

Telemedicine in the UK- it's Starting to Happen

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ABSTRACT

Setting up telemedicine needs to happen at scale if it is to be effective. That requires planning, engagement and some up skilling of users with prior agreements on information governance, privacy impact assessment, informed consent, medical defence organisation indemnity, protocols as well as the budget for the cost and set-up of equipment (maybe encrypted video link, or web cams) and upskilling (patient or service user, clinicians, administrators). This chapter focuses on how telemedicine is perceived and is being rolled out in the UK and draws on the drive for adoption via the West Midlands Academic Health Science Network. It is extracted from the newly published Guide to Digital Healthcare: Chambers R, Schmid M, Birch-Jones J. Digital Healthcare: The Essential Guide. Oxford: Otmoo Publishing, 2016. https://itun.es/gb/k_Xveb.l (Apple) and bit.ly/2duAMdG (print).

POTENTIAL OF TECHNOLOGY ENABLED CARE AND SERVICES FOR DELIVERY OF HEALTHCARE

Digital technology offers great opportunities for transforming health and social care services and associated outcomes, and for improving the experiences of patients or service users and their carers.

The five 'big enablers' of the shift in modernising healthcare are thought to be: finance, integration, workforce, technology and empowerment [1]. Technology enabled care services (TECS) can therefore underpin more effective and productive working and thus save money, aid integration across health and social care settings, support the workforce in more efficient and virtual delivery of care as well as empower citizens.

More productive delivery of digital care should provide:

- teleconsultation integrated into care pathways with technology enabled services in practice and care/nursing home settings
- fewer unnecessary face-to-face consultations for follow-up care of long-term conditions or redressing adverse lifestyle habits
- better time management for clinicians
- learning by doing and sharing care; being more confident and competent with telemedicine consultations
- regular follow-up care with appropriate healthcare staff.

WHAT IS TELEMEDICINE?

Telemedicine is a term that has varied interpretations. It sometimes relates to the use of sensors and electronic means of communication from one clinician to another, to aid diagnosis and clinical management; this might typically be by a pre-booked video conference between family physician or community nurse and consultant for a shared patient consultation (the patient may or may not be present too) [2]. Sometimes the term telemedicine has a wider application, such as 'distance medicine using information and communication technologies to examine, monitor, treat and care for patients over a distance ... both within and between all kinds of healthcare institutions as well as to monitor and provide support to patients living at home' [2]. Even a consultation generated by a clinician phoning an individual patient to relay information might be considered as 'telemedicine' by some.

Telemedicine and teleconsultation include 'the use of video conferencing facilities (or high quality webcams) to enable remote consultations between patients and healthcare professionals, as well as peer to peer consultations between health professionals' [5].

The terms 'e-health' and 'telehealth' are sometimes wrongly interchanged with the term 'telemedicine'. Like the terms 'medicine' and 'healthcare', the term telemedicine is used to refer to the provision of clinical services while the term 'telehealth' can refer to clinical and non-clinical services such as medical education, administration, and research. The term 'e-health' is often used as an umbrella term that includes telehealth, electronic medical records, and other components of health infrastructure technology **(IT)**.

Describing the actual telehealth or telemedicine application, or distinguishing between them, will depend on their purpose and whether for instance the way of using the equipment renders it as a medical device. If the telehealth system is just a communication tool, it is not diagnostic, and it is not a medical device. Its success then depends on the user following the detail in the shared care management plan previously agreed with their health or social care professional.

Video consultation can provide a remote facility for clinicians to deliver face-to-face care without the patient attending an in-person consultation. It doesn't directly replace face-to-face meetings but can be used in an integral way for the right person as an alternative to the patient attending a clinic session or the clinician making a home visit.

The use of technology, such as vital signs monitoring and communication with patients through the use of telehealth equipment, should enable more effective management of resources, as it frees clinicians to focus on and engage in treating and reviewing a housebound patient's medical condition, rather than spending time travelling to the patient's home or care homes.

