

TECHNOLOGY ENABLED CARE

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CYMRU

NHS Wales Video Consultation Service

Phase 2a Evaluation

Discussion & Conclusion of Quantitative Data

Phase 2 Executive Summary

In the [Phase 1](#) evaluation (March to September 2020), which is considered the 'roll-out' stage of the NHS Wales Video Consulting (VC) Service, the TEC Cymru research team were evaluating the 'use and value' of the VC service to simply answer their key question – 'is it working'? The end of Phase 1 report concluded that there was a large and growing appetite for VC in Wales across a wide range of care sectors, specialities and patient types. However, it was recommended that more evaluation and dedicated research was needed to understand and plug some of the identified gaps. This led to additional resource for Phase 2 (further evaluation = 'scale-up' stage) and Phase 3 (research, e.g., experimental and observational work now lockdown restrictions are easing).

This section will discuss and compare the Phase 1 and 2 datasets and attempt to answer the 'key questions' set out in Phase 2. The section will conclude with an outline of the next steps for the Phase 3 research.

Please note: For more information on the difference between evaluation and research, and asking key questions versus research questions (and why they differ) please see our *Research & Evaluation Framework* for further guidance, available on TEC Cymru's [Evidence Portal | Digital Health Wales](#).

Discussion

Key Question 1: How has the 'use and value' of VC in Wales remained consistent between Phase 1 (the roll-out) and Phase 2 (the scale-up)?

The Phase 1 (March 2020 and August 2020) and Phase 2 (September 2020 and February 2021) data have remained consistent across measures of 'use and value' (e.g., satisfaction, suitability and acceptability) across many care sectors and specialities, among patient groups. Many of the findings also suggest significant improvement and growth, in use and value. However, one area of decline (or lack of consistency in use and value) has been the continued use of VC in Primary Care, where uptake has decreased since Phase 1, despite the extension of VC in Phase 2 to other Primary Care services (to include Dental, Optometry & Pharmacy).

Furthermore, despite the Phase 1 and 2 data being captured within the same duration period (6-months each), the uptake in participation in feedback data between roll-out (in Phase 1) and scale-up (in Phase 2) has more than doubled. In Phase 1, data was based on 10,401 clinicians and patients, and in Phase 2, data is based on 22,978 clinicians and patients.

In addition, the spread of use between Phase 1 and 2 across all parts of Wales demonstrate better geographical spread of VC uptake across Health Boards. This improvement in proportion across Health Board suggests that VC uptake is not just continuing to be used in Wales, but rather an improved spread of VC uptake suggests its continuing to be valued more consistently on a national level, which is now more comparable to Health Board [general population size](#).

In Phase 1, the care sector distribution consisted of 33% of respondents in Primary Care and 67% Secondary/Community Care. However, in Phase 2, only 5% of the overall proportion were in Primary Care, compared to 95% in Secondary/Community Care. Looking at the Attend Anywhere platform data during the Phase 2 period, based on 126,000 consultations, 7,184 were for Primary Care, which represents a 5.7% proportion of the overall total. Combining the evaluation data with the platform data, this suggests that consistency by care sector has weakened as a comparison. The decline

in Primary Care may be associated to the service not perceiving VC's use or value as a long-term option (thus only using in roll-out, not scale up) e.g., the return to face-to-face as Primary Care service reopen, or that Primary Care are using different platforms for VC that TEC Cymru are not aware of. Nevertheless, Secondary/Community Care have observed a three-fold increase between Phase 1 and 2, and therefore this suggests not just consistency, but also improvement and growth for use and value. Finally, between Phase 1 and 2, the rating of 'quality' across all care sectors and specialities has remained consistently high (scored between 'Excellent, Very Good or Good'), with a slight increase for patients (91.4% in Phase 1 and 92.4% in Phase 2) and a slight decrease for clinicians (74.7% in Phase 1 and 71.9% in Phase 2).

Key Question 2: For whom, under which circumstances and to what extent is VC working?

As mentioned in the answers above, proportionate use of VC is improving across Health Boards in Wales, particularly for Secondary/Community Care. Interestingly, the type of appointments across these specialities is generally consistent, with the most common use of VC for 'first appointments' (27.7%), 'therapy/treatment' (26.1%) and 'reviews' (23.4%). It is also reported by clinicians that a face-to-face appointment was prevented 85.3% of the time. These findings suggest that across a range of health conditions, specialities and appointment types, VC has been working well.

