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Virtual Access to Care: Summary of the Desk Research

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December 2021

Guy's & St Thomas' Charity &..

King's college hospital charity

Generously supported by Guy's & St Thomas' Charity together with King's College Hospital Charity.

‘A Different Perspective’ on the NHS and Social Care by Shani Shamah, Citizen Reader:

You just have to care – to make a difference in someone’s life, you don’t have to be brilliant, rich, beautiful or perfect.

Giving peace of mind is a priority – help people to make deliberate lifechoices to protect mental, emotional and spiritual state.

Help fight the demons – waking-up every morning to continue fighting thedemons is so tiring and demands continual bravery

Holding the hand-wonderful people who can guide and support are needed to help find oneself again. It is the minimum – I achieved because Ihad my husband to hold my hand to guide, encourage and push me to takecontrol and self-manage to move forward.

Maintain a sense of normality – even in times of trauma trying tomaintain a sense of normality is called surviving.

Everyone deserves a life that is worth living

Keep me informed before + after

Use language I understand

Check my digital literacy

Check that I have access

Prepare me for what to expect

Take part in the design process

Integrate with pathways

Schedule continuity

Be digital ready with the right tech

Design in/exclusion criteria

I expect the same level of care. I want the choice of virtual or in person.

I need to feel confident that it is effective and safe to see people virtually

reassure me

don't rush

SAFE CONFIDENTIAL COMFORTABLE

Virtual Access to Care

If you design and implement virtual access using available best practice, you will secure high levels of patient satisfaction and uptake.
Also you will improve quality fairly.

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drawn by GRAPHIC CHANGE

This desk research has been commissioned by the Joint Programme for Patient, Carer 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 GSTT Charity and supported by KCH 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 will support the delivery of the three projects outlined above.

This desk research summary provides background information and context to help shape and inform the project.

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1. Scope of the desk research

A brief review of the available intelligence was conducted by the academic team in 2021. We also consulted a citizen reader, who provides her thoughts and commentary.

This paper provides the key messages from the desk research in relation to virtual access to care. In this context, 'virtual care' and the terms 'virtual access', 'virtual consultations' and 'virtual appointments' have been used in relation to appointments delivered over the telephone or via video, with the person using the health service(s) (and not communication with another professional or a written-only consultation). The desk research does not cover other forms of virtual care (such as the use of apps, advice and guidance etc) but we appreciate there is crossover, for example, where people maybe directed to virtual self-care whilst they wait for or following an appointment, or virtual technology is used to triage etc.

The term 'person/people' is used rather than 'patients', except when quoting other sources. The purpose of the desk research was to collate the 'Best of the Best' guidance in relation to delivering virtual care.

The desk research questions were:

- What constitutes a successful virtual appointment (whether by telephone or video), from the perspective of patients, carers/ family members and 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?

The literature search question was therefore:

"What makes a successful virtual (healthcare) appointment compared to face-to-face from the different service-user, carer and clinician perspectives?"

2. Key messages from the desk research

2.1 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.

without significant process change." STP Clinical Lead NHSE (2020)

[1] Whilst not explicitly in the literature, there are also other inequality considerations for virtual service design, which may include ensuring that staff at all levels understand local inequalities, that the Equalities Act 2010 is followed and that there is a reasonable adjustment flag where needed

2.2 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.

2.3 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/ digital literacy) which should include:
    - clinical factors such as need for physical examination
    - safeguarding or social concerns
    - interpersonal factors such as language difficulties or emotive and sensitive conversations
    - 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, provideprompt questions to help people prepare, do they need someone to be there withthem (or is a translator required?), can they access WIFI? Clarify what to expect.

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 coulddo to help. It would be useful for patients to be alerted to this fact beforehand sothat 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 respondfully 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.

Our infographic at the front of this document summarises the key messages.

