Experience of virtual appointments/ meetings survey report

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Reshaping Our Services: Remote Working Work stream
Quality Centre
South London & Maudsley NHS Foundation Trust

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Executive Summary

Due to the coronavirus pandemic, many face-to-face meetings and patient appointments were replaced by virtual contact. The use of video and telephone calls for meetings/ patient appointments has increased significantly in the South London & Maudsley NHS Foundation Trust since lockdown measures were imposed on 23rd March 2020.

An online survey on the experience of virtual appointments/ meetings was open for eight weeks to staff, service users, carers. This report presents findings based on 545 responses from staff (n=474), service users (n=47) and carers (n=24).

From responses to a global question on user experience and one on future intent, three profiles of virtual contact users was constructed.

- **resistant** (n=84): those who reported that their virtual contact experience was "worse/ much worse" than that in face-to-face contact, and they are "somewhat/ very unlikely" to want it in the future

- **ambivalent** (n=338): those who did not find virtual contact experience better than that in face-to-face contact, yet they showed no intention to reject it in future

- **receptive** (n=123): those who found virtual contact "better/ much better" than face-to-face contact and are "somewhat/ very likely" to want it in future

Quantitative analyses focused on understanding possible explanations for these main reactions among staff and patients/ carers, augmented by qualitative analyses of responses to open-ended questions.

Headlines from quantitative analyses:

- On the prospect of virtual contact, there appears to be more room for persuasion among staff than among patients/ carers.

- Administrative staff lean toward being receptive, whereas psychologists/ psychotherapists lean in the opposite direction.

- For virtual meetings and care provision, staff tend to lean toward being receptive. For virtual therapy, this balance is in the opposite direction.

- Familiarity with virtual contact may have a role in explaining the three reactions among staff.

- Having the right place (rather than the right equipment) may be more of an issue for staff. This appears to be the opposite for patients/ carers, but the sample is small with poor representation of ethnic minority and other sampling biases.

- Patients/ carers who perceived having more choice are also more receptive to prospects of virtual contact.

- For both staff and patients/ carers, the perceived lack of acceptability and appropriateness (rather than the lack of feasibility) might be driving their resistance.

Headlines from qualitative analyses:

- Rapid theming identified perceived advantages and disadvantages which were at times contradictory
    - o Advantages included being able to continue engagement with colleagues and with treatment plans, more focussed time together and how virtual working can help reduce symptoms and increase openness and honesty
    - o Disadvantage included the limitation of interaction, some meetings taking longer and that virtual meetings can exacerbate symptoms and allow people to be more withdrawn

- Most respondents appreciate the choice to work remotely

- Most respondents have adapted to working remotely, though the processes and structures in which they function have not always followed alongside

- There are five key contributors to successful virtual working which generated ideas of change.
    1. Access to necessary equipment and data
    2. Support to facilitate virtual working
    3. Clear virtual working guidelines
    4. Choice of interaction type
    5. Access to the appropriate environment in which to work remotely

Learning and next steps

- Going forward, the prospects of virtual contact for work and patient care should not be thought of as an either good or bad thing. Discussions about what the patient/ carer wants and needs for the care to be timely, person-centred and frequently reviewed.

- Repeated population-based surveys about the impact of virtual contact on quality and safety in healthcare must continue to gain vigilance about how clinical services and patient choice evolve in post-lockdown climate.

- Systematic sampling and its associated resources must be in place for reaching under-served populations so that survey findings are not affected by socioeconomic disparities and digital divide.

- Concerted collaboration with other public health organisations (e.g. Health Innovation Network) should be considered to revisit missed opportunities for harmonising study and survey design in ways that offer robust learning across NHS Trusts and reduce survey fatigue in clinicians and patients / carers.

Introduction

The purpose of this report is to bring together the online survey results relating to the respondents experience of virtual working with wider and national contexts. The report sets out the analysis of the data collected as well as the ideas for change and further exploration.

NB: terminology clarification. Virtual working/ appointments/ meetings and remote working/ appointments/ meetings are used interchangeable and refer to individuals engaging with one another either by telephone or video call rather than face to face.