In addition, during both Phase 1 and Phase 2, patient demographic data remained consistent on a weekly basis (in other words, measures such as age and gender hardly alter in range). However, some small shifts (in a positive direction) have occurred under the comparison of phases. For example, in Phase 1, 17.7% of the respondents were over 65 years old, and in Phase 2, this increased by 3% to 20.7% of respondents over 65 years old. This proportion of VC users is almost comparable (0.1% difference) to the national population of over 65 year olds ([20.8%](#)). Furthermore, in Phase 1, the majority of VC users were female (62.2%). However, in Phase 2, the distribution between gender improved by proportion, with 57.1% female, 42.2% male (0.4% other/non-binary). This data is also almost comparable to the national population data ([women 51%; men 49%](#)).

The Phase 2 data captured additional socioeconomic measures such as ethnicity and household income. The Phase 2 data reports that 96.2% of patients were White or

other White or Irish and 3.8% were within BAME categories (Black, Asian, Mixed/Multiple group, or other Ethnic group). This is lower than the national population for [BAME groups \(5.2%\)](#).

For household income, the highest distribution of responses were from patients with household incomes of less than £15,000 per year and the least from patients with incomes more than £150,000 a year.

Phase 2 Data also captured an additional measure on disability, which demonstrates that 29% of the VC users have a disability. This highlights that where some disabilities may hinder accessing care e.g., transport or family/carer support, VC presents a valuable alternative option, to access to services in the future.

[Welsh population data](#) suggests that 64.9% live in urban areas, and 35.1% in rural. The Phase 2 data demonstrates VC uptake on relatively comparable levels, with 30.9% reporting rural areas (country & village) and 67.5% in urban (city and town).

Overall, the Phase 2 data on demographics suggests that regardless of patient age, gender, ethnicity, household income, disability, place (urban/rural) or health status, VC can support the delivery of healthcare across patient groups. This data challenges the 'digital divide' or digital [exclusion](#) for NHS Wales patients accessing digital healthcare and suggests that further thinking is needed in what support can be offered to make digital healthcare sustainable. The Phase 2 findings point out that VC uptake has been accepted and rated highly by all types of patients using the VC service, and that the proportionate level of uptake is representative of the Welsh general population. It is nevertheless acknowledged that VC is not for everyone, and that face-to-face will always need to be used for many patient types. This data merely suggests that VC is a tool that can be used in NHS Wales, and ultimately can free up services and resources for those who need face-to-face appointments.

Key Question 3: What are the challenges of VC?

The challenges for using VC were relatively minimal for patient users. The least reported challenge by patients were 'issues with space or privacy' (96.6% 'not at all'). The most reported challenge by patients were the 'preference for a face-to-face or telephone appointment' (12% 'a lot'). Challenges such as 'issues with device, internet, visual or audio' were minimal challenges for the patient (ranging 1.8% to 4.2% as 'a lot'). Challenges with having a 'lack of confidence' using VC and the perception of

VC 'not being clinically suitable' were also reported as minimal challenges for the patient (ranging 1.2% to 2.1% as 'a lot').

The least reported challenge by clinicians were 'lack of confidence' in using VC (94.3% 'not at all'). Although further work is to be done to create a more digitally skilled and competent NHS, which may include incorporation of digital competency in curriculum for healthcare and social care workforce in training, especially as they will be the future NHS workforce using newer digital ways of working.

The most reported challenge by clinicians were technical issues associated to poor audio, visuals, internet or device (ranging 15.7% to 8.5% 'a lot'). The challenge of VC being perceived as 'not clinically suitable' for the patient was reported as a minimal challenge by clinicians, with only 2% stating this challenge as 'very relevant' or 'relevant'. From the clinician's perspective, the preference for a face-to-face appointment was reported as 'very relevant' or 'relevant' by 16.7% (for the patient) and 21.3% (themselves as clinicians).

Key Question 4: What are the benefits of VC?

The benefits of using VC for both patients and clinicians were rated very high. The least reported benefit by patients were 'lowered stress and anxiety' (74.3%) as 'very beneficial' or 'beneficial'. The most reported benefits (as 'very beneficial' or 'beneficial') by patients were 'lowered infection rate' (94.2%); 'saved travel and parking' (92%) and 'saving the environment' (91.1%). Other patient benefits were also rated highly, such as 'saved time and preparation' (87.3%); not 'having to take time off work/school' (81%); 'improved convenience' (87.6%); 'improved access to care' (85.5%); 'saved money' (81%); and 'improved family involvement' (78.6%).

