you to invite a patient/ local citizen to join you. Could you do that?

We are looking for a real mix of people (age, gender, ethnicity, borough, adjustments).

It is easy to invite someone – just ask them at an appointment/ clinic and you share the information attached (we will provide you with printed copies).

Please ask your invitee for consent to share their contact details with us so we can stay in touch with information about the workshop. Their name and contact information will not be shared with anyone else. If your invitee changes their mind about attending, and lets you know, please pass this on so we can remove their details from our system.

All the information you provide will be shared securely with LSBU. Please email your invitees details to gst-tr.engagement@nhs.net as follows:

1. Workshop name, date and time
2. Their name and preferred contact details.
3. Their characteristics as follows (this information is only used for monitoring purposes so we can be sure we have diverse participation)

- Gender – please state
- Employed/Unemployed/Retired please state:
- Ethnicity -please state if known
- Child 0-12 years
- Teenager 13-18 years
- Adult 19-65 years
- Adult 65+ years
- Comorbidities (Y/N)
- Physical disability Y/N
- Leaning disability Y/N
- Carer (Y/N)
- Digital Access (can access online) Y/N

9.

Further information on the project and printable information for the public can be found on the following pages.

Invitation from Guy's and St Thomas' and Kings College Hospital to help improve virtual access to care

Introduction

Guy's and St Thomas' NHS Foundation Trust (including Evelina London Children's Healthcare and the Royal Brompton and Harefield hospitals) and with King's College Hospital NHS Foundation Trust, are working with patients, carers, and communities to improve quality for Virtual Access to Care (delivered by phone or online).

This is an invitation to help improve and focus on virtual access to care.

London South Bank University (LSBU) has been asked to work with the NHS to bring together local people and health professionals to improve these services.

We do this through a series of discussions where everyone shares their experiences and ideas to work out what is possible in the future; and tries these ideas out in practice, to see what works. This is not just about talking; it's about doing things differently and working together. To do this we will be running a series of workshop discussions and you are invited to participate in the first workshop. If you would like to continue after this workshop, we will invite you to the future workshops.

Dates and Times

This is the date for the first workshop

	IN PERSON
IBD	5th May 2022, 11:30 – 15:00 Health Systems Innovation Lab, School of Health & Social Care, London South Bank University,

	56 Tabard St, London, SE1 4LG

At the end of the first workshop, you can sign up for the follow-up workshop 2 weeks after this first one, if you want to continue to participate.

Do I have to take part?
No. It is entirely up to you to decide. If you do not want to take part that's OK. Your decision will not affect the quality of care you receive.

What will I need to do if I take part?

- If you agree and consent, your healthcare professional will share your name and preferred contact details with LSBU so they can send you the information for the workshops. The contents of your medical records will not be shared. We also ask for information including age group, ethnicity, gender, employment status, caring responsibilities, digital technology access and disabilities for monitoring purposes.
- If you later decide not to take part you are free to withdraw at any time, without giving a reason, by contacting LSBU (see below)
- If you choose to take part, you will be asked to sign a consent form before the workshop. The consent form will be stored by the NHS and a copy of the consent form will be kept by LSBU.

Further information
For further information, please see the attached information sheet below. We will also be running some optional online 'open house drop-in' sessions to help you get ready for joining in online or face-to-face, which we will invite you to.

Please email us at this address if there is anything else you would like to know: healthlab@lsbu.ac.uk

Or telephone us and leave a message at 07909 534 296. We aim to respond within 5 working days.

Thank you,

Prof Rebecca Malby on behalf of the whole team

Christine Burke, Anam Farooq, Mary Ryan, Sandi Smith, Shani Shamah, Lucie Stephens, Kanar Ahmed

Health Systems Innovation Lab

School of Health & Social Care

London South Bank University

56 Tabard St, London SE1 4LG

Additional Information

What is this project about?
This project brings people and health and care professionals together for an honest discussion about what can be done, both by the NHS but also by people and communities.

How will we do this?
We are asking citizens experience of virtual appointments to collaborate/work with us to improve services. We can only do this by talking together and testing out our ideas.

We start in workshops which bring together 20-30 people, citizens (patients, carers) with health professionals (doctors, nurses, therapists, administrative staff, the IT services).