There is much debate as to the benefits and challenges of telemedicine. On the positive side, video consultation should be more convenient for patients and potentially save costs of time and travel (for health and social care staff and patients/service users); on the negative side, there are significant technical, logistical and regulatory challenges and potential clinical risks [3].

Video consultation might be provided via an encrypted connection rather than a non-confidential video interaction via Skype. Skype might be set up between clinician and patient who has their own access to Skype via their mobile phone, iPad, computer or other device; or it might be set up for clinician to clinician interaction for a remote peer professional meeting or between practitioners in different settings (such as acute hospital and general practice settings). Sometimes connectivity can be difficult, such as in multi-dwelling occupancies such as a care home with flats for independent residents, or with particular mobile phone services. This type of delivery of care has become increasingly well established in rural communities where travel can be challenging, such as remote areas in the USA. People with disabilities or who have mobility issues or mental health problems such as agoraphobia can really welcome video conferencing which enhances access and availability of care. According to Greenhalgh et al., 'Having a multidisciplinary team working on a video or teleconference with team, carer and patient stops people having to go in for an appointment and saves money' [4].

EXAMPLES OF TELEMEDICINE IN UK

Video consultations underpin telemedicine as in our Examples which show how telemedicine can be applied for different patient groups, in varied health settings for a specific purpose; and the improved quality of delivery of care.

Example 1: skin cancer diagnosis.
In Doncaster in the UK a mobile technology company has created the 4GEE service that focuses on skin cancer diagnoses. Family doctors can connect a microscope to their own smartphones to take a detailed picture of the suspect skin lesion and email this to the associated skin specialists. The dermatologist team sends back the diagnosis promptly – within an average 48 hours, saving an estimated \$80 a patient who would otherwise have been referred to the hospital outpatient department for a face-to-face consultation. (<http://ee.co.uk/business/large/why-ee/4gee-case-studies/NHSDoncaster>).

In practice, the use of video technology may be as simple as two clinicians discussing a case via Skype or as complex as bespoke video technology linking family doctor teams with care homes. Increasingly, there is a need to explore the use of readily available platforms such as Skype or FaceTime which offer the potential for interacting directly with patients. This could be as part of a self-monitoring programme or an asthma review consultation.

Care at a distance or ‘in absentia’ care has been running for years in different manifestations (see Example 2 of long distance neurology services that were in place until 2004); but as technology develops the challenge is to radically change the way health services are delivered. As pressure builds from the bottom up, the system itself will be under pressure to meet the new ‘digital native’ patient who wants to email and Skype the nurse as well as monitoring their own health through wearable technology. The introduction of video consultations is beginning to disrupt traditional care pathways. As homes and people become more connected and we see a growth in the Internet of Things, patients will expect the health system to be up to speed with their demands for flexible modes of delivery of care.

Example 2: How a telemedicine service for Parkinson’s disease operated more than 10 years ago in one local area in England (Dr Beatrice Summers, consultant neurologist University Hospital North Midlands).
‘Until 2004, I ran a neurology service which had been set up using a webcam. I used to be responsible for neurological services in Cannock and Rugeley as well as Stafford. There was a cable between hospitals in Stafford and Cannock (which probably is no longer used as these hospitals are now owned by two different NHS trusts). A webcam was installed for my use in a clinic room in Cannock Hospital. I could look at the images from my computer in the Stafford Hospital.
‘A receptionist would take an individual patient and usually a relation to the room at a designated time.
‘Patients would travel from Tamworth as well as from local areas of Cannock and Rugeley. When they arrived, I would telephone them. I could see how well their Parkinson’s disease was controlled.
‘I used this system for alternate follow-up appointments. I had made the initial diagnosis on a face-to-face basis.
‘I asked for feedback from the patient and their relation. The majority of individuals were happy with this service, though the odd individual felt it did not suit them. The service did not involve Skype. I was never able to extend my service so that local GP practices could be linked with my computer.
‘These days telephone clinics are standard for Parkinson’s disease, but they do not enable visual assessment of people’s motor difficulties.’