Background

In response to the coronavirus pandemic, service have had to reduce the number of face-to-face appointments and meetings to comply with lockdown measures (commencing from 23rd March 2020) and support the reduction of the virus transmission. This has meant a significant adjustment to how services are delivered and received. It is, however, crucial to continue the provision of care to service users. As such, where possible, virtual appointments and meetings have been offered. Figure 1 below shows the number of calls that have taken place on Microsoft Teams in South London & Maudsley over the last 12 months (the organisation's preferred virtual platform). The graph shows the sudden increase in the number of video and telephone calls being conducted via Teams. Usage on other platforms (e.g.: mobile phone, WhatsApp, Facetime) have not been compiled.
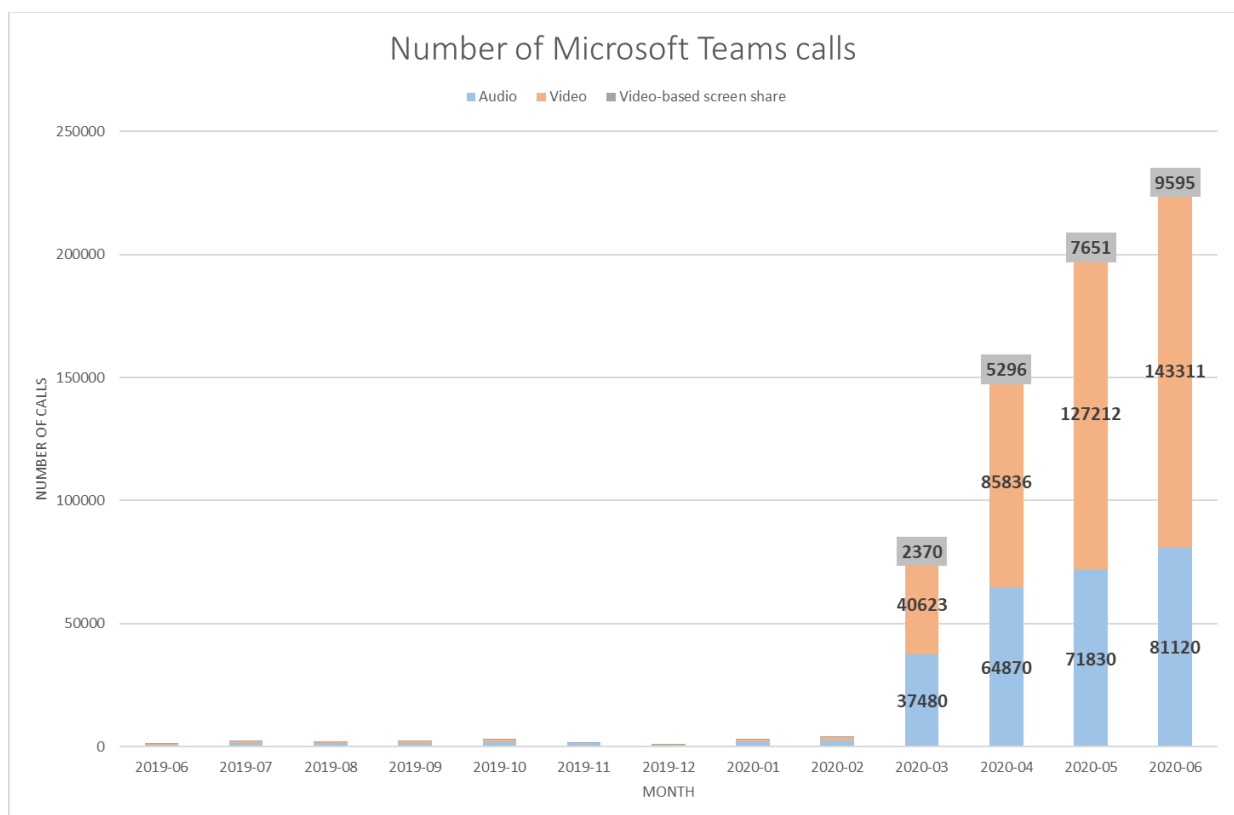

Figure 1: number of Microsoft Teams calls over the last 12 months
Data source: Internal Microsoft quality dashboard

The rapidity in service delivery change has meant that the organisation's usual ways of testing new working (using quality improvement methodology to initiate small scale plan, do, study, act cycles with deliberate and considered spread and sustainability plans) have been unable to take place. It is acknowledged that the experience of virtual appointments and meetings will be variable. To this end, an online survey was developed which could be completed by service users, carers/ supporters, volunteers and Trust staff to better assess the experience from which learning, recommendations and actions can be taken forward. The link to the online survey was shared on 29th April 2020 and closed on 23rd June 2020.

The survey was initially developed to capture service user and staff experience of virtual appointments and meetings. It was tested with 28 people. The results provided great learning, and the feedback from the results was two-fold; 1. More services were interested in adopting and using the online survey, 2. Adaptations were required to be able to use it across the organisation (including stratifying questions).

As the remote working work stream progressed, the survey was adapted and refined through rapid iterations and testing with service users to inform the survey items. It was also reviewed and approved by the Quality Improvement & Implementation Science Clinical Academic Group (QIIS CAG).

Concurrent context changes

Since the distribution of the survey, there have been some major changes in the wider system aimed to facilitate and promote remote working.

1. Microsoft Teams was upgraded which allowed for up to nine people to be displayed on a screen at any one time (it was four). This allowed for group meetings/ sessions to be more inclusive.
2. In the inpatient forensic services guidance was issued promoting the use of tablets and iPads to support therapeutic engagement.
3. The organisation has implemented a mechanism where staff can request and receive equipment to their remote working address to ensure they able to complete their roles, safely with the software, hardware and furniture necessary.
4. Maudsley Charity have provided finances to the Trust to purchase mobile phones for service users who may otherwise be isolated/ require a face to face visit.
5. An FAQ has been drafted which outlines and supports the promotion of patient choice in the utility of virtual meetings and appointments.
6. 'Beth', an online communications platform for staff, service users and carers has been launched

National picture of internet and smartphone usage

It is important to set out an understanding of the national usage of smartphone and the internet. 87% of adults use the internet almost daily (ONS, 2019). 78% of adults use a smartphone on a basis with 76% of those accessing the internet through

this device (Ofcom, 2018[a]). Data indicates that 93% of people have access to internet in their home (ONS, 2019). 29% of low-income or unemployed individuals and 36% of older adults (compared to 3% of 24-35 year olds) do not access the internet (Ofcom, 2018[b]).

Survey Findings

Quantitative

To address a key concern around the uncertain impact of remote ways of working on patients and staff, two global questions were posed to respondents with Likert scale response options. The first captures their experience, the second captures their intention.

Table 1 Global appraisal

		INTENTION How likely are you to want to have virtual appointments/ meetings in the future?					
		Very unlikely	Somewhat unlikely	Neither	Somewhat likely	Very Likely	
EXPERIENCE **How does the virtual appointment/ meeting compare to meeting face to face?**	Much worse	22	17	4	7	4	54
	Worse	10	30	28	54	26	148
	Neutral	1	4	28	82	105	220
	Better	0	0	0	5	73	78
	Much better	0	0	0	2	43	45
		33	51	60	150	251	545

Based on responses to both questions, three groups of respondents were delineated. The first (top left rectangle in Table 1) comprised mostly respondents who reported that their virtual contact experience was "worse/ much worse" than that in face-to-face contact, and they are "somewhat/ very unlikely" to want it in the future. This group is likely to be resistant to the prospects of virtual contact, mainly due to poor prior experience.