We need to hear everyone's experiences and ideas to work out what more is possible. We then put these ideas into practice, testing out what works. This is not just about talking, it's about doing.

Dates and Times
This is the date for the first workshop

	IN PERSON
IBD	5th May 2022, 11:30 – 15:00 Health Systems Innovation Lab, School of Health & Social Care, London South Bank University, 56 Tabard St, London, SE1 4LG

At the end of the first workshop, you can sign up for the follow-up workshop 2 weeks after this first one if you want to continue to participate.

If you are a member of the public, you are likely to receive the invitation from someone in the health service that you know. They will ask you if they can share your contact details (email or telephone) with us here at LSBU as we are organising the workshops. This means we can send you information about the workshops beforehand.

Expenses
If you are joining a virtual workshop you will be able to claim expenses up to a maximum value of £5.
We can provide Vouchers to members of the public that join the workshops (Value £15).

If you are joining an online workshop
We use an online platform called Zoom. If you haven't used zoom before we will show you how to use zoom before the workshop starts. Let us know if you do not have a computer

and we will see if we can find a computer for you to borrow. We can also help with Wi-Fi data if this is a worry for you.

The blue link will take you to some information that helps everyone to work together online:

https://www.lsbu.ac.uk/business/research-enterprise-and-innovation/health-systems-innovation-lab/what-we-do/hsil-online-delivery

We are happy with children/ dogs/ cats and parcel delivery people in the background, we just try to keep as focused as we can on working together.

Online workshops will not be recorded.

What are the disadvantages/risks of taking part?

There are no risks involved in taking part in these workshops.

What are benefits of taking part?

We hope you will enjoy contributing to the development of services to help improve the services the NHS offer to you and people like you now and in the future. After the first workshop, if you would like to remain involved, or help your local community provide support then there will be the opportunity to keep participating.

What will happen to information collected about me?

If you agree, your contact details will be shared by your healthcare professional with the LSBU team.

The workshops are themed according to health issues e.g., people with diabetes, so you will be in a group which identifies you as someone living with this health condition, but this will only be known within the workshop. You will not be identified in any publications or shared materials outside the workshops.

The information LSBU will be given is your name and your preferred contact details (email / address / telephone). We also collect information about age group, ethnicity, gender for monitoring purposes.

LSBU will keep this information for 3 months and only use it for the purposes of this work. This information will not be shared with anyone else. You have a right to request that your personal information is deleted at any time.

The information you discuss during the workshops will be anonymised and you will not be identified in any information presented or published later on.

If you wish to withdraw from this study during a workshop the information you have provided up until you withdraw may still be used (but will be anonymised).

Confidentiality and your rights

The contents of your medical records will not be shared.

If you agree to take part in this work, you will need to sign and date a Consent Form which we will provide on the day. The form will be stored by your hospital and a copy will be kept by the researchers.

Your GP will not be informed if you take part (unless they are also at the workshop).

Results of the work
At the end of the work the ideas and solutions generated during the workshops will be shared across the NHS locally and nationally and we will enter it for publication in a health journal. LSBU are very happy to share with you with a copy of any progress summaries or publications (you can choose to be contacted with this information on the consent form).

Adjustments and accessibility
We can accommodate for any specific needs so please let us know if you require an interpreter, need any adjustments, have any access requirements or you would like to attend the workshop with someone else (e.g., a parent or carer).

Other information
Your health care professionals have not been paid for inviting you to join the workshops.

Who should I contact with questions?
You can email or call us at London South Bank University with any questions using the contact information below:

Email: healthlab@lsbu.ac.uk

Telephone: 07909 534 296 please leave a message and we will respond within 5 working days.

Thank you for reading the information sheets and for considering taking part in this work.

Thank you

Prof Rebecca Malby on behalf of the whole team,

Christine Burke, Anam Farooq, Mary Ryan, Sandi Smith, Shani Shamah, Lucie Stephens and Kanar Ahmed

Health Systems Innovation Lab, School of Health & Social Care,

London South Bank University,

56 Tabard St, London, SE1 4LG

Telephone Script for Invitations
Telephone Calls to People who are Accessing Virtual Clinics

1. You will be provided with a list of telephone numbers of patients
2. The script is below followed by a set of FAQs to help you answer any questions
3. Please record if the person wants to come to the workshop if not
4. If they do want to come, please note the person's contact details and send them to healthlab@lsbu.ac.uk
5. If they don't want to come, could you find out tactfully why they don't want too and make a note and let us know (email Becky)

SCRIPT

Good morning/afternoon. My name is ______________ and I'm calling from London South Bank University. Please could I speak to [name of patient]?