According to a report from Tractica in the US, the extent of telehealth video consultations across the globe is increasing [2]. Tractica forecasts that the market for devices, software, services, and applications in this area will see strong growth over the 2014 to 2020 forecast period. Starting from a base of 19.7 million consultations in 2014, the market will expand at a compound annual growth rate (CAGR) of 34.7% through to 2020, by which time 158 million sessions are forecasted to be performed annually.

This presents the UK health and social care systems and others in the Western World with a challenge. Are we in a position to be able to deliver this form of service delivery? And do we have enough knowledge within the system to ensure that services at the frontline have the confidence to roll out the use of video consultations? Might patient or service user safety be at risk if video consultations are substituted for face-to-face care? Is the increased efficiency and productivity expected from Skype or video consultations worth the effort?

BENEFITS OF TELEMEDICINE

Video consultation can help to reduce demand on health services. There are some excellent examples of where the use of video is beginning to reduce demand on services eg virtual ward rounds within a care home using iPads.

Remote healthcare services and technology are quickly becoming commonplace across the globe. Telemedicine is enabling health professionals to evaluate, diagnose and treat patients remotely using the latest technology. In many situations, the use of video technology offers benefits as an alternative to traditional face-to-face support including the following.

- Minimising travel: many patients find it difficult to travel to hospitals, or clinics for any number of reasons. The use of video can be a great option for patients where travel is difficult, as an option to traditional care. It can be particularly beneficial for those in isolated communities in rural areas where public transport access is limited or where travel to large cities may be a daunting prospect. A good example could be a weight management clinic with a high number of young mums on the register where childcare is an issue for them so Skype or FaceTime could help connect them to a health professional from the comfort of their home. In Lancashire, Skype was used in the urgent care service to connect deaf patients with interpreters. This reduced waiting times for the patient and costs to the hospital associated with callout fees.
- Improving networks: besides doctor-to-patient communication, video conferencing allows hospitals to create networks to provide each other with support. By easily sharing their expertise outside their own organisations, medical or nurse specialists can offer incredible value to their health or social care colleagues.
- Reducing the spread of infections: remote consultations can eliminate the possible transmission of infectious diseases between patients and medical staff. This is particularly an issue where spread of 'flu or other infections are a concern.

- Reducing stress: the offer of a remote consultation via video link will not only relieve the pressure of the patient visiting the health practitioner, which can be daunting for some who suffer from 'white coat syndrome', but also ensures that those with phobias do seek medical help if required.

- Encouraging self-care: the use of video consultations can also be linked to self-monitoring equipment to ensure that patients or service users are using the equipment properly to take their readings.

CHALLENGES TO USING TELECONSULTATIONS AS A MODE OF DELIVERY OF CARE

Before you set up Skype you will need to consider a number of factors. Initially you should have discussions internally with IT providers and information governance (**IG**) services to ensure that they are comfortable with the approach. Example protocols which can be found on the website www.digitalhealthsot.nhs.uk have satisfied these types of concerns and include medical indemnity considerations. You might adopt or adapt some sections or a document for your own purpose - taking your own professional responsibility for the document that must fit with local IG and security procedures.

The second key aspect will be promoting the service and gaining consent from patients or service users. You will need to be clear with the patient that this form of consultation does not replace the existing services but enhances them. Patients will need to be selected to ensure that you are not adding to an already stretched workload. These patients may be ones who are responsible for repeat non-attendance or may be suffering from a long-term condition where accessing GP services is difficult. They may also be using self-monitoring equipment. Once you have agreed the approach you can begin the process of organising the Skype clinics. This is straightforward and involves the practice or clinic compiling the Skype contact list, messaging the patient to inform them when their consultation will take place and then contacting them at the given time as you would with a telephone consultation. It is important before commencing any consultation that you again ask the patient to confirm that they are happy using Skype and that they are broadcasting from a private room.