The second (top right rectangle in Table 1) comprised respondents who did not find virtual contact experience better than that in face-to-face contact, yet they showed no intention to reject it in future. This group is potentially ambivalent (due to poor prior experience half the time) but they are likely open to persuasion about the prospects of virtual contact.

The third (bottom right rectangle in Table 1) comprised respondents who found virtual contact "better/ much better" than face-to-face contact and are "somewhat/ very likely" to want it in future. This group is likely to be receptive to the prospects of virtual contact.

Based on these three profiles, labelled as **resistant** (n=84), **ambivalent** (n=338), and **receptive** (n=123), subsequent analyses focused on understanding possible explanations for these main reactions among staff and patients/carers.

Do staff, patients and carers react differently to remote ways of working?

Table 2 Reactions to remote ways of working

	Staff	Patient	Carer	
Resistant	66	14	4	84
Ambivalent	305	20	13	338
Receptive	103	13	7	123
	474	47	24	545

Table 2 shows that the predominant reaction, ambivalent but are likely open to persuasion, has a larger majority in staff (64%) than in patients (43%) and carers (54%). In other words, there appears to be more room for persuasion among staff.

Among staff, the balance between the two poles tend to lean toward being receptive. This is not apparent in patients/carers, but their numbers are too small for any certainty in this conclusion. Furthermore, there is poor representation of ethnic minority in this sample (Table 3).

Table 3 Ethnic group representation

	Staff	Patient	Carer	
White	301	31	13	345
Black	62	2	6	70
Others	46	8	0	54
Did not say	65	6	5	76
	474	47	24	545

How do different staff groups react to remote ways of working?

Four major occupational groups (n=375) among 474 staff were reviewed.

Table 4 Staff reactions to remote ways of working

	Admin	Psychologist / Psychotherapist	Psychiatrist	Nursing
Resistant	2	30	9	15
Ambivalent	42	118	37	48
Receptive	21	19	12	22
	65	167	58	85

The predominant reaction, ambivalent but are likely open to persuasion, varies moderately in their majority between psychologists/ psychotherapists (71%), administrative staff (65%), psychiatrists (64%), and nursing (56%).

The balance between the two poles tend to lean toward being receptive, particularly among administrative staff. However, this balance is in the opposite direction among psychologists / psychotherapists.

Do staff reactions to virtual contact depend on the type of work?

Four major types of work were reviewed. A staff member might have had virtual contact for more than one type of work, so the numbers below refer to reactions of staff whose virtual contact included the type of work (rather than reactions to the specific type of work).

Table 5 Staff reactions to remote ways of working by type of work

	Meeting	Individual therapy	Group therapy	Providing care
Resistant	12	43	7	37
Ambivalent	89	126	33	189
Receptive	41	25	6	60
	142	194	46	286

The predominant reaction, ambivalent but are likely open to persuasion, shows a similar majority regardless of type of work (meeting: 62%; individual therapy: 65%; group therapy: 72%; providing care: 66%).

For virtual meetings and care provision, the balance between the two poles tend to lean toward being receptive. For virtual therapy, this balance is in the opposite direction.

Do staff reactions to virtual contact depend on the operational context?

Table 6 Staff reactions to remote ways of working by Directorate

	Southwark	PMOA	Croydon BDP	Lambeth	CAMHS	Corporate	Addictions	KCH
Resistant	32	17	18	10	6	0	0	1
Ambivalent	68	74	58	54	48	24	4	0
Receptive	29	15	26	17	18	15	1	0
	129	106	102	81	72	39	5	1

The majority (ambivalent but are likely open to persuasion) appears to be larger in PMOA, Lambeth and CAMHS. The balance between the poles tend to lean toward being receptive in CAMHS and Croydon & BDP. This is less clear in other Directorates due to small subgroup numbers.

Table 7 Staff reactions to remote ways of working by services

	Adult comm	Adult Inpatient	Adult Others	CAMHS comm	CAMHS forensics	CAMHS national	CAMHS Others
Resistant	13	4	4	10	0	2	13
Ambivalent	82	15	11	10	1	22	44
Receptive	28	5	3	1	0	2	11
	123	24	18	21	1	26	68

Table 8 Staff reactions to remote ways of working by services

	Admin / Clerical / Management	Corporate	National & Spec	P&P	PMOA comm	PMOA National	SU&C
Resistant	1	0	2	15	1	0	1
Ambivalent	5	28	7	39	1	1	6
Receptive	4	22	2	13	0	0	3
	10	50	11	67	2	1	10

Among clinical services for Adult, the majority (ambivalent but are likely open to persuasion) appears slightly larger in Inpatient and Others than in Community. The

balance between the poles tend to lean toward being receptive in Adult Community. This is less clear in the other two groups due to small subgroup numbers.

Among clinical services in CAMHS, there is a prominent majority (ambivalent but are likely open to persuasion) in CAMHS national and specialist as well as Others. The balance between the poles clearly leans toward being resistant in CAMHS Community, but evenly split in national and specialist as well as other services.

P&P also has a large majority (ambivalent but are likely open to persuasion) with an even split between the poles.

Corporate services show the clearest indications of being receptive.

Do staff reactions to virtual contact depend on familiarity of use?

Table 9 Staff reactions to remote ways of working by mode of contact (more experienced users)

	Phone	Video	Both	
Resistant	5	22	23	50
Ambivalent	23	128	98	249
Receptive	4	43	42	89
	32	193	163	388

Table 10 Staff reactions to remote ways of working by mode of contact (less experienced users)

	Phone	Video	Both	
Resistant	3	6	5	14
Ambivalent	4	31	16	51
Receptive	1	7	6	14
	8	44	27	79

Among more experienced users (i.e. 10 or more virtual contacts), the predominant reaction, ambivalent but are likely open to persuasion, shows a similar majority regardless of mode of contact (phone: 72%; video: 66%; both: 60%). The balance between the two poles tend to lean toward being receptive if these more experienced users had any video chat contact (only or with phone calls).

