ESSS Outline

Scoping the field- Video consultations in social care

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Introduction

This evidence summary seeks to address the following question relating to technology enabled support in health and social care: What is the current evidence around video consultations in health and social care?

About the evidence presented below

We looked on google scholar, SCIE database searching for terms like: ‘technology in care”, “telecare”, “technology and social care”, “technology and social work”, "video consultations in social care".The evidence is a mix of academic studies, grey literature from the social care sector and recommendations from both clinical and social care contexts.

Accessing resources

We have provided links to the materials referenced in the summary. Some materials are paywalled, which means they are published in academic journals and are only available with a subscription. Some of these are available through The Knowledge Network with an NHS Scotland OpenAthens username. The Knowledge Network offers accounts to everyone who helps provide health and social care in Scotland in conjunction with the NHS and Scottish Local Authorities, including many in the third and independent sectors. You can register here. Where resources are identified as ‘available through document delivery’, these have been provided to the original enquirer and may be requested through NHS Scotland’s fetch item service (subject to eligibility).

Where possible we identify where evidence is published open access, which means the author has chosen to publish their work in a way that makes it freely available to the public. Some are identified as author repository copies, manuscripts, or other copies, which means the author has made a version of the otherwise paywalled publication available to the public. Other referenced sources are pdfs and websites that are available publicly.

Executive summary

This outline illustrates that telecare is an ever-expanding field with applications in a variety of contexts. Video consultations have become increasingly popular during COVID-19 and they are now being used in social care settings. Social care systems recognise the transformative potential of technology, and social care professionals are keen to engage with technology in ways that help them deliver better outcomes for their service users.

In Scotland the most widely used video conferencing system is the Australian platform Attend Anywhere, but branded in Scotland as 'Near Me'.There are a range of other similar products, but many follow a similar approach of recreating the process of a real life consultation.

Overall, both practitioners and service users report video consultations are beneficial in reducing geographical barriers, freeing up resources for professionals and reducing risk of infection during COVID-19. Nonetheless, barriers still remain such as lack of private space, technology breakdowns and privacy concerns for both practitioners and service users.

The evidence below also suggests that there are a range of ethical issues that need to be considered in video consultations like cybersecurity, limited interactions which prevent practitioners from getting a holistic perspective of each case as well as questions around recording the consultations.

Recommendations include the need for better training among professionals and the need for integrated IT systems which accommodate the new technologies smoothly. Evidence also suggests that video consultations need to be culturally sensitive and adequately facilitated when language barriers exist. Also encouraged is the introduction of local hubs or community based borrowable devices where people can access Near Me if they do not have their own device. Recommendations include the need for better training among professionals and the need for integrated IT systems which accommodate the new technologies smoothly.

Background

Technology enabled care is seen as an open and constantly evolving field, as it adapts and incorporates new technology and responds to the changing care needs and contexts of societies - particularly in the current COVID-19 crisis. Four elements are seen as essential to the field:

1. Its purpose is to provide support.
2. It is intended to overcome geographical barriers, connecting users who are not in the same physical location.
3. It involves the use of various types of ICT.
4. Its goal is to improve health (and wellbeing) outcomes (WHO, 2009).

Wright (2020) considers digital technologies in care to include the following:

- Telecare and telehealth or telemedicine. These include any devices and software, sensors, computers, mobile/wearable devices, alarms, smart hubs used to interact with and monitor users generate and analyse data about them, and connect or provide them with care and health services.
- ICT for social communication. This includes the technologies that are used in care contexts, such as smartphones, tablets or other computers with software apps such as Zoom, Skype or FaceTime to enable video calls with friends, family members or caregivers; websites or apps for reminiscence or other types of therapy, “brain training” exercises, and entertainment; social robots; virtual reality; and other interactive tools.
- ICT to provide biomechanical support, mobility, exercise and rehabilitation. For example, lifting or exoskeleton robots, presence- or voice-operated doors or curtains, and robotic walkers.
- Online platforms used to organise care labour or deliver information about social care. This includes platforms such as Supercarers, Elder, and My Home Touch, that connect care service users and care workers.

This outline will focus especially on telecare and the use of video technology in service provision. Telemedicine or telecare was coined in the 1970s, which

means “healing at a distance” (WHO, 2009). Usually, it signifies the use of information technology to improve patient outcomes. There is no definitive definition of telemedicine. As a result, the World Health Organization has adopted the following broad description (WHO, 2009, p9):

“The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities”.