The equipment required is straightforward - a laptop or PC and webcam but you will need to check your broadband connection speed beforehand by testing the approach before going live.

Examples 3, 4 and 5 all illustrate how different healthcare teams in the UK are using telemedicine to deliver care to their patients.

All Skype-Skype voice, video or file transfers and instant message interactions are encrypted; but a call from Skype to a mobile or landline phone is not. Then the part of your call involving the ordinary phone network is not encrypted. Skype is on the NHS G cloud which contains approved software for use by NHS organisations.

Example 3: Use of Skype underpinning sign language interpretation.

East Lancashire Hospital Trust piloted the use of Skype in urgent care with deaf patients. The normal process for communicating with deaf patients who visited urgent care was to contact the local Deaf Society who would arrange for an interpreter to visit the hospital. This had a cost attached to it but also prolonged the length of time a patient had to stay in one of the UK's busiest urgent care units. The pilot project involved providing staff at the hospital with a laptop equipped with Skype that was directly linked to an iPad handed to the on-call interpreter. Staff in the urgent care team received training in the use of Skype and the laptop was stored securely near to the triage team. In the event of a deaf patient arriving at the urgent care department, hospital staff were able to contact the interpreter via Skype, reducing the on-call time as well as the length of patient's stay in urgent care. Posters were displayed in urgent care informing patients that the service was available.

Example 4: Use of FaceTime.

Seriously ill patients at Liverpool's specialist brain hospital the Walton Centre have been able to talk to their families using adapted Apple iPads.

The Centre used the technology to allow patients silenced through illness to communicate with doctors and also loved ones at home using FaceTime video calls. The iPads were fitted on hospital trolleys. There are two on a trolley and the screens tilt over patients. One iPad points at the patient's face and the second shows the written messages, allowing relatives to see and communicate with their families.

Example 6 confirms that the majority of patients welcome Skype consultations as those with Parkinson's disease did in Example 2.

Example 5: Family doctors pilot the use of Skype with patients.

Doctors at Cavendish Health Centre in London piloted the use of Skype consultations with patients, with 95% of patients involved saying they 'would use it again'.

Ninety-four per cent reported that they were satisfied or gave a better rating that the consultation had met their medical needs and 78% were satisfied with how long they waited for the appointment. A broad mix of patients had used the service including working people and parents of young children. Two-thirds of patients joined the remote consultations from home but more than a quarter – 28% – Skyped from their workplaces.

Dr Alice Fraser, the lead GP at the pilot practice, said: 'The flexibility that remote working offers means clinicians can make more efficient and productive use of time... Our patients with mobility or transport problems could get a more detailed consultation via Skype than a telephone conversation might allow, so this service proved especially useful for them.'

RISKS AND BARRIERS OF UTILISING TELEMEDICINE

The downsides of using video technology where it is not yet set up include the cost of provision of the equipment and training for staff who will use it. Adopting a 'train the trainer' approach will encourage adoption by cascading learning throughout the organisation. Virtual consultations may also lead to potentially decreased interaction with the health or social care practitioner, so clear forward planning is required to determine the types of intervention where remote consultations will be used. This is also important to ensure that remote consultations don't become another additional pressure on the organisation.

Services that have used Skype for consultations often report that the use of video consultation focuses the patient on the issue for which they want help. However, for it to work effectively and be embedded within day-to-day practice, the use of video consultation has to show that it is reducing time, pressure and cost of health or social care usage as well as improving the quality of service for the patient. This will allow clear business cases to be developed to roll out its use.

There is a school of thought that suggests virtual consultations can lead to overprescribing as the health practitioner errs on the side of caution. The setting of clear parameters for clinical protocols from the outset can address this.