3. Contextual information

3.1 Background from our Citizen Reader

"The experience of COVID-19 has demonstrated the need to reconsider the way that the NHS has traditionally delivered services. Restarting routine care and elective surgery also highlights the continued potential for technology. The benefits of a new technology don't come from how it performs in isolation, but from fitting it successfully into a live health care setting and redesigning ways of working for maximum gain. Some NHS long-term plan (2019) commitments have been accelerated by the COVID-19 response, such as improving access to remote consultations in primary care and outpatients - however these changes will need careful monitoring and evaluation. The overall picture is one of major delay, disruption, increased demands on services. For instance, previous national targets, such as for expanding access to mental health services, will now need to be revised to account for the greater need. Additionally, COVID-19 has exposed the widened existing inequalities in health and care throughout the country.

I am concerned for the impact the pandemic has had on people's attitude to accessing care and the impact on their choices and behaviours. How people are experiencing care delivery, how to secure ongoing involvement to continue to innovate in service delivery building on progress made in the pandemic. The COVID-19 pandemic has seen many health and care services turn to digital technology to continue meeting patients' needs. The relationship between the NHS and the public is complex.

The best advice I have read is from National Voices (2020) which states that people want to have choice and be able to state their needs. People need to feel heard and that what they say they need has been considered. They also want to know that the person who they are talking to 'cares' and wants to be helpful, rather than is just managing a resource.

An NHS where patients stay at home and rarely attend GP surgeries or hospital out-patient appointments is likely in a decade's time, according to US health expert (Pym, 2019). Many patients, according to this report, will be managing their own long-term

conditions, for example high blood pressure and lung disease, with wearable devices and sensors, which will be much more effective than occasional appointments with a doctor.

What is needed is better communication with patients:

- *NHS trusts, primary care trusts, managers and clinicians should actively communicate the benefits of and promote the use of technologies that can improve patient outcomes and patient experience (including those that offer more convenient access to and transactions with the health system).*
- *Clinicians – in hospitals and community settings – should encourage patients to make full use of the technology available, for information, transactions and monitoring where this is appropriate to their condition.*
- *Technology (especially consumer-facing technology) should be targeted appropriately to ensure maximum uptake. This will mean initially targeting those most likely to embrace the service (for example, as a result of information technology (literacy, value, or convenience).”*

3.2 A Good Consultation

What makes a good consultation? Regardless of virtual or face to face consultations, there are several frameworks that can be used to facilitate a good consultation. Understanding the patient-clinician dynamic is a good first step. The Health Foundation ‘When doctors and patients talk: making sense of the consultation’ paper (2021) helps understand the power dynamics and anxieties that may be underlying. Many models have been developed to aid good consultation practice[1]. Two examples are shown below:

[1] it should be noted that these relate to the person-professional interaction and do not include adjustments (such as the use ofinterpreters) or considerations for inequalities.

1. The RESPECT Model (taken from ACOG, 2021):

Rapport	· Connect on a social level. · See the patient's point of view. · Consciously attempt to suspend judgement. · Recognize and avoid making assumptions.
Empathy	· Remember that the patient has come to you for help. · Seek out and understand the patient's rationale for behaviours or illness. · Verbally acknowledge and legitimize the patient's feelings.
Support	· Ask about and try to understand barriers to care and compliance. · Help the patient overcome barriers. · Involve family members if appropriate. · Reassure the patient you are and will be available to help.
Partnership	· Be flexible with regard to issues of control. · Negotiate roles when necessary. · Stress that you will be working together to address medical problems.
Explanations	· Check often for understanding. · Use verbal clarification techniques.
Cultural Competence	· Respect the patients culture and beliefs. · Understand that the patient's view of you may be defined byethnic or cultural stereotypes. · Be aware of your own biases and preconceptions. · Know your limitations in addressing medical issues across cultures. · Understand your personal style and recognize when it maynot be working with a given patient.
Trust	· Self-disclosure may be an issue for some patients who arenot accustomed to Western medical approaches. · Take the necessary time and consciously work to establish trust.