Among less experienced users (i.e. fewer than 10 virtual contacts), the predominant reaction, ambivalent but likely open to persuasion, is a smaller majority in staff who had any virtual contact by phone (phone-only: 50%; both modes: 59%) relative to staff who had only video chat contact (70%). The experience of any virtual contact by phone appears to limit room for persuasion. The balance between the two poles tend to be evenly split among less experienced users regardless of mode of virtual contact.

The potential interaction between mode and frequency suggests that familiarity with virtual contact may have a role in explaining the three reactions

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Do staff reactions to virtual contact depend on having the right equipment?

Table 11 Staff reactions and whether they have the right equipment for virtual contact

	CD	D	N	A	CA	
Resistant	6	13	7	32	8	66
Ambivalent	12	39	18	146	90	305
Receptive	5	6	6	44	42	103
	23	58	31	222	140	474

CD: completely disagree / D: disagree / N: Neither / A: Agree / CA: Completely agree

Table 11 shows staff reactions to virtual contact according to how much they agree/disagree that "*I have the right equipment for virtual appointments/ meetings*"

The predominant reaction, ambivalent but are likely open to persuasion, shows the smallest majority in staff, who completely disagree that they have the right equipment, compared to all others (52% vs 67%, 58%, 66%, 64% respectively). Not having the right equipment appears to limit room for persuasion.

Among staff who have the right equipment (particularly if they completely agree), the balance between the two poles tend to lean toward being receptive. Among staff who do not have the right equipment, this balance is in the opposite direction.

Do staff reactions to virtual contact depend on having the right place?

Table 12 Staff reactions and whether they have the right place for virtual contact

	CD	D	N	A	CA	
Resistant	5	20	10	25	6	66
Ambivalent	7	43	44	144	67	305
	(54%)	(63%)	(80%)	(65%)	(57%)	
Receptive	1	5	1	51	45	103
	13	68	55	220	118	474

CD: completely disagree / D: disagree / N: Neither / A: Agree / CA: Completely agree

Table 12 shows staff reactions to virtual contact according to how much they agree/disagree that "*I am able to have a virtual appointment/ meeting free from interruption*"

The predominant reaction, ambivalent but are likely open to persuasion, shows a far larger majority in staff, who neither agree/ disagree that they have the right place for virtual contact, compared to all others (80% vs 54%, 63%, 65%, 57% respectively).

Among staff who have the right place for virtual contact (particularly if they completely agree), the balance between the two poles tend to lean toward being receptive. Among staff who do not have the right place, this balance is sharply in the opposite direction. The contrast here is somewhat sharper than the preceding one, suggesting that having

the right place (rather than having the right equipment) may be more of an issue for staff.

Do patient reactions to virtual contact depend on having the right equipment?

Table 13 Patient/Carer reactions and whether they have the right equipment for virtual contact

	CD	D	N	A	CA	
Resistant	1	1	0	12	4	18
Ambivalent	0	1	4	15	13	33
Receptive	0	0	1	8	11	20
	1	2	5	35	28	71

CD: completely disagree / D: disagree / N: Neither / A: Agree / CA: Completely agree

Table 13 shows patient/carer reactions to virtual contact according to how much they agree/disagree that "*I have the right equipment for virtual appointments/ meetings*".

The patient/carer sample is small and there is poor representation of ethnic minorities in this sample. Here, another potential sampling bias can be seen. Patient/Carer respondents mainly included people who have the right equipment for virtual contact. These respondents tend to lean toward being receptive only if they completely agree that they have the right equipment. They are less receptive in general otherwise.

Do patient reactions to virtual contact depend on having the right place?

Table 14 Patient/Carer reactions and whether they have the right place for virtual contact

	CD	D	N	A	CA	
Resistant	2	4	2	8	2	18
Ambivalent	0	3	3	20	7	33
Receptive	0	0	3	8	9	20
	2	7	8	36	18	71

CD: completely disagree / D: disagree / N: Neither / A: Agree / CA: Completely agree

Table 14 shows patient/carer reactions to virtual contact according to how much they agree/disagree that "*I am able to have a virtual appointment/ meeting free from interruption*".

Consistent with the study limitations mentioned above, the patient/carer respondents in this sample mainly included people who have the right place for virtual contact. These respondents tend to lean toward being receptive only if they completely agree that they have the right place. They are less receptive otherwise though the contrast here is not as sharp as the preceding one. For patients/carers, it may be that having the right equipment matters more than having the right place. A more systematic sampling and survey design is needed for understanding patient and carer needs.

Do patient and staff reactions to virtual contact depend on having choice?

Table 15 Patient/Carer reactions and perceptions of having choice

	CD	D	N	A	CA	
Resistant	3	3	3	7	2	18
Ambivalent	0	4	12	14	3	33
Receptive	0	0	2	9	9	20
	3	7	17	30	14	71

CD: completely disagree / D: disagree / N: Neither / A: Agree / CA: Completely agree

Table 16 Staff reactions and perceptions of having choice

	CD	D	N	A	CA	
Resistant	9	13	18	25	1	66
Ambivalent	10	49	82	111	53	305
Receptive	1	9	19	37	37	103
	20	71	119	173	91	474

CD: completely disagree / D: disagree / N: Neither / A: Agree / CA: Completely agree

Table 15 and 16 shows patient/carer and staff reactions (respectively) to virtual contact according to how much they agree/disagree that "*I have a choice in choosing how my virtual appointment/ meeting takes place*".

While the patient/ carer sample is small and there is poor representation of ethnic minorities in this sample, the finding here is as anticipated. Perceptions of choice appears to have a consistent association with reactions to virtual contact. Patients/ carers who perceived having more choice are also more receptive to virtual contact. This is also the case for staff.