A key barrier to adoption will be internal cultures within a healthcare provider organisation. Concerns about security will often be at the top of the list. When developing a case for use of video consultation, it is important to acknowledge that most interventions carry a risk. The use of postal services to carry information to a patient is not without risk. Telephone consultations or the use of email are not without risk either - where you cannot be absolutely sure that the recipient is the patient or service user you are meant to be communicating with. The key is about managing the risk at a level that your organisation feels comfortable with. We have developed a number of protocols and documents that will help organisations manage the risks. These have been endorsed by our commissioning organisation's Caldicott Guardian. The Standing Operating Procedure form for the rollout of Skype in general practice and associated Privacy Impact Assessment IG document can both be found on the website www.digitalhealthshot.nhs.uk alongside an example practice protocol, which is included (in brief) as the Appendix in this chapter.

Another concern is about the security of Skype - common questions are answered at: <https://support.Skype.com/en/faq/FA31/does-Skype-use-encryption>.

BENEFITS OF SKYPE/VIDEO CONSULTATIONS FROM A PATIENT'S PERSPECTIVE

They are:

- provide convenient and increased accessibility to their clinician (e.g. doctor or nurse)
- enable you to discuss any health concerns or worries you might have
- give your clinician an opportunity to treat any health issues in a timely manner
- might help you to avoid visits to their family doctor or emergency department.

References

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APPENDIX

EXAMPLE PRACTICE PROTOCOL FOR SKYPE OR VIDEO CONSULTATIONS WITH PATIENTS IN THEIR OWN HOME OR A NURSING/CARE HOME

Stage 1: Practice Organisation and Set-Up

Practice manager or clinician affirms that medical defence organisation covers this activity.

It is the responsibility of the individual clinician to decide on the suitability of using Skype or video technology (as opposed to face-to-face consultation in surgery or patient's (care) home setting; or telephone or email consultation) per presenting complaint for each patient.

Nursing or care home

The XX organisation will set up the video consultation equipment in each nursing or care home that has agreed to participate.

Individual independent patients

Skype should be set up in one consulting room in the practice that is designated for Skype or video consultations (practice manager confirms which room), utilising a spare screen monitor if one available. If necessary your IT service provider should lift the firewall from practice computers once Privacy Impact Assessment/Standard Operating Procedure documents are endorsed by CCG's Caldicott Guardian.

Skype security

The practice needs to avoid people being able to search for doctors or practice nurses as individuals randomly without clinician invitation to a booked consultation. Go to 'tools', 'options' and then 'privacy'. This will also help practice to avoid falling prey to a phenomenon called 'vishing' (short for video phishing). You can also block specific users in the 'options' menu.

Training

Skype/video pilot lead supported by XX will upskill practice team including clinicians who will use Skype or video consultation technology. Training will include set-up, selection criteria, informed consent etc.; with appropriate paperwork.

Evaluation

each clinician will capture information about the patient Skype or video consultation using data collection form for the first XX patients.

Stage 2: Prior to Skype or Video Consultation

Patients might measure biometrics

Prior to Skype or video consultation or during it - by arrangement: e.g. blood pressure, temperature, weight, oxygen saturation, pulse rate, blood glucose, sputum colour, peak flow. The clinician should ensure that any equipment used is valid and reliable; and the patient has been trained to take that measurement in reliable way (e.g. sphygmomanometer, peak flow meter).

Inclusion and exclusion criteria proposed for patients who might consult remotely via Skype or encrypted video link between practice and nursing/care homes

Practice team will trial these potential selection criteria for selecting patients to conduct remote consultations. After three months selection criteria will be modified to take account of clinicians' experiences. It is the responsibility of each clinician to select patients for Skype or video consultation depending on their symptoms, signs, cognition, support, confidence, preferences.

a. Skype - by GP or practice nurse with independent patient in own home or patient's chosen private setting

Inclusion criteria:

- Children aged between 13 and 15 years with parental consent
- 16 years of age and above
- Routine review by practice nurse or GP of any chronic condition, including:
 - o asthma
 - o diabetes (including follow-up for insulin initiation)
 - o depression (mild/moderate)
 - o anxiety (mild/moderate)
 - o smoking cessation (follow-up)
 - o hypertension review (with home blood pressure monitoring readings)
 - o COPD review
 - o epilepsy review
 - o weight management
- Medication review
- Low-risk patients requesting a consultation for any symptom (see following section 3 below).

