Attend Anywhere: video consultation platform to deliver outpatient orthopaedic rehabilitation

Quick intro to yourself and any contact details you're happy to share …

My name is Anthony Gilbert; I am a physiotherapist at the Royal National Orthopaedic Hospital in Stanmore. Up until very recently my HEE/NIHR funded PhD (within the School of Health Sciences at Southampton University) was focused on patient preferences for videoconferencing consultations. I have paused this and have been supporting the rapid roll out of virtual clinics across the hospital, accelerated further by COVID.

What physio services do you provide? (e.g. specialty, conditions, location, patient demographics)

Physio–wise, our department covers acute inpatients (elective orthopaedics, paediatric orthopaedic surgery, orthopaedic oncology, spinal cord injuries / orthopaedics) and many of these patients are followed up as outpatients. In addition, our outpatient services covers pain management programmes, hypermobility programmes, shoulder rehabilitation and amputees. Our patients can include those who are at any stage on a surgical pathway. We have a lot of variation!

What tools are you using to deliver your physio services digitally?

We have previously used Skype to contact patients which worked well. We are currently rolling out 'Attend Anywhere' https://nhs.attendanywhere.com/rc/Content/Home.htm across the hospital.

How have these services replaced face to face contact?

Due to the COVID-19 outbreak, we initially set a target of 80% outpatients to be seen virtually. In the last week, this increased to as many patients as possible. All of our clinicians have triaged their lists to determine who could safely be 'seen' by either telephone or video call. Only post-operative / acute patients who need to be seen will be attending the hospital.

What is the clinician's experience of using the digital tools?
Generally speaking, our clinicians (across the trust, including medical, surgical, AHPs) have found the use of video call calls helpful to achieve what is needed during the current time. We have established a feedback form for clinicians and patients to fill out and over the first 80 or so calls satisfaction is approximately 80/100 (will 100 being satisfied). It has been helpful for our physios to demonstrate exercises to patients. Physios who have been using the phone calls often find themselves having to think about the language they use to explain what they want their patients to do! It requires a completely different skillset.

It can be frustrating when patients are not able to get onto the system and there has been a huge amount of effort required by admin staff and support workers to provide patients with troubleshooting advice. We are ironing out these issues as we go…

Do you have any patient feedback on digital physio service offer?
By and large, patients who have used the technology seem to like it and we are getting high satisfaction scores within this group. However, a large proportion of patients (approximately 90%) are choosing to use phone calls rather than video calls when offered. This is something that we at the RNOH will be investigating moving forwards – anecdotally it appears that many patients who are unfamiliar with the setup prefer to choose a phone call. I have been researching this as part of my PhD and there are a large proportion of patients who state they prefer face to face over video call because they have expectations about interactions with their physiotherapists. This may change over time and we will be evaluating patient experiences as we continue to roll these clinics out.

Any top tips to others exploring using digital tools in physio services?
NHS X have changed their guidance on virtual consultations for healthcare during the current climate. Please see www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance - Information governance has been relaxed somewhat during this crisis. Some of my earlier (yet to be published) research shows that a high proportion of patients do have access to smart phones, laptops and tablets – it may be that using various platforms like FaceTime or Whatsapp Video will make it easier for patients to access virtual care. Downloading apps or creating logins might be challenging for some patients who are not technologically savvy. Platforms like Skype and Zoom are free, other platforms such as WebEx are being offered for free during the current crisis. Check out the CSP website – this is being updated regularly and is a fantastic resource. This excellent v-log by eGP learning captures some of the key considerations for clinicians new to this way of consulting with patients https://www.youtube.com/watch?v=F8PccszVoyk&feature=youtu.be .

Any system wide change is challenging and it has been no exception for us, particularly under the circumstances. I have outlined some of the things I feel have worked well:

1. **Project lead** – Joe Billany is an NHS Graduate Trainee who has been tasked with leading the roll out. It has been excellent having a point of contact that people can turn to. I would advise, for anyone looking to do this, to have an identified project lead.
2. **Implementation team** – we have an MDT who have been involved in the rollout of non face-to-face clinics. This has included a clinician / researcher (Anthony Gilbert, physiotherapist), Operational Managers (Luke Martin, Adam Allain, Shiv Bagdai), Administration Staff (Becky Tobin) and Improvement Managers (Ruth Adam & Noreen Galvin). All bring their own perspective and it has been excellent to have many hats contributing towards discussions. Implementing these rapid changes has knock on effects on many of the processes that are 'business as usual' such as: the impact on prescribing / delivering medications; obtaining scans

(eg MRI / CT scans or x-rays), the impact on patient transport, phone / broadband capacity and routine documentation. Whilst clinicians being asked to conduct phone clinics off site doesn't sound too challenging, this brings in a whole host of potential issues surrounding documentation and communication that may impact further along the pathway. A daily teleconference has enabled us to troubleshoot issues and communicate out changes to colleagues. From a personal perspective, I have found having an expert improvement methodology on the team really helpful. This work needs coordination, particularly in the early stages. Structure, routine and documentation of all issues are essential.