2. Tidy and Knott (2021) - Adopting an open and self-critical approach to consultation analysis - the basic skills are outlined in the table below:

Welcoming	Does the clinician encourage comfort and trust from the outset? Is the patient at ease and ready to bare their soul? Do not be finishing off the notes for the last patient when thenext arrives. Check the records before the patient enters soas to be able to offer full and undivided attention. It may be mundane to you but to the patient this might be the most important thing to have happened all week.
Questions	Questions should be open, giving the patient the opportunityto expand - not closed and limited or leading. In reality we sometimes have to break this rule to get a meaningfulanswer from certain people. Try not to interrupt unless for clarification, although some people do need reining in. Listen and maintain a flow. Sometimes patients say something that needs further investigation, but it isinappropriate to break the current chain of thought and focus. They should be returned to later in the consultation, but it is very easy to forget until after the patient has left theroom. A useful tip is to write a note to remind oneself beforethe patient leaves.
Listening	Appear attentive and maintain eye contact as much as possible. It may or may not be appropriate to make notes asthe patient speaks. In the early days of computers patients used to complain, 'He was more interested in that screen than in me'. Listening includes looking and noting non- verbal cues and body language.
Response	This involves clarifying points, summarising, reflecting statements and feelings, ascertaining understanding and possibly defusing anger. Empathy forms an important response and, for some patients, may be all that is required,thus forming a therapy as well.
Explanation	Use language that the patient will understand. Give important information first. Possibly repeat important pointsand ascertain that the patient understands. Written information or visual aids may help too.
Closure	The closing act of a consultation used to be the issuing of aprescription and no consultation was complete without one.Some form of closure is required with clarification of what isexpected of the patient or the next step. Make correct, adequate and contemporaneous notes.
Safety-netting	Clinicians are encouraged to consider: What do I expect to happen if I am right? How will I know if I am wrong? What would I do then?

Best practice for general consultations should be incorporated into all virtual consultations.

3.3 From our Citizen Reader:

"(I expect) that I am listened to and that my ideas and concerns, expectations have been met and a 'plan of action' is in place for potential treatment. I expect a rapid response. It is obvious to me that in health care, the days of business as usual are over. Around the world, every health care system is struggling with rising costs and uneven quality despite the hard work of well-intentioned, well-trained clinicians. For me at its core is maximizing value for me as a patient: that is, achieving the best outcomes for me it should not be surprising that I remain indifferent to quality measuresthat may gauge a provider's reliability and reputation but say little about how its patients actually do. The only true measures of quality are the outcomes that matter to me, forexample to be able to live my life and not to just exist. I expect the same quality of service delivery (the 'soft skills') no matter how it is delivered."

3.4 Local Peoples (Patient/Carers) Experience with Virtual Appointments.

Public feedback from the GSTT Partnership and Ipsos MORI evaluations (GSTT, 2020; Ipsos MORI, 2021) provided the following intelligence on peoples (service users, carers and parents) experience of care during the pandemic.

A Virtual Outpatient Clinic Evaluation survey was conducted early in the pandemic (GSTT, 2020) to explore the experience of patients (n=2882) accessing virtual appointments for RBH. Ipsos MORI conducted a survey evaluation of patients, carers and parents (n=1,501) who had used GSTT, KCH and RBH services between November 2019 and January 2021, to explore their experiences of NHSE services during the pandemic. The survey was not specifically focused on virtual care or access, but it was conducted over telephone so that people who did not have access to or preferred not to use digital devices could share their views.

GSTT (2020) Virtual Outpatient Clinic Evaluation key findings:

- Of those that had a virtual appointment, the majority (89.4%) were conducted by telephone.

