Meeting – 18th January 2021 – via 'Teams'

PPI Members Present:

1. Anthony Gilbert – research physiotherapist
2. Helen Harte – PPI Coordinator
3. Geoff Buckley – Public / Technical Author
4. Juliet McQue – Patient
5. Elayne Coakes – Patient
6. Jan Letocha – Public / Website Developer
7. Greg Booth – Physiotherapist
8. Anju Jaggi – Physiotherapist
9. Vandana Luthra – Research Governance Facilitator

Online Housekeeping

- Mute when not talking.
- Regular breaks
- Move around
- Permission to record meeting granted (all have signed RNOH media consent)

Group Code of Conduct:

- To respect the views of others in the room
- To respect confidentiality
    - Of each other who might offer personal information
    - Of the research itself, as results might be shared within this forum before they are publicly available
- To recognise the contribution of others
    - The steering group will be acknowledged in publications as part of the CONNECT Project Steering Group
- To provide good, constructive feedback

Terms of reference for the group:

- To offer honest advice

- To constructively challenge
- To advocate on behalf of who you are representing
- To offer a unique, expert, perspective
- To proof read and review documents
- To engage with the group when attending meetings

Points of Discussion:

Phase 1 presentation:

Q: Patient safety – where does this fit in with the feasibility?

For phase 1 – this was based on the literature and patient safety / suitability is important to consider. These things came up in Phase 4 – there is something about clinicians and how they view virtual consultations, and these criteria will need to be set.

Contribution from physio member – there is work going on to look at safety from within the RNOH. Eg of shoulder unit, they wont see new patients virtually as they need to assess patients physically first. There needs to be further research looking at the safety and effectiveness of virtual consultations to understand if virtual is effective.

Phase 4 covers safety and implementation considerations.

Phase 2 presentation:

Comments on phase 2 outputs – Anthony and Geoff have both edited the wording

- How do we offer patient choice? Do we pass out these outputs with emails or appointment letters? It is important to share how treatment can be delivered.

It is important that we provide patients with knowledge around the choices available. For the pathway we need to consider how this information is communicated and where it is communicated within the pathway.

- were the 20 patients interviewed chosen because they came forward or was it based on conditions?

We looked at 10 females, 10 males (both groups split equally 50 years and above, 49 and under) across a range of problems.

- Need to consider the space and safety, some conditions its more appropriate to use hands on. What do you do if a patient needs equipment?

That is one of the implementation factors we need to consider. This study was conducted before the COVID pandemic. If patients need equipment this is something we need to think about, how we support them to engage, provide them with

equipment or choose exercises that don't need equipment. This is something we have identified in phase 4.

- a lot of people don't have access to the equipment needed. For these you might ask them to come in. How will you deal with these patients who can't come in (eg because of COVID) but cant access the equipment? Eg a lot of my friends have difficulty using technology…

Physio member – agrees, finds this with their own personal experience with family members. Eg given of a patient who needs to login to book an appointment. We need to think about patient skills.

- are patients aware they can chop and change from a virtual to F2F and vice-versa?

This is important. From phase 4 it is likely the pathway would be flexible, and a conversation would be have regarding patient choice before the next. Also, the pathway would need to be flexible so that they can change on the day if this was needed (eg due to snow, illness – or to receive hands on if they felt that was needed). We need to be clear about what the pathway looks like.

Also there will need to be an understanding that if the clinician needs to 'see' them this conversation is allowed. It needs to be flexible.

We need to be careful that we don't apply the pandemic mindset of forcing patients into VC after COVID-19. We need to understand if this is an effective approach. One thing that is needed is a trial of effectiveness and this is needed in rehabilitation.

- example of working in a GP surgery as an administrator – going forwards online might be easier for the surgery, this might be something that healthcare professionals want post-COVID. It's the GP's that find it easier not the patients as they can type whilst the patient was on the phone etc.

Virtual doesn't work for everyone and one thing this research does show is that practitioners shouldn't be forcing this on patients and there needs to be a conversation first.

- there needs to be flexibility… if someone is on a F2F pathway but opts for a virtual consultation to prevent missing an appointment – is that a good use of that technology? Have heard some examples of patients driving when having a call. How do you safeguard the value of a virtual call?

This is important. Other work that has been done recently has identified a number of issues. At RNOH we have found the number of patients missing appointments has increased because they forgot. It is likely that many patients are now squeezing appointments into their life which might reduce their focus or attention. There is something about the end of an appointment to reflect which is missed and this might reduce effectiveness. Something we might need to consider is recommending patients to reflect before or after to maximise the value of the appointment.

- did you ask the question against digital literacy?

Not overtly – we didn't focus on digital literacy although this was something that was covered in terms of access to physical or informational resources. It has been covered a little in the Discreet Choice Experiment.