[NOTE: If the names person is not available, please do not leave a message.

NOTE: Establish safely that you are talking to the named person from list and check it is convenient to talk. If it is not convenient to talk, ask if you may call back and agree a time.]

Say that we are working with Guy's and St Thomas's hospital to help improve virtual access to care.

You are not calling about their health, treatment of care.

You are ringing to invite them to take part in an online workshop that brings local people together with health professionals (doctors, nurses and therapists) working on virtual access to improve local services.

The workshop gives you the opportunity to discuss your ideas and share your experience. We will be working out to work out what is possible in the future; and will be putting these ideas into practice, to see what works.

The workshop is on

[Note: use the relevant workshop for the person you are talking too]

xxxxx

The workshop starts at 1pm and run for 2 hours. There are lots of opportunities to share your story, and you will be mostly in a small online group. There is a 20 minute break in the middle. If you are finding the workshop tiring, you can take a break at anytime.

We will be online between 12.00 and 1pm to check you have everything you need to take part and to go through the consent.

Come for as much as you can/ want too.

If you would like to continue to take part after this workshop, we will invite you to the future workshops.

Please can we take a contact email address or postal address to send you the workshop information?

Do you know anyone else who you think would like to join the workshop?

[Note: If they do, please ask them to take down our email address or telephone number to pass onto this person/ people]

Thank you for agreeing to join the workshop, we will be back in touch with you tomorrow with the joining information. If you have any questions, then our email is:

healthlab@lsbu.ac.uk

And our telephone number is 07909 534 296 please leave a message and we will get back to you within 24 hours. It will be myself, or my colleague Ambra.

Thank you so much for talking to me today, I have enjoyed meeting you

[and of course, add in a nice goodbye]

Questions and Answers

Do I have to take part?

No. It is entirely up to you to decide. If you do not want to take part that's OK. Your decision will not affect the quality of care you receive.

What will I need to do if I take part?

If you agree and consent, then we will send you joining instructions for the workshop.

We also ask for information including age group, ethnicity, gender, employment status, caring responsibilities, digital technology access and disabilities for monitoring purposes.

If you later decide not to take part you are free to withdraw at any time, without giving a reason, by contacting us.

If you choose to take part, you will be asked to sign a consent form before the workshop. The consent form will be stored by the NHS and a copy of the consent form will be kept by LSBU.

Expenses

You will be able to claim expenses up to a maximum value of £5.

We can provide Vouchers to members of the public that join the workshops (Value £15).

If you are joining an online workshop

We use an online platform called Zoom. If you haven't used zoom before we will show you how to use zoom before the workshop starts. Let us know if you do not have a computer and we will see if we can find a computer for you to borrow. We can also help with Wi-Fi data if this is a worry for you.

We are happy with children/ dogs/ cats and parcel delivery people in the background, we just try to keep as focused as we can on working together.

Online workshops will not be recorded.

What are the disadvantages/risks of taking part?

There are no risks involved in taking part in these workshops.

What are benefits of taking part?

We hope you will enjoy contributing to the development of services to help improve the services the NHS offer to you and people like you now and in the future. After the first workshop, if you would like to remain involved, or help your local community provide support then there will be the opportunity to keep participating.

What will happen to information collected about me?

If you agree, I will share your contact email address with the LSBU team.

The workshop is about Long COVID, so you will be in a group which identifies you as someone living with this health condition, but this will only be known within the workshop. You will not be identified in any publications or shared materials outside the workshops.

LSBU will keep this information for 3 months and only use it for the purposes of this work. This information will not be shared with anyone else. You have a right to request that your personal information is deleted at any time.

The information you discuss during the workshops will be anonymised and you will not be identified in any information presented or published later on.

If you wish to withdraw from this study during a workshop the information you have provided up until you withdraw may still be used (but will be anonymised).

Confidentiality and your rights

The contents of your medical records will not be shared.

If you agree to take part in this work, you will need to sign and date a Consent Form which we will provide on the day. The form will be stored by your hospital and a copy will be kept by the researchers.