- Overall, the majority of people (81%) rated their experience as very good or good.
- Some people wanted to be offered the option of being seen in-person (23% would choose this option for a future appointment).
- More communication was needed about changes to the appointments or cancellations by the hospital.
- Some patients were unhappy with being discharged over phone or video.
- When asked ‘What could we improve?’ 69% got what they wanted but issues included lack of investigations, blood tests, scans and spirometry. This question also highlighted that the quality of IT used by GSTT clinicians was sometimes a problem.
- One patient suggested “a YouTube video on how the process works”

Ipsos MORI (2021) survey key findings:

- The majority of people (91%) felt comfortable attending a face-to-face appointment, but less so when it was for someone else.
- Of those who felt uncomfortable attending a face-to-face appointment, the risk ofcatching coronavirus was the main reason for this.
- Similarly to the GSTT survey, of those who had a virtual appointment, the majority were conducted by telephone.
- Outpatient appointments were the most common reason for visiting a hospital for those who used a health service recently.
- Use of services was continuous throughout the pandemic but increased in frequency as time went on; this does not reflect what was seen in other NHS reports (reduced number of referrals and more people ‘staying away’).
- Nine in ten patients and parents felt comfortable with accessing face to face GP appointments for themselves or for their child if they needed to access a health service.
- Of the patients whose appointments had been cancelled, around half were not offered a further appointment (12 out of 25 patients).
- Of those who did not attend services or had an appointment but did not attend their appointment (n=45), no longer needing the appointment was the most important reason given for not using the service (n=11).

Risk areas highlighted in the GSTT Virtual Outpatient Clinic Evaluation (2020):

- Just over a third (36.74%) of people had concerns prior to their appointment but this rose to 44% or more for people with any form of disability or aged 85 and over. Older people also reported more difficulty booking online appointments.
- Some people with disabilities preferred virtual appointment whereas for other disabilities there was a barrier - each person is individual, for example face to face was preferred for memory loss, or sensitive issues.
- People felt face-to-face would reduce the risk of providing inaccurate photos or descriptions of their issue; this should also be a consideration for those with limited IT skills/access and those with communication or language difficulties.
- After appointments there was a delay in receiving info on following up or treatmentetc. or uncertainty about when medication prescriptions would arrive. Some alsohighlighted no response/ acknowledgment when they sent the Trust an email. Ofthose whose appointments were moved or cancelled, some were not offered another appointment.
- Carers consistently showed higher levels of concern or unease – particularly about virtual appointments.
- People from Ethnic Minority backgrounds had higher levels of concern, and lower levels of comfort using services face-to-face and virtually. This is reflected in the Ipsos MORI survey (2021), where eight in ten patients from an Ethnic Minority group had used a health service since the first lockdown, compared with nine in ten White patients.
- Half of those who had used a virtual service said nothing would make it easier for them to use it. Amongst those who said they would feel uncomfortable using a virtual outpatient appointment, most simply prefer face-to-face appointments.
- Other considerations included some people not feeling safe/comfortable to speak in their home environment, unsure about effectiveness (e.g., virtual physiotherapy) and unsure how to rebook if they cancelled or missed the call.
- Ethnic groups: The majority of respondents stated they had a White background (73%), 10% Black background; 5% from an Asian background; 1% Chinese background and 2% from Other Ethnic backgrounds. The proportion of ethnic minorities in this survey do not mirror the general London population (as per the 2018 census) where 40.2% of residents identified as either Asian, Black, Mixed or Other Ethnic group (Gov UK, 2020).