Do patient and staff reactions depend on how involved they feel in the virtual contact?

Table 17 Patient/Carer reactions and how involved they feel in the virtual contact

	EN	SN	N	SI	EI	
Resistant	2	4	8	4	0	18
Ambivalent	0	3	1	12	17	33
Receptive	0	0	0	4	16	20
	2	7	9	20	33	71

EN: extremely not involved / SN: somewhat not involved / N: neither / SI: somewhat involved / EI: extremely involved

Table 18 Staff reactions and how involved they feel in the virtual contact

	EN	SN	N	SI	EI	
Resistant	2	17	9	22	16	66
Ambivalent	1	17	47	93	147	305
Receptive	0	1	3	27	72	103
	3	35	59	142	235	474

EN: extremely not involved / SN: somewhat not involved / N: neither / SI: somewhat involved / EI: extremely involved

Table 17 and 18 shows patient/carer and staff reactions (respectively) to virtual contact according to their responses to "*How involved did you feel as part of the virtual appointment/ meeting?*".

In the small and predominantly White sample of respondents, patients/ carers tend to be receptive only when they felt "extremely involved" in the virtual contact they had. They are less receptive in general otherwise. This is also the case for staff.

Do patient and staff reactions to virtual contact depend on whether they a disability?

Table 19 Patient/ carer reactions to remote ways of working by disability

	None	Mental health	Developmental	Hearing / Sight	Physical health	Prefer not to say
Resistant	4	6	2	0	2	4
Ambivalent	12	10	0	1	6	3
Receptive	11	6	1	0	0	2
	27	22	3	1	8	9

Table 20 Staff reactions to remote ways of working by disability

	None	Mental health	Developmental	Hearing / Sight	Physical health	Prefer not to say
Resistant	48	3	2	1	3	7
Ambivalent	224	6	8	10	16	32
Receptive	68	2	2	4	10	16
	340	11	12	15	29	55

Table 19 and 20 shows patient/carer and staff reactions (respectively) to virtual contact according to whether they reported having a disability. In both patient/ carer and staff, respondents lean toward being receptive if they reported no disability. The numbers in all others are too small to offer insight.

Can the Trust do anything improve virtual appointments/ meetings?

Table 21 Patient/ Carer reactions and their perceptions about what can be done to improve virtual contact

	No	Maybe	Yes	
Resistant	10	6	2	18
Ambivalent	11	12	10	33
Receptive	9	2	9	20
	30	20	21	71

Table 22 Staff reactions and their perceptions about what can be done to improve virtual contact

	No	Maybe	Yes	
Resistant	21	17	28	66
Ambivalent	67	68	169	304
Receptive	26	21	56	103
	114	106	253	473

Patients/ carers who thought that something can be done to improve virtual contact tend to lean toward being receptive. Those who were unsure or thought nothing can be done by the Trust tend to lean toward being resistant.

Staff who thought that something can be done to improve virtual contact tend to lean toward being receptive. This is less clear in all others.

Perceived acceptability, appropriateness, feasibility of virtual contact among patients/carers and staff
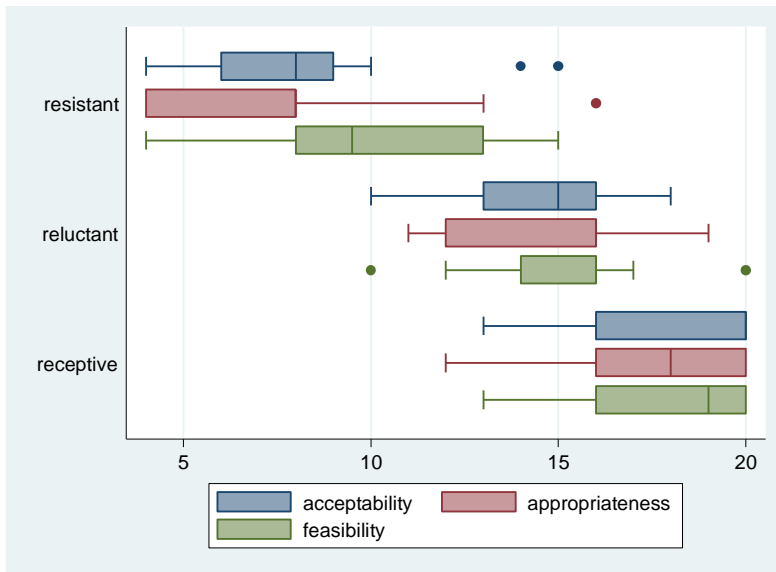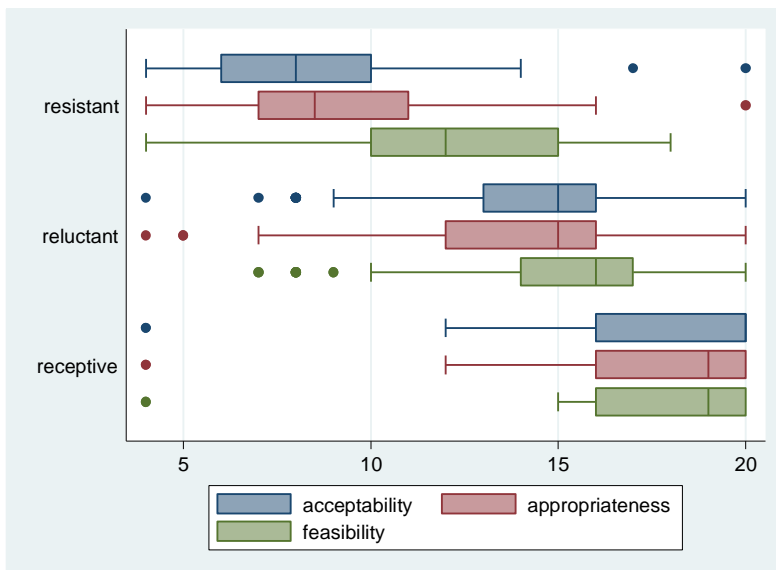

Figure 2 Patient/Carer perceptions

Figure 3 Staff perceptions

Perceptions of acceptability, appropriateness and feasibility of virtual contact did not show apparent differences between patients/carers and staff (Figure 2 and 3). In general, the more they perceive virtual contact to be acceptable, appropriate and feasible, the more favourable reactions they have. Of note, among respondents in the resistant group, feasibility ratings tend to be higher than acceptability and appropriateness ratings. For them, the perceived lack of acceptability and appropriateness (rather than the lack of feasibility) might be driving their resistance. This finding needs to be interpreted carefully as ethnic minorities are not well-represented in this sample.