Your GP will not be informed if you take part (unless they are also at the workshop).

Results of the work

At the end of the work the ideas and solutions generated during the workshops will be shared across the NHS locally and nationally and we will enter it for publication in a health journal. LSBU are very happy to share with you with a copy of any progress summaries or publications (you can choose to be contacted with this information on the consent form).

Adjustments and accessibility

We can accommodate for any specific needs so please let us know if you require an interpreter, need any adjustments, have any access requirements or you would like to attend the workshop with someone else (e.g., a parent or carer).

Other information

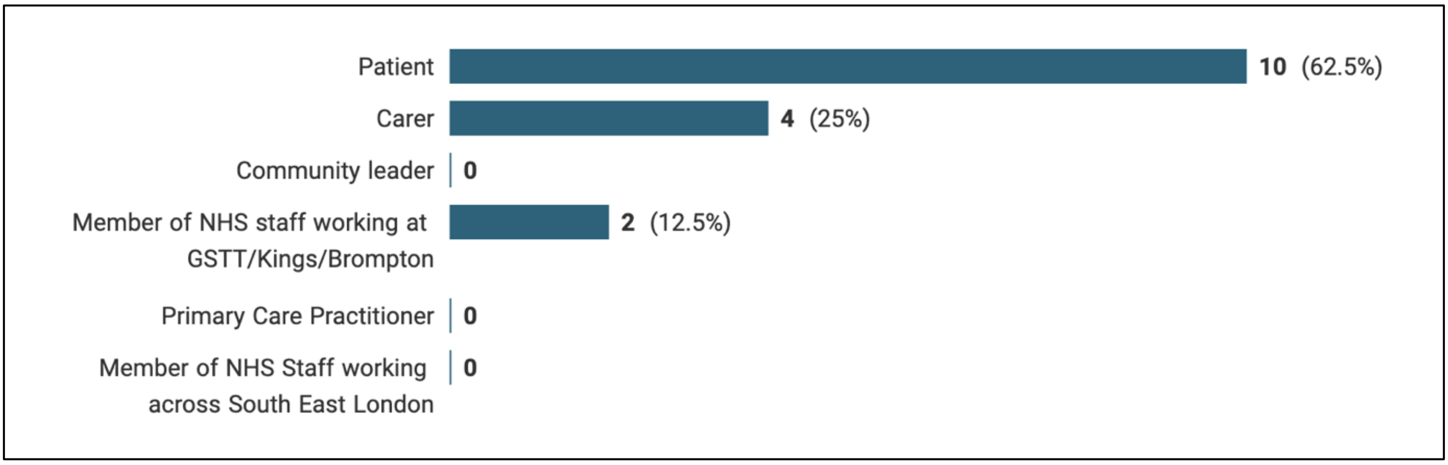
Your health care professionals have not been paid for inviting you to join the workshops.