Exclusion criteria:

- Children aged 12 years and under
- Acute deterioration of the above chronic conditions
- Any condition requiring face-to-face clinical assessment or clinical examination
- Intermediate to high-risk patients for specific symptoms (see following section 3 below).

b. Encrypted video consultation – by GP or practice nurse with resident registered patients in nursing/care homes**Inclusion criteria:**

- 16 years of age and above
- Any chronic health condition for routine review including:
 - o asthma
 - o diabetes
 - o depression (mild/moderate)
 - o anxiety (mild/moderate)
 - o smoking cessation (follow-up)
 - o dementia (mild/moderate)
 - o hypertension review (with home blood pressure monitoring readings)
 - o COPD review
 - o epilepsy review
 - o lifestyle habit review
- Medication review
- Intermediate or high-risk patients judged to be reasonably well and alert, requiring a consultation for any symptom where there is an ability in the home for care home staff to assess and convey basic vital signs reliably, e.g. heart rate, temperature, oxygen saturation levels, blood pressure readings (see section 3 below for further details).
- Review of rashes
- Urinary infection – proven by urine dipstick already.

Exclusion criteria:

- o Low or intermediate patients who care home staff feel are distinctly unwell (and for instance will need clinical assessment of heart and lungs)
- o High-risk patients where it is not possible to monitor vital signs.

Distinguishing between high and low-risk patients

Risk is based on the potential significance of the presenting complaint given their past medical history or care home staff description of patient’s symptoms.

Low Risk	Intermediate Risk	High Risk
0–2 co-morbidities;	≥3 co-morbidities of any significance	≥3 co-morbidities of any significance
Co-morbidities that are present must be of low significance in terms of patient longevity, e.g. osteoarthritis (OA)	Co-morbidities present should not be directly related to presenting complaint	Co-morbidities that could be related to presenting complaint
		Current or previous diagnosis of cancer Age >90 years Poor mobility Dementia

Examples of each

Low risk patient:

- 20-year-old male, past history - eczema; complaining of slightly low mood
- 80-year-old female, past history - OA, hypertension; complaining of dysuria.

Intermediate risk:

- 50-year-old overweight male, past history - hypercholesterolaemia, hypertension (both well controlled); complaining of lower back ache
- 70-year-old female, past history - 2 of transient ischaemic attacks (**TIAs**), hypertension, raised cholesterol; complaining of skin rash on lower legs.

High risk:

- 80-year-old female, past history - vascular dementia, COPD, hypertension; complaining of worsening breathlessness with a cough productive of clear sputum
- 90-year-old male, past history - ischaemic heart disease, two previous stent insertions; complaining of chest wall pain.