Telemedicine or telecare applications can be classified into two types, depending on the timing of the information transmitted and the interaction between the individuals involved—be it practitioner to practitioner or practitioner-to-patient:

1. Store-and-forward, or asynchronous, telemedicine involves the exchange of pre-recorded data between two or more individuals at different times. For example, the patient or referring health professional sends an e-mail description of a medical case to an expert who later sends back an opinion regarding diagnosis and optimal management.
2. In contrast, real time, or synchronous, telemedicine requires the involved individuals to be simultaneously present for immediate exchange of information, as with videoconferencing. In both synchronous and asynchronous telemedicine, relevant information may be transmitted in a variety of media, such as text, audio, video, or still images.

These two basic approaches to telemedicine apply to an array of services in diverse settings (Blackburn et al 2011).

Increasingly, technology is being used in support services beyond telehealth and telemedicine to include social and community care (SCIE 2020), which this outline will focus on. This outline considers technology enabled social and community care to be that which intends to provide support and to

overcome physical and geographical barriers; involves the use of different technologies and has a goal to improve individuals' outcomes. The primary focus of this outline will be on video consultations and their role in the delivery of social services.

Policy context in Scotland

In Scotland, telehealth and telecare gained a central role in transforming the delivery of health and care in Scotland with the eHealth Strategy for Scotland 2011-17(Scottish Government, 2016). This strategy led to the establishment of a Digital Health and Care Institute in October 2013. The 2018 Digital Health and Care Strategy paper laid out plans to continue the digital transformation of health and care in Scotland, quoting the Scottish Government's Health and Social Care Delivery Plan: "Digital technology is key to transforming health and social care services so that care can become more person-centred" (Scottish Government, 2018 p.3).

Systems of video consultations in technology enabled care

The evidence suggests that video consultation systems follow the process of a real life consultation. In Scotland, the platform used by NHS Scotland is Attend Anywhere, renamed as Near Me.

Wherton J and Greenhalgh T (2020), Evaluation of the Attend Anywhere/ Near Me video consulting service in Scotland, 2019-20

The Attend Anywhere/Near Me system originated in Melbourne, Australia, in 1998. It operates by selling licences to healthcare organisations on a not-for-profit basis. Each clinician or staff member within a service has their own clinic account and can use the same waiting area. Attend Anywhere uses internet browser-based video technology that a member of the public can access using their own device, be it a laptop, tablet or mobile phone. Attend Anywhere comprises three principal components, which reflect in person consulting processes:

1. A service and operations layer – this includes professional help from a team of experts (e.g. guidance, implementation protocols, template patient leaflets).
2. A management layer. This includes a web-based software which allows the care provider to see when the patient has arrived in the virtual waiting area, and to manage video appointments through existing processes and systems. Staff can create/manage the waiting areas, control access to them, and view detailed reports about adoption and use.
3. A video technology layer which is integrated with the software platform in a way that meets security and privacy requirements.

One of the defining features of the Attend Anywhere model for video consulting is the 'inbound' (or ' person-centric') workflow, which seeks to emulate how patients physically attend their appointments. For example, a single button on a website (or consistent web link address on an appointment letter) offers a consistent channel or 'front door' for patients to access a 'virtual waiting room' (potentially managed by a receptionist), before being joined virtually by the clinician.

Agnisarman S, Narasimha S, Chalil Madathil K, Welch B, Brinda F, Ashok A, & McElligott J. (2017) Toward a More Usable Home-Based Video Telemedicine System: A Heuristic Evaluation of the Clinician User Interfaces of Home-Based Video Telemedicine Systems. JMIR human factors, 4(2), e11. https://doi.org/10.2196/humanfactors.7293

This article provides some other examples of video systems of technology enabled care.

Doxy.me is a free Web-based system (as opposed to downloaded desktop applications) specifically designed for telemedicine purposes. Clinicians create an account and a personalised waiting room where they communicate with their patients, either copying and emailing or directly emailing the address of their waiting room. By clicking on this link, it directs the patient to the clinician's waiting room. There is a self-view box at the top right and a chat box at the bottom right of the screen. Volume and video control buttons

are located below the patient's video. In addition to these features, the clinician can edit the waiting room and change the account settings.

Vidyo is one of the leading telemedicine videoconferencing desktop-based application solutions. After creating an account, the clinician receives an email with log-in credentials and a Vidyo portal. The Vidyo desktop application is downloaded by clicking the portal. The clinician sends a Vidyo meeting invitation after logging into this application. He or she can change the video quality and other settings by clicking on the configuration button. In addition, this task bar includes the volume and video control buttons, group chat option, self-view option, screen layout option, and end call option.

VSee is a telemedicine system which requires the clinician to create an account and install a desktop application. After logging into the account, the clinician invites patients by entering their email ids or copying and emailing them an invitation link. This system includes an option for text chatting with the patient and separate windows for self-view, clinician's video, chat box, and contacts, with the microphone and camera settings being found on the self-view window.