- PPI group member shared their own experience of falling ill – without access to VC would not have attended any appointments, as unable to travel. The sheer challenges of travel is around accessibility, if unable to drive. Some people might prefer virtual because of the sheer location inaccessibility of some hospitals.

This is something that has come across and is partly the reason why Anthony wanted to look at this.

- has had several operations at RNOH and has always been given the option of Stanmore or Bolsover St or locally. With virtual consultations will more people look to continue specialist care at RNOH as there is less travel required?

This is something we need to look at.

Phase 3a / Phase 3b + COVID implementation:

- It is interesting to see that the type of intervention does not influence preferences. If we (as a physio) are going to give physical interventions this tends to be better F2F whereas communication can be more VC. Does this come in later on?

That is covered in Phase 4. Although we can say we predict what someone is going to choose, we decided to be as pragmatic as possible so didn't model types of treatments in the decision making, we just went for the status quo. These were the factors that were most important. We stopped the DCE early due to COVID so it is limited with what it can do.

- given COVID has made such a difference with everyone's lives, people are using VC more than before. People are really embarrassed to see themselves on video and that puts people off. It might be a couple of years before a lot more people use VC, it will become really popular.
- there is some literature that talks on the work of being in a conversation when seeing yourself on camera. There is a sensory overload, it would be interesting to look at people in a couple of years to see if its easier.
- I was surprised at the data to see that so few people wanted a second appointment, maybe that was because of seeing themselves??

Phase 2 covered some of this and how people seeing themselves impacted. Psychological status was a key part of the previous findings. What this means is the impact of attending a hospital, or how they respond virtually. It's a two way thing. This is a really important point.

- Lots of people are self conscious!

- It is not just what they look like, its where they are. They might be worried about what the room looks like, what the decorations look like. Some people can only do it in their bedrooms and they get self-conscious. They might be more embarrassed about that compared to what they look like.
- It is good to be able to do it at home because you can see if you are doing it right

Some people were surprised that it was good. They wouldn't have considered this before COVID. Something that might be useful is setting out the pathway, letting them know that the option is there but the first appointment is F2F and that a conversation will be had. That might be the one thing this PhD research contributes to the literature!

Phase 4 & Future Considerations:

What do we think, are there any key take home points to focus on?

- There is a need not to just return to business as usual after this pandemic. There is something about the acceptability at RNOH versus the GP surgery. Is that about the accessibility of the site and is it more acceptable in tertiary care? Is there a difference in the broad acceptability within the healthcare system?
- As a patient – absolutely! Shared experience of accessibility of getting to the specialists, virtual has been critical to help them receive the treatment. Even not shielding the patient has COVID to consider. I would only go in if it was absolutely necessary. Carrying on, thinking to the future, can people afford to take that sort of time out? The ability and the capability of VC is going to be such a boom to these kinds of patients.
- Shared experience of developing virtual pain management programmes. A lot of feedback was about not having to take the trip down, so they started the programme in a better frame of mind. Also being able o sleep in their own bed rather than in the hospital made it better for them. These are people who know how their fatigue and pain affects them. Patient experience research is important. Effectiveness is also an important question.
- The technology has been thrust forwards in the last year. COVID has moved it so far forward. There must be a huge saving for the patient and the NHS through reduced travel. It created more space within the hospital. There is a lot more working from home. People are connected and aware so it will be used more and more.
- Face to face initially generates more trust. People miss not going into work and people miss not seeing people F2F. You miss out on meeting people and sharing knowledge.
- The questions that were asked were pre pandemic – you may now get different data?

The DCE qualitative study was conducted in August 2020 and the implementation interviews were conducted in Oct – Dec 2020. This has captured some of the COVID

experience. In the DCE we found that 73% preferred F2F – It would be interesting to see how this changes in about 5 years time.

It would be really useful to meet again soon to go though the final study with you all soon.

- Is there a significant philosophical question about moving to virtual? Will virtual see a shift in our value system?
- I wonder whether this will make people reflect on what the value of physiotherapy is.
- Do you feel it takes away one of the reasons you got into physio in the first place? Physio is very touchy feely!
- If we are not in the same space, are we meeting our need for human contact?
- We are getting stuck into one or the other – if there is a need to do face to face they won't be offered VC. it needs to be flexible.
- Your pre PhD work was on SKYPE consultations! The speed of transition is phenomenal.
- We have gone so far with COVID restrictions and we cannot see an end to it. It will be a completely different world without pubs and cinemas etc. video call will become part of our daily lives.

The opportunity of this research is to determine what post-COVID19 rehabilitation looks like. It is important this research makes a difference. We need to maximise the impact as much as possible.

5 MINUTES LEFT – final thoughts?

- How much will things change going forward because of COVID? Need to consider this.
- Patient safety and economics is really important to consider for the future.

Next meeting: TBC via 'Teams'