Appendix 3: Participation by Workshop

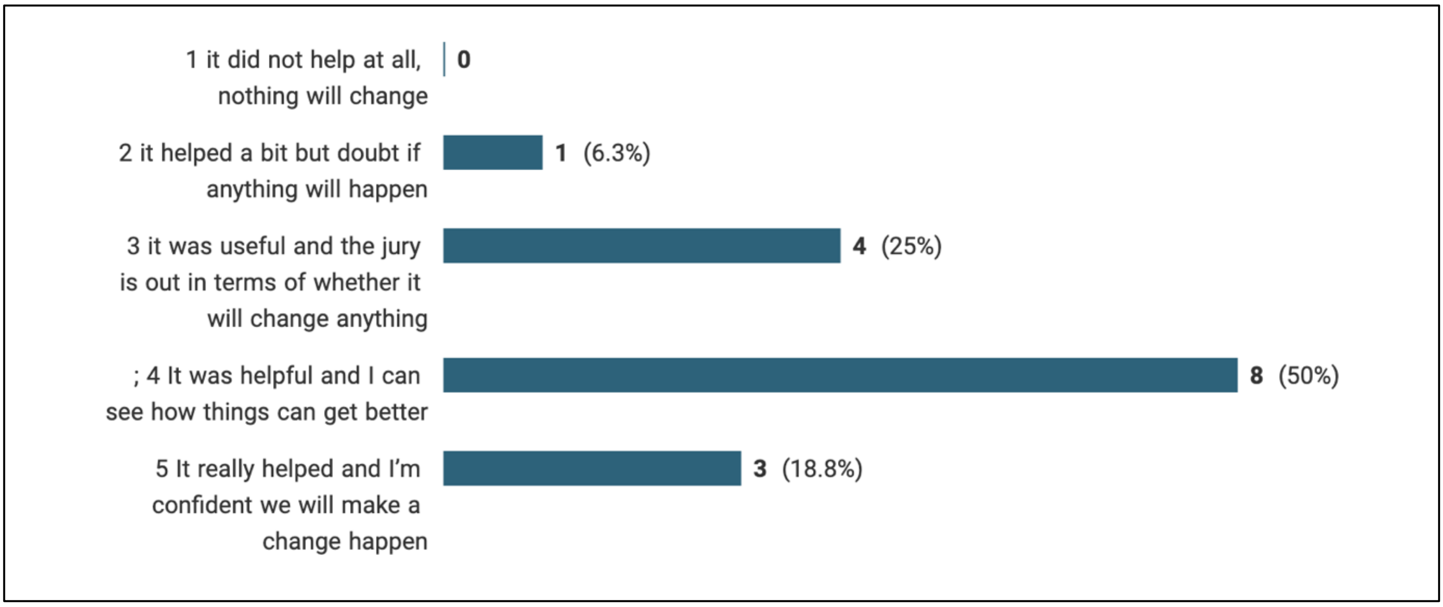
Virtual access to care	Patients	Staff
Virtual access to care Trauma and Ortho	3	2
Virtual access to care Urology	2	4
Virtual access to care Renal	4	3
Virtual access to care IBD	3	2
Virtual access to care lung disease	7	3
Virtual access to care Virtual Pioneers	8	6
Virtual access to care HIV	4	3
Virtual access to care Workshop 2	13	7

Feedback from Participants

Over the course of the workshops, we both asked participants for feedback at the end of every session and used this to modify future sessions and provided a short feedback survey. Uptake was very low on the latter (n=16) and our view is that people within the workshop felt very comfortable giving direct feedback in real time at the end of the workshop.



Qn 1 How well do you think the workshops helped you and the others at the workshops understand what is needed and what to provide/ support on a scale of 1-5? (Most responses after the first workshop)



It helped to me to believe we could make change.
I think a lot of key points were identified. My concern is what restrictions there will be to making the changes to optimise the system e.g., the issues in the check in system at the kidney clinic at Guys, which has apparently been a hospital wide upgrade, have been going on for 12 months now. Whether the issue is staff training, the system itself or something else, the fact that for something quite straightforward a solution has yet to be found. I think unless formal processes are introduced it there will be a lot of staff and departments that just do what is easier for them in the moment.
Based on years of experience, and the fact that virtual is now well embedded and difficult to change.
Digital literacy is something we will pick up.
Those running the workshop seemed dedicated to facilitating and pushing for change. Those participating had excellent insight and provided useful and practical suggestions, some of which would be very easy to implement.

Qn 2 Is there anything else you would like to comment on?

Having health workers involved with discussion gives clearer insight to improving technology and to ensure patient and staff care.
I think the workshops are a great idea and a good way for people to give specific examples of what issues and concerns they have.
I think the facilitators could have kept a stronger rein on proceedings and both sessions monopolised by one or two people and we didn’t get to focus entirely on what we were there for!!
As per my answer (3), even with best efforts in mind, it is not easily to translate into action. I think being realistic and upfront in the workshops may help to manage expectations.
It might be helpful and valuable to study or consider impact on people or populations who are not using or actively not using virtual platform. This might be possible by simply doing a data analysis exercise by looking at the appointments and patients records over the past 10, 5 or 3 years on how often some patients were previously requesting for appointments or have now been requesting for appointments and how their health conditions have changed over time.

Qn 3 Has taking part in the workshop led to anything for you? For instance, something you are doing differently based on the conversations/ meeting with other people from the workshop outside/ changing the way you provide a service?

No not yet, there’s a way to go! Thank you.
I have made contact via email with one of the staff at Guys that was on the workshop to get help with further information and contacts. This has been greatly beneficial for me.
No