Polycom, a licensed Web-based application that can be purchased from the Polycom website, provides telemedicine and video services for remote conferencing and collaboration. The clinician receives an email with log-in credentials and a link for accessing the account. After logging into the account, the clinician selects the devices or system, which includes an option for adding participants and managing meetings. The clinician invites patients by emailing them the address of his or her chat room; after clicking this link, the patient is then directed to the meeting. There is a self-view option on the left side of the screen, the participant list on the right, and the patient's video in the middle. The control buttons are below the patient's video.

The examples below highlight that systems of telehealth have similar functionalities and use.

Video consultations and social care

In the context of COVID-19, many more services have turned to video and digital consultations in order to provide their service - (our outline in May for example, showed how domestic abuse services were adapting the way they delivered their services in a digital context - Bocioaga, 2020). This is a developing area of social services, with limited resources.

SCIE(2019) Digital Capabilities for Social Workers

Key messages:

- Social workers want to engage with digital technology; however, they want it to enable relationship-based practice and improve the experiences of people who use services.
- Social workers can help to shape policy, practice, procurement and technology if they are digitally literate and actively engaged in decision making and planning locally and nationally.
- Managers should address training needs and ensure critical reflection on the ethics of digital technology in supervision.
- Senior managers should ensure that social workers have current and functioning equipment, reliable connectivity, and systems that enable rather than hinder practice and integration.
- Strategic leaders should ensure that social workers and experts by experience (EbE) are involved in the design, development, and procurement of digital technologies. These should be underpinned by principles of co-production.
- Educators should include digital capabilities in social work education programmes using the Health and Care Digital Capabilities Framework and the Professional Capabilities Framework.
- EbE want technology to improve outcomes for them, meet their distinct needs, and increase access to information and services. Use of digital technology should be rights-based – e.g. right to self-determination, consent, privacy and confidentiality.

- Technology developers and suppliers should meaningfully involve social workers and EbE to ensure efficacy, efficiency, and effectiveness.
- The sector should work together to ensure systems work across health, care and related services as social workers and services demand interoperability and integration.
- Policy makers should provide a conducive policy framework that promotes systems integration, coherent regulations on data governance and a digitally ready workforce.
- Sector leaders should ensure transparency around purpose, design and procurement of systems and the increasing use of AI and predictive analytics in social work.

ADASS (2019) Connected social care - Adult social care leaders explore the pros, cons and challenges of tech-enabled care

This document is a roundtable discussion among Local Authority representatives and care representatives in England.

The key points from this discussion are that:

- Technology offers multiple potential benefits in adult social care including enhanced communication, freed up workforce capacity and more reliable advice
- Technology should follow form, not function. It needs to enhance independence, inclusion, and be immediate.
- Off-the-shelf technology might challenge council risk frameworks but can offer benefits in terms of ease of use and accessibility.
- Technology is individual. Social care workers should work with people to identify the technology that can best help them.
- There is a risk of poorer communities being left behind because of limited means to adopt new technology and councils' inability to fund it.
- Better data could enhance the delivery of services, but councils may require staff with distinct skill sets to use it effectively.
- Personal budgets may hinder the adoption of technology if the funding is allocated week to week.

- The implications of the possibility that technology might replace people in delivering some aspects of care remains under discussed.
- The way banks and retailers have shifted services online in the past decade could provide insights for adult social care.
- People still want council oversight, but if this is taken too far it can become a barrier to adopting useful technology.

Dr. Carol Tozer, director of adult social care at Isle of Wight Council, said there is a need to assess the value of new technology against what she called the "three 'I's":

- The first 'I' technology must deliver is independence, without a doubt digital technology can help people with independence and communication.
- The second 'I' was inclusion and how a person can use technology to help live their lives as part of their neighbourhoods and communities.
- The third – and I think most challenging – 'I' is immediacy. The changes in technology are happening really fast, which means there's a danger of getting too bound up in the technological aspects when we need to focus on the idea of form following function and the technology making a measurable difference for independence and inclusion.

SCIE (2020) Building rapport and establishing meaningful relationships using technology in social work

This briefing for social workers and social care practitioners aims to help practitioners understand how to build rapport and establish relationships with the people you work with using technology.

The brief advises practitioners to:

- Be flexible, use processes, procedures and forms to support your intervention, not to drive it. Shape your intervention within legislative context in line with the individual's circumstances.
- Be empathetic and professional at the same time.
- Focus on the individual, their life, their circumstances and their personal outcomes.