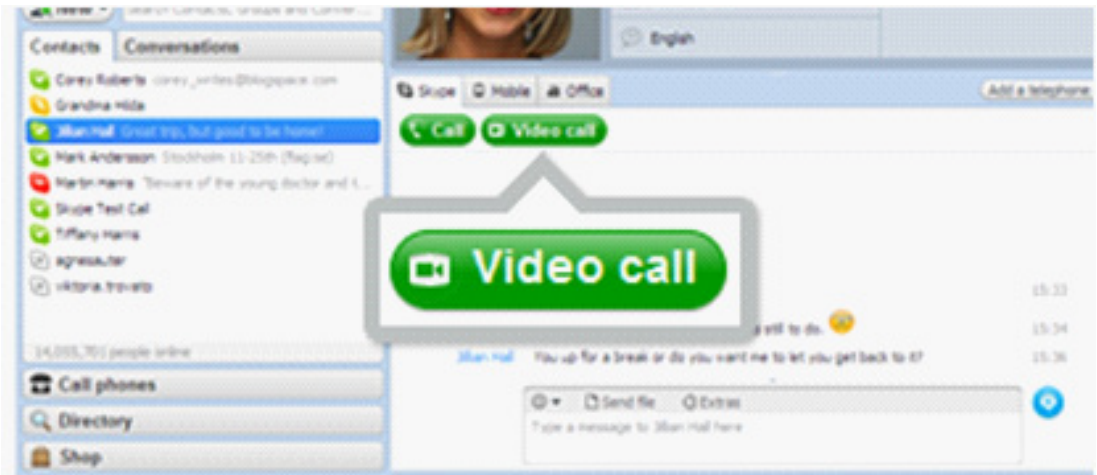
Stage 3: Conducting the Video Consultation

Skype for patient who lives in own home

The GP or practice nurse explains to the patient how the remote consultation will take place and gives them a copy of the information leaflet. If they want to proceed to plan a future Skype consultation the family doctor or practice nurse obtains written, informed consent at preceding face-to-face meeting.

Once the patient has given informed consent to use Skype they will need to give the clinician or practice staff their Skype ID details so they can add them to the list of Skype contacts the practice holds. To do this they search for the patient's name in the Skype search bar and then send them a request to be on the list of practice contacts. Add individual patient's details rather than wait for them to send the practice a request so you are sure they are the correct person. Advise the patient that they should set up Skype their end in a private area and ensure that only people they are happy can overhear or view their Skype consultation are nearby.

Ask the patient to make a booked Skype consultation with specific clinician in reserved appointment slots or book in yourself. To make a Skype call ensure that you've got a webcam plugged in; click the green video call button to make it a Skype video call.



Useful things you can do on a video call:

- Resize the screen - click and drag the corner of the video screen to make it bigger or smaller.
- Move it around - click and drag the video of yourself around your screen.
- Instant message (IM) at the same time - click the Show messages link at the top of the video to instant message while you're on the call. If you are having any problems with Skype visit <https://support.Skype.com/> where you can access more tips and ask questions.

If there is no Skype connection with the patient or they do not answer when the clinician initiates the Skype connection, clinician will leave a message (press the '+' symbol and click on 'video message').

The clinician should be clear from the start that they are allocating a fixed amount of time and that they will contact the patient, NOT the other way round - at a booked time. This will ensure that there is no expectation on the patient's part that they can use Skype for other issues. If a patient does contact the practice by Skype, simply decline the call.

Video consultation between GP or practice nurse and staff or patients in a care/nursing home

The practice guidance is similar to that for Skype usage above. The practice clinician or nursing/care home staff can gain written informed consent from individual patients (so long as they can understand the process); if the patient is unable to understand the request for informed consent, the care home staff can do so on their behalf (in similar way to care home staff deciding when a patient requires a home visit from a GP).

The consulting area for video or Skype in the nursing or care home should be private - in a similar venue to that for a face-to-face consultation with GP. The room should be well lit so that the patient's image is clear.

If the video session is already connected and paused from a previous patient, a care home staff member will recommence the call and clarify that the next patient's privacy is assured (i.e. the previous patient has left the room). The care home staff will end the Skype or video consultations once all patients have been seen and discussions between GP or practice nurse and care home staff have been completed.

Stage 4: During the Skype or Video Consultation

Throughout the entirety of the consultation the following approach must be taken: usual best practice clinical management, careful active listening, frequent checking for understanding and an interested response.

If during the Skype or video consultation it transpires that a face-to-face consultation should take place, this should be arranged in an appropriate timeframe.

The clinician should write up notes of the consultation in the usual way in the patient's medical records. They should not make a video recording of the consultation, unless they're prepared to gain further specific informed patient consent and adhere to the detailed national information guidance and confidentiality requirements.