Qualitative

The free text responses of the survey (four items) underwent rapid theming. The intention was to separate the data by respondent population (i.e. staff, service user/ patient, carer/ supporter, other), however through the analysis it emerged that there were no unique items between these groups and that the themes were consistent across the groups. It was identified that:

- Most respondents appreciate the choice to work remotely (especially to avoid contracting or transmitting coronavirus) and still fulfil care needs or their work obligations through virtual platforms
- Most respondents referred to their use of video calling as part of the survey (rather than telephone)
- Most respondents have adapted to working and delivering services virtually. Though the processes and structures have not wholly followed alongside (e.g. still sending letters of appointments, provision of FP10's, etc.)
- There are clear advantages and disadvantages to remote working (table 23)
- There are clear contributors to the success of remote working, namely,
  1. Access to necessary equipment and data
  2. Support to facilitate virtual working
  3. Clear virtual working guidelines
  4. Choice of interaction type
  5. Access to the appropriate environment in which to work remotely

Table 23: Advantages and disadvantages of remote working

Advantages	Disadvantages
People able to keep in touch (with care coordinators, have supervision, etc.)	Impact on work/ life balance and boundary setting
Continue with treatment and work	Limitation of interactions: - extent of treatments that can be offered (e.g. behavioural experiments, interactions with young people, loss of body language cues) - Collegial interactions and support
Meetings are more focussed which means less time spent on one appointment	Some meetings and assessment have taken much longer to be able to get an accurate understanding
It helps reduce symptoms (e.g. less anxious as don't have to travel to appointment)	Can exacerbate symptoms (e.g. more anxious as not used to technology)
An individual can be more open and honest and they are comfortable in their home	An individual can become more withdrawn, or 'check out' as they are distracted by being at home

Generated ideas

The free text survey items specifically asked about ideas on how to improve virtual working. The analysis from these items generated 23 ideas which would support the five core contributors to remote working and are captured in table 24.

Table 24: Change ideas to support the core contributors of remote working

	Provide necessary equipment/ access/ data	Technological support to facilitate virtual working	Have clear virtual working guidelines	Choice	Environment
Change ideas	Consider loan/ purchase scheme for SU/ carers for laptops/ tablets	Work with Recovery College to develop training which can be accessed by all	Have guidance in an easily located place on Maud	Give SU/ carers option of booking appointments online	Need to consider access to safe and confidential spaces to have conversations
	All staff be given VPNs	Work with LEAP to deliver training on MS Teams	Develop guide on best practice (e.g. mute mics, use hands up, use chat)	Give people choice of telephone, video call or face to face	
	All staff be given standard equipment	Develop a how-to guide	Guidance on virtual working and wellbeing	Give people choice of having camera on/off	
	Wards/ inpatient settings need to be furnished with equipment	Consider more bespoke support for YP, OA, LD and Forensic population	Inform SU/ carers/ supporters with enough time to get selves and equipment ready		
	Consider alternative to MS Teams (e.g. whatsapp/ facetime)	Clarity on when to and not to have virtual sessions	Encourage use of video camera to help develop rapport		
	Improve wifi connections on hospital sites	Upgrade MS Teams to be able to see more people			
	Provide staff with internet dongle (e.g. for homes with poor connectivity/ many in household using internet)	Develop live IT chat for accessible by staff and those external to organisation			

Wider impact of virtual working

Whilst the survey provides in depth understanding of experiences, other routine measures collected by the organisation is important to consider. Data in relation to the number of complaints, self-harm and suicide events which occur can provide some further contextual information about the unintended impact of our shift in working style.

Complaints

Figure 4: C Chart of complaints
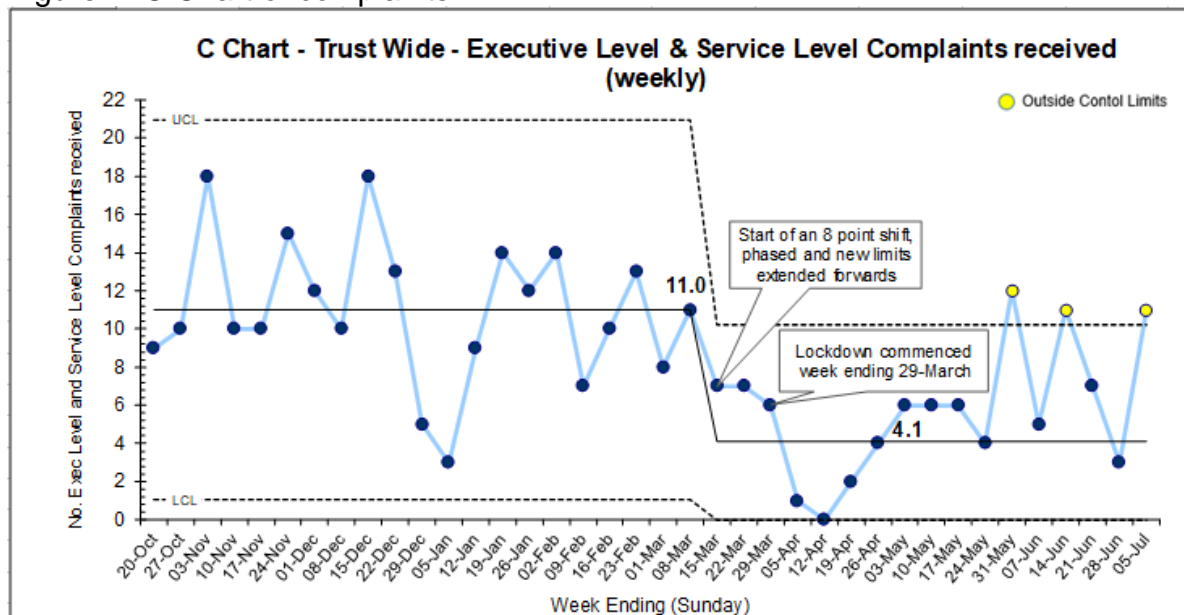
Data source: Datix. Data exported on 06/07/2020 at 16:20. Chart created using QI Charts.
Data definition: Complaints defined as the following Datix types: Executive level or Service Level. Charted by date first received.
Baseline of 20 points was applied to identify special cause (showing complaints received in same period as self-harm and suicide for continuity)