The least reported benefit by clinicians were 'improved family involvement for the patient' (59.9% 'very beneficial' or 'beneficial'). The most reported benefits by clinicians were 'lowered infection rate' (92.3%) and 'saved travel and parking' (84.1% 'very beneficial' or 'beneficial'). Other clinician rated benefits such as 'more efficient use of their clinical time/space' (74.8%) and 'saving the environment' (79.8%) were rated as 'very beneficial' or 'beneficial'. Clinicians also rated benefits for the patient/NHS service such as 'increased access to care' (72%); 'reduced waiting times' (68.6%) and reduced DNAs' (61.1%) as 'very beneficial' or 'beneficial'.

'The total calculation of travel savings suggests that on average a patient or clinician saves almost 1-hour per appointment/or working day in travel. This calculation is based on 12,612 respondents. However, if a patient journey saving is multiplied against the usage figures for the first year (162k Consultations) over 157k hours were saved for patients.'

The patient enablement scale findings (the 'able to' scores) reflect that digital ways of working have potential to not only enable, but empower the patient groups, and this needs to be explored further.

Key Question 5: How does the Phase 2 data demonstrate potential for sustainability and long-term use?

The answers above demonstrate that VC is highly rated, clinically suitable, and is well accepted by patients and their clinicians. It has also demonstrated that regardless of geographic, sociodemographic or health status, there has been a consistent appetite for VC during Phase 1 and Phase 2 which suggests improvement and growth across many areas. Unfortunately, consistency was not observed in Primary Care, and therefore, we could suggest that long-term sustainability is less likely for Primary Care, compared to Secondary/Community Care. However, there will always be patients who will need face-to-face appointment, but a hybrid approach would be an ideal option moving forward.

However, it is clear that in Secondary/Community Care, VC is on the rise. This is greatly supported by patients reporting 91.1% of the time that they would use VC again in the future, and only 0.8% said they would not. Furthermore, 58.3% of patients report that they had only used VC on the day of their appointment. The remaining patients had used it once, twice, or three times or more prior to their consultation. This suggests that the preference for future use and number of times using the service isn't impacted on, and therefore has potential for sustainability for new and continued users. Furthermore, according to 64.8% of patients, the choice to use VC was made by the service, while 20.5% of patients were given the choice and opted to use VC. This suggests that the services themselves are making clinical judgements based on carefully selected VC patients, and therefore being more proactive in offering the VC

service, and this may suggest VC is becoming embedded in services, with potential for long-term sustainability.

Conclusion & Next Steps

The Phase 1 and Phase 2 data have remained consistent across measures of 'use and value' (e.g., satisfaction, suitability and acceptability) across many care sectors and specialities and among patient groups, with many of the findings suggesting significant improvement and growth in use and value.

The Phase 2 data suggests that VC is working well for many health conditions and patient types, regardless of socioeconomic and geographic characteristics. This challenges some of the presumptions around digital divide or exclusion. Rather, it would suggest that for all types of patients in Wales, VC can help support healthcare delivery in many ways. In addition, the data indicates a long-term need for VC, which tends to be associated with the significant benefits of using VC which clearly outweigh the challenges. These findings will continue to be supported and updated by ongoing evaluation, while new Phase 3 research will investigate new areas via in-depth, experimental and observational studies.

As the TEC Cymru team move onto Phase 3, which is more research central (rather than evaluation), gaps identified within Phase 1 and 2 can continue to be explored, with emphasis on VC effectiveness and efficacy and sustainability. A wide range of studies and desktop activities are now taking place in Phase 3, such as Randomised Controlled Trials, Case-Control Studies, Pathway Comparisons, Ethnographic and Observational Studies, Health Economic Analysis, Mathematical Modelling and more. The TEC Cymru team are also conducting an in-depth analysis of the National Population Data & NHS data to continue to compare the VC data, and its use and value, benefits and challenges, and also to keep a close eye on digital inclusion and exclusion.

Owners & Authors of the Data

Owners:

This Data Is the Ownership of Technology Enabled Care Cymru and their Funders The Welsh Government.

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The data was collected, analysed & written up by TEC Cymru's in-house Research & Evaluation Team

Referencing the Data:

When using the data as a source please reference the authors and main owner (TEC Cymru) of the data appropriately.

For example:

Johns et al (June, 2021) Phase 2a Quantitative Data. The NHS Wales Video Consulting Service, Technology Enabled Care (TEC) Cymru. Cited at (add the website or other source that this document was retrieved, plus date retrieved)

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