Remote consultation checklist for clinician

		Clinic staff* or clinician** action
1.	The patient*** has received an explanation of the use of Skype/video for a remote consultation with the clinician.	Practice staff – any
2	A copy of the remote consultation patient information leaflet has been given and explained to the patient.	Practice staff – any
3.	Any concerns about remote consultation have been addressed.	Clinician
4.	The remote consultation patient consent form has been given and explained to the patient.	Clinician
5.	The remote consultation consent form has been signed by the patient or their representative.	Clinician
6.	The clinician has prepared his/her consulting room to maximise privacy.	Clinician
7.	The patient is undertaking the consultation from their home or chosen private setting [or care home] at pre-agreed time booked into specific clinician's appointment list.	Patient [and care home staff]
8.	The Skype call is instigated by the clinician at a date/time which has been agreed with the patient [or care home staff]. Clinician logs onto Skype system and searches for patient Skype ID and then clicks the video call button.	Practice staff – any
9.	On answering the Skype call, the patient should acknowledge whether or not it is appropriate to undertake the consultation.	Patient
10.	The clinician will introduce themselves to the patient and: <ul style="list-style-type: none"> confirm that the patient is happy to take part in the remote consultation, making it clear that if a physical examination is required, the clinician will invite the patient to come to the practice [or visit the Care Home if appropriate, i.e. patient housebound]. the patient's identify should be checked by asking them to confirm their name and date of birth. 	Clinician
11.	Prior to concluding the consultation, the clinician will clarify that the patient understands the outcome of the consultation and has no further questions.	Clinician
12.	The clinician will record the bodily measurements that patient provides, observations and outcomes of the consultation in the same way as a face-to-face consultation is recorded in the patient's electronic primary care record and any agreed actions are carried out.	Clinician

* Practice staff = any member of the practice team including administrator, receptionist, manager, or clinician by arrangement.

** Clinician is the GP or practice nurse initiating and conducting the Skype/video consultation.

*** The term 'patient' used here means patient participating in Skype/video consultation or their carer/family.

Patient informed consent for Skype or video consultation

Practice:

Patients under the care of XX practice can access a clinician via a Skype or video remote consultation. The remote consultation will provide you with the opportunity to speak to, and see, your clinician and have your health needs assessed on a remote basis; to discuss any existing health issues and other matters that you want to discuss. The Skype or video consultation is set up to meet national recommended standards to ensure data privacy for you as an individual patient.

My rights:

- I understand that the NHS privacy and confidentiality policies and procedures relating to my medical information also apply to Skype or video remote consultations.

- I understand that the Skype or video technology used by the clinician is encrypted to prevent the unauthorised and unlawful access to my personal confidential data.
- I have the right to withdraw my consent to the use of Skype or video (opt out) at any time.
- I understand that the clinician has the right to withdraw (opt out) his or her consent for the use of Skype or video consultation at any time.
- I understand that the remote consultation will not be recorded.
- I understand that the clinician will not allow any other individual who is not directly involved in my care to listen to, or watch, my Skype or video session.

Patient consent to the use of Skype or video for remote consultation

- I have read and understand the patient information provided regarding Skype or video. I have had the opportunity to discuss this information and all my questions have been answered to my satisfaction.
- I hereby give my explicit consent for the use of Skype or video in my medical care and authorise the clinician to use Skype or video to undertake remote consultations.

Patient name:	
Date of birth:	
Address:	
Patient's Skype identity details	
Signature:	
Date:	

In the case of the patient not being able to give consent, the patient's name and address should be completed above in addition to the section below:

Name of patient's representative (e.g. carer/family, care home staff member):	
Capacity of representation (e.g. lasting power of attorney for their health and welfare; parent of child under 16 years of age; responsible care home staff member):	
Representative's address:	
Home's Skype identity details	
Representative's signature:	
Date:	