A downward shift is noted starting from 15th March 2020 with the mean number of complaints reducing from 11 weekly down to 4.1 weekly. (This reduction should not be associated with an improvement, as, due to the pandemic, figures may be affected due to many reasons.) This shift resulted in the rephasing of the mean and control limits. More recently some spikes in the number of complaints can be seen with points outside of control limits shown in yellow. It is important to be cautious in the interpretation of this shift as the data points outside of the control limits may be indicative of a new trend.

Self-harm

Figure 5: C Chart of self-harm incidents
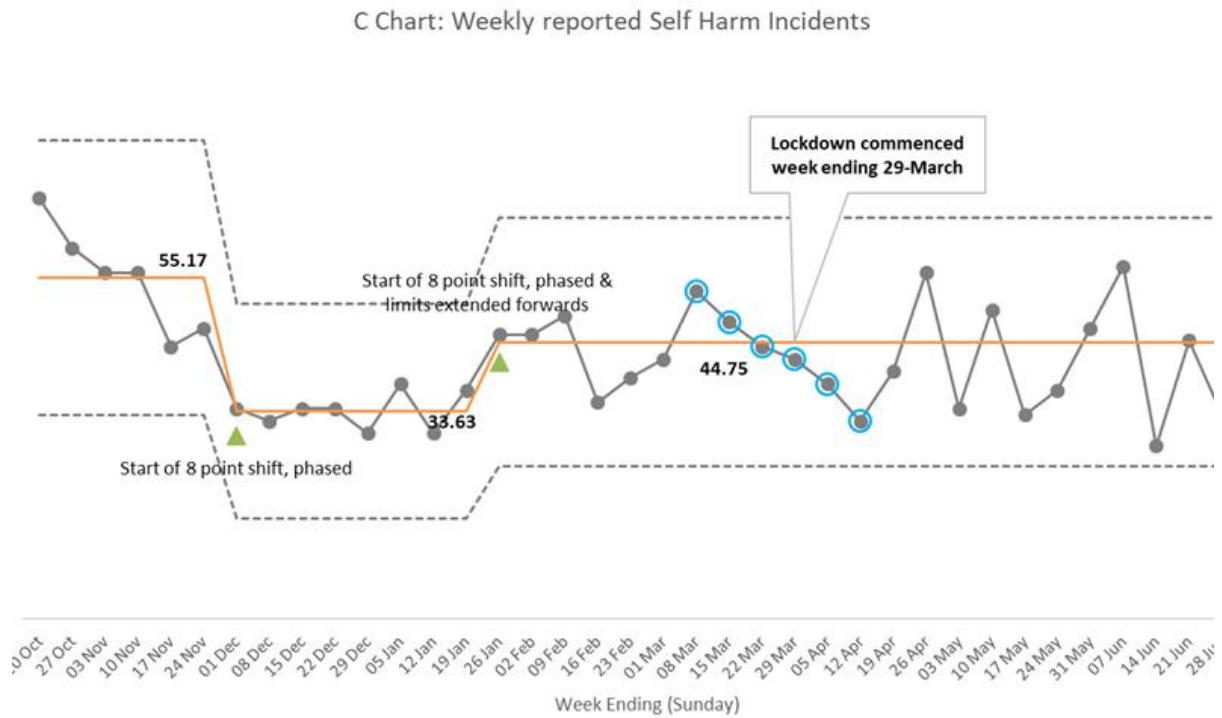
C Chart: Weekly reported Self Harm Incidents