- Although based on small numbers there are some distinct variations in experience between Ethnic groups which are summarised below:
    - People who had concerns prior to their appointment – 36.74% people overall stated they had concerns. Concerns were higher for White and Black Caribbean people (72% n=10) and Pakistani people (51% n=17)
    - Length of appointment - the following groups were more likely to feel the appointment was too short: White and Black African people (21% n=3) Pakistani people (19% n=6) and those from Other Black backgrounds (13% n=2)
    - Getting everything they needed out of a virtual appointment compared to a face-to-face appointment: 17.52% of all people said they could not however, this increased to 36% (n= 5) for White and Black African people and 39% (n=12) for Pakistani people.
    - Confidence and trust in staff – this was very strong, with just under 5% of people overall reporting negatively on this. This rose to 12% (n=3) for people identifying as Pakistani.
    - Involvement in care – 7.08% of people overall said they were not involved but for Pakistani people this was 26% (n=8) and 15% for both White and Asian (n=2) and any other mixed group (n=6)
    - Information provided about their condition or treatment – overall the majority of people felt they got the right amount of information and only 11% did not. This figure was higher for some ethnic groups Black Caribbean (15% n=18); Indian (14% n=10); Pakistani (19% n=5); White and Asian (21% n=3) and any other mixed background (18% n=6)
    - People knowing who to contact if they had a concern after the appointment ended – overall 20.54% of patients said no, but this was higher for Chinese people (38% n=11); Other Asian groups (34% n=14) and Pakistani people (32% n=10).

Regarding the ethnic differences seen in the GSTT and Ipsos Mori survey results, it is important to consider these issues are not just about virtual care, the issues experienced by minorities can be found across NHS care and crucially, can't just be resolved by a virtual plan alone, as problems arising are often systemic and present widely in clinical practice.

4. The ‘Best of the Best’ Guidance

The following guidance was identified as being particularly useful to the hospital setting and covers a range of considerations for virtual consultations. An extended guidance list is also provided below.

4.1 The Top Four

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

4.2 Further examples of practice guidance

- Primary Care toolkit (useful in all settings) – ‘Using Online Consultations In Primary Care’ NHSE (2020). Full step by step guide including planning servicesfor digital set up, how to map challenges, co- designing with people, use of champions, carers: https://www.england.nhs.uk/wp-content/uploads/2020/01/online-consultations-implementation-toolkit-v1.1-

updated.pdf

- 'COVID-19: video consultations and homeworking' (BMA 2021) - relevant for those working from home to deliver care: https://www.bma.org.uk/advice-and-support/covid-19/adapting-to-covid/covid-19-video-consultations-and-homeworking
- 'Guidance on the introduction and use of video consultations during COVID-19' (Wherton et al, 2020). Useful supplementary information: https://bmjleader.bmj.com/content/4/3/120.citation-tools
- Oncology - Banerjee et al (2021): 'Communicating effectively via tele-oncology (Comskil TeleOnc): a guide for best practices for communication skills in virtual cancer care' (see tables): https://pubmed.ncbi.nlm.nih.gov/33544315/
- 'Considerations for psychologists working with children and young people using online video platforms' (British Psychological Society, 2020): https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Considerations%20for%20psychologists%20working%20with%20children%20and%20young%20people%20using%20online%20video%20platforms.pdf

Good examples of NHS websites which include staff and public resources:

- University College London Partners webpage provides a list of communication templates, learning resources and guides: https://uclpartners.com/work/non-face-to-face-virtual- clinics-examples-and-resources/
- West Suffolk NHS Foundation Trust webpage provides tips for the public: https://www.wsh.nhs.uk/News-room/news-posts/Virtual-appointments-A-handy-guide-for-patients.aspx
- Cambridge University Hospitals webpage includes information on how people can prepare for virtual consultations: https://www.cuh.nhs.uk/our-services/outpatients/video-consultation-appointments/

The Guy's and St Thomas's Hospital NHS Foundation Trust (GSTT) website information (as an example) is as follows. Some additions from the above list would be very beneficial tothe Trust and its partners to help make their pages more comprehensive (for example including the Healthwatch information outlined below).

- GSTT telephone clinic information: https://www.guysandstthomas.nhs.uk/patients-and-visitors/patients/outpatients/telephone.aspx
- GSTT video consultation information: https://www.guysandstthomas.nhs.uk/patients-and-visitors/patients/outpatients/video- consultations.aspx

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