3. **Ongoing evaluation** – we are doing our best to evaluate each consultation and clinic. It has enabled us to capture issues as they arise and shape the changes that we make. This will continue and is a useful way to shape future service changes.
4. **Administrative support** – our admin staff have been fantastic. In a very short space of time all patients with clinic appointments have been contacted by various members of the admin staff. I have been very impressed by the hospital's quick response and after discussing with other colleagues around the country I believe we were one of the first trusts to implement these changes. It has led to some confused and distressed patients (particularly before the national measures to close schools etc) not being too happy – the administrative staff have managed this challenging situation incredibly well.
5. **Clinical Support staff** – we are asking our teams to work in a completely different way. We are learning as we go. Our support staff have been outstanding at adapting to the challenge and are a really useful resource to help shape these changes – they understand the processes better than anyone else and have been invaluable contributors to the direction of travel as we roll virtual clinics out.
6. **IT Team** – our IT staff have been brilliant. As you can imagine – they have been overwhelmed with support requests and over the last week or so have had to prioritise COVID response tasks. They have enabled hardware (upgrades of computers / tablets), ordered in new stock (webcams and headsets) and installed these for virtual consultations whilst having to deal with the COVID response plan to enable working from home in accordance with government guidance.
7. **Flexible clinicians** – our clinicians have been understanding and embraced the challenge. We have some video consulting champions who have embraced the new format of consultations. It has been really useful to get personal stories and share these with other staff. All have been open to learn, attend training sessions, trial the technology and even troubleshoot and provide support for their patients. One clinician told me how nervous they felt before doing a video call – that has not been lost on me and I have been grateful for everyone's attitude towards this. For those who have not used this technology before I get the sense that there is a fear of the unknown, not just the technology but managing complex patients in a different way. At the RNOH we manage a complex tertiary caseload of patients and we want to do the best job we can. I think there is a lot we can learn from this experience to support optimal management of patients – particularly if there is to be a digital legacy as a result of COVID. It's not just the patients who need support but the staff too. Something for us all to consider in a few months when we have some breathing space.
8. **Understanding patients** – our patients have been willing to respond to the situation and some have been keen to support with video calls. This has not been without issues and has been frustrating for those when the technology fails (and it does, and will fail). We need to think about their preferences though and this is something we are collecting in our evaluations. My view is that digital shouldn't *replace* face to face care… but, for now, patients are extremely grateful for the opportunity to engage with their care, see their clinician and not have to travel. This is extremely important for our vulnerable patients we are trying to protect.

9. **Leadership** – Finally, the leadership from within the trust has been excellent. The need to convert to virtual consultations was communicated early. This is not a role I was expecting to step into (last week my PhD was looking very different) but the Trust have done all they can to make a success of this and resources have been appropriately allocated. My Therapies Director, John Doyle, has given me the opportunity to be involved in this rapid implementation and the feedback I have had from colleagues is that they value the support that the implementation team have been able to provide. Most of my focus has been across physiotherapy and wider therapies. This rapid roll out has required a huge amount of resource in the early stages across the trust. This has been extremely well supported. I am certain this support will be a large contributor to any ongoing success of this implementation work.

My take home advice from the last few weeks: (if you can manage) don't take shortcuts and give this work the attention it deserves. We have a lot to learn over the coming months and it is important we think carefully about how we shape the digital legacy from COVID-19 in physiotherapy. As a colleague said to me recently in a meeting: 'we won't be returning to normal, we will be returning to better'. I would love physiotherapists (and the wider MDT) to work together to decide what 'better' looks like. I feel we all have a responsibility to do so.

I am extremely grateful to my funders for the opportunity to step back in to the workforce to support patients and colleagues. It has been fantastic being able to support colleagues implementing virtual colleagues at speed during this challenging time.

These are my own views.

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