Data source: Datix, data updated as of 06/07/2020 10:10am. Charts created from Excel Tool.
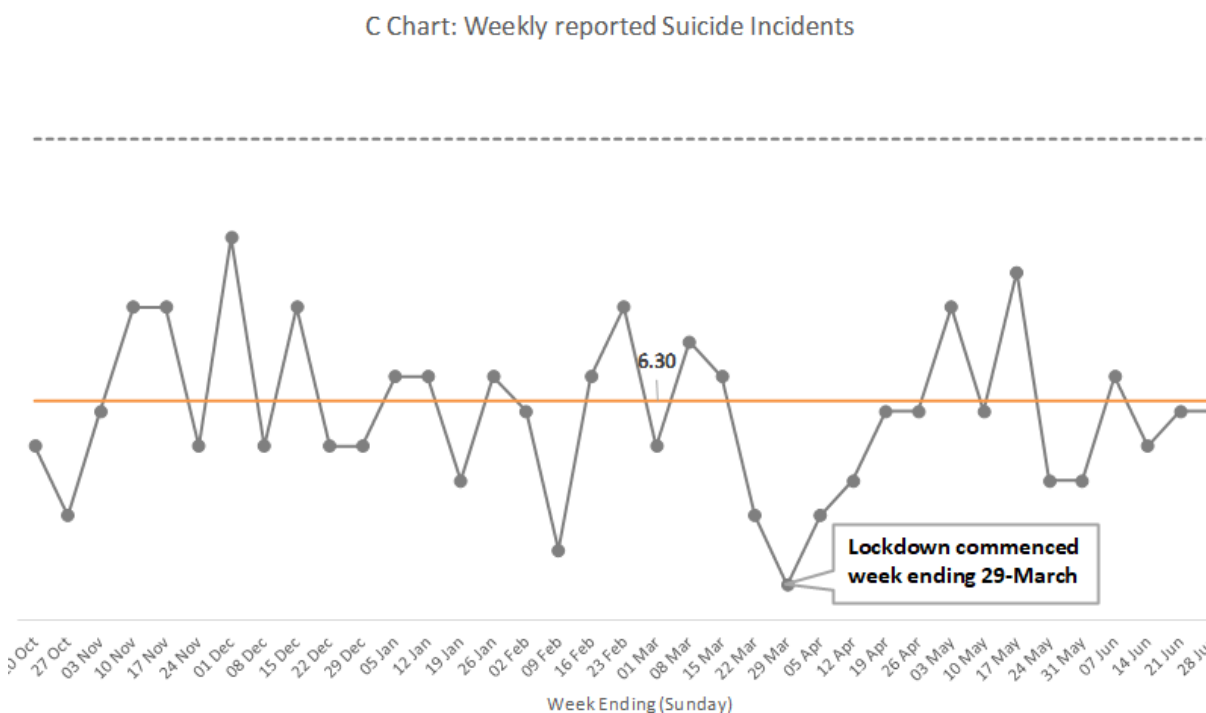Data definition: Self harm incidents defined as the following Datix categories: Actual Self-harm, Alleged/Suspected Self-harm & Attempted Self-harm (excludes Threatened Self-harm & Accidental Self-harm)
Baseline of 20 points was applied to identify special cause

Prior to the pandemic and the associated lockdown measures, the data indicates a shift down in the mean from 1st December 2019, and then a shift up from 26 January 2019. There was a downward trend (identified by points circled in blue) from 8 March, during the lockdown period, however this was not sustained and did not result in a shift. The reduction does not imply an improvement, and further understanding is required to understand the contributory factors to this data. It is possible that due to the pandemic this data is artificially deflated.

Suicide

Figure 6: C Chart of suicide incidents

C Chart: Weekly reported Suicide Incidents

Data source: Datix, data updated as of 06/07/2020 10:10am. Charts created from Excel Tool.

Data definition: Suicide incidents defined as the following Datix categories: Attempted Suicide, Probable Suicide & Suicide - (Inquest confirmed)

Baseline of 20 points was applied to identify special cause

In relation to suicide incidents, there are no changes noted in the 9-month period reviewed with the mean number remaining at 6.3.

Survey limitations

Whilst the survey was rapidly developed it underwent scrutiny from service users, carers, staff and the QISS CAG to ensure face and content validity. However, there are limitations to the survey design which has impacted our data collection figures and analysis. The survey was

- ✗ Difficult to complete if an individual had a telephone appointment or meeting (relies on staff to talk through the questions with an individual)
- ✗ Not embedded into a rigorous system which would allow it to be sent out and completed by individuals (it relied on someone remembering to send it out)
- ✗ Not designed to support a matched-pairs approach (to see how a respondent's experience may change over time)
- ✗ Unable to effectively reach service user/ patient, carer/ supporter and third sector individuals to provide a holistic data set to capture experience. This was despite a concerted effort in May 2020 to address this.

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Conclusions

The shift to virtual working has led to innovative and rapid changes taking place in how mental health services are delivered and received at South London & Maudsley NHS Foundation Trust. The survey, which was completed by 545 individuals, was open to staff, service user, carers and others for eight weeks from 29th April 2020 and closed on 23rd June 2020.

The quantitative analysis of the data showed three main types of responses (resistant, ambivalent and receptive) to virtual working. These groups are delineated through their responses to questions relating to their experience of virtual working and how likely they are to want virtual meetings in the future. The analysis considered these groups in relation to their profession/ role, the type of service offered online, operational directorate, familiarity with online working, provision of equipment and appropriate environment, disability and ethnicity. The labels do not necessarily imply an unfavourable preference to virtual working as it is likely to be influenced by the task and nature of the engagement between individuals.

The qualitative analysis highlighted key costs and benefits to working virtually. At times the generated concepts were contradictory, indicating that the experience of working virtually was experience very differently by different individuals. The qualitative analysis also identified five contributors to successfully working virtually in the future, which would benefit from further consideration and investment (Equipment/data, support for virtual working, clear guidance, choice and environment). Against these contributing factors, respondents provided change ideas which would progress the consideration and investment in these areas to promote the use of virtual working, particularly for those delineated into the resistant and ambivalent groups.

Learning and next steps

- Going forward, the prospects of virtual contact for work and patient care should not be thought of as an either good or bad thing. Discussions about what the patient/ carer wants and needs for the care to be timely, person-centred and frequently reviewed.

- Repeated population-based surveys about the impact of virtual contact on quality and safety in healthcare must continue in order to gain vigilance about how clinical services and patient choice evolve in post-lockdown climate.

- Systematic sampling and its associated resources must be in place for reaching under-served populations so that survey findings are not affected by socioeconomic disparities and digital divide.

- Concerted collaboration with other public health organisations (e.g. Health Innovation Network) should be considered, to revisit missed opportunities for harmonising study and survey design in ways that offer robust learning across NHS Trusts and reduce survey fatigue in clinicians and patients / carers.

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