Practitioners are advised against:

- Making assumptions, instead they should get background information from evidence and corroborate asking the individual.
- Deciding the best means for the interaction without the individual's input.
- Focusing solely on solving a problem or closing a case.
- Allowing insecurities or prejudices about a particular means of communication to get in the way.

Perspectives of using video consultations in telecare: practitioners and service users

The evidence below reflects on the experiences of using video consultations. While the majority of evidence is from telemedicine and clinical settings, similar challenges would exist for social care. This is why this evidence is included.

Challenges for practitioners

The Telemedicine Support to Promote Maternal and Newborn Health in Remote Provinces of Mongolia project aimed to reduce infant and maternal mortality while addressing the gap between urban and rural health care services (WHO, 2009).

Some major challenges experienced from the practitioners' perspective included:

- Equipment breakdowns (early use of inexpensive but low-quality goods may have compounded this problem)
- A lack of maintenance support in rural hospitals, IT specialists, and medical engineers
- Slow Internet bandwidth (sometimes too slow for synchronous connection

- Some staff reported they were reluctant to change practice patterns and uptake new technologies (WHO, 2009)

For professionals, besides poor quality of calls, the major disadvantages were concerns about missing something on video and a preference to see patients in person (Wherton & Greenhalgh, 2020).

Benefits for practitioners

Health professionals felt the major benefits for using video consultations was enabling patient access to services, both in terms of wider access and delivering a method of consultation that patients requested (Wherton & Greenhalgh, 2020). According to the Near Me evaluation, practitioners also felt that video consultations were beneficial for:

- Lower infection risk.
- Reducing environmental impact.
- Freeing up resources within the service through reduced travel. (Wherton & Greenhalgh, 2020)

Benefits for service users

Caffery LJ, Bradford NK, Smith AC, Langbecker D (2018) How telehealth facilitates the provision of culturally appropriate healthcare for Indigenous Australians. Journal of Telemedicine and Telecare 24(10):676-682. doi:10.1177/1357633X18795764

This study explores how telehealth facilitates or impedes the provision of culturally appropriate healthcare to Indigenous Australians from the perspective of staff at an Aboriginal Community Controlled Health Service (ACCHS).

They found that:

- Telehealth enabled specialist consultations to be conducted in the safe environment of an Aboriginal Community Controlled Health Service instead of a mainstream health service

- Telehealth improved affordability and convenience and brought a reduction in the stress of healthcare
- The presence of an Indigenous health worker could facilitate culturally appropriate healthcare and provide advocacy
- Overall, telehealth supported a holistic view of health.

Other applications:

Several participants described how telehealth had been used for broader community applications, such as video conferences between Elders and community members in prison. These video conferences supported the emotional and social well-being of the community members and assisted their ongoing inclusion in the community.

Wherton J and Greenhalgh T (2020) Evaluation of the Attend Anywhere / Near Me video consulting service in Scotland, 2019-20

The evaluation of Near Me in a health context found that video consultations:

- Enable people to attend appointments safely, reducing the risk of infection, particularly for older people, individuals shielding and pregnant women.
- Improved access to health and care services through removing travel barriers. This is relevant for people with disabilities, elderly/frail people, people suffering chronic pain, people with caring responsibilities, and people living in rural, remote and island communities.
- Reduced time off work or education to attend appointments was especially relevant for carers, young people, and low socio-economic backgrounds.
- Supports carers, family members and translators to be involved in an appointment, particularly for ethnic minorities, those with disabilities and older people.

Caffery LJ, Farjian M, Smith AC. Telehealth interventions for reducing waiting lists and waiting times for specialist outpatient services: A scoping review. Journal of Telemedicine and Telecare. 2016;22(8):504-512. doi:10.1177/1357633X16670495

This article undertook a scoping review of the published literature to identify and summarise key findings on the telehealth interventions that influence waiting times or waiting lists for specialist outpatient services. Evidence shows that electronic consultations and image-based triage of referrals can be effective in reducing waiting lists and waiting times.

Challenges for service users

Peddle, K. Telehealth in Context: Socio-technical Barriers to Telehealth use in Labrador, Canada. Comput Supported Coop Work 16, 595–614 (2007). https://doi.org/10.1007/s10606-006-9030-3

This article examines the factors surrounding the lack of uptake of technology enabled care in the Labrador peninsula in Canada.

The author argues that telehealth via videoconferencing is often deemed necessary, but it is used much less frequently to mediate distance in health care than anticipated by health care and technology workers in the Labrador context.

Data analysis revealed several constraints that have limited the usage of new technologies for health communication in Labrador. Most importantly, this study showed that barriers to telehealth use are not simply technical, but relate to social issues of privacy, culture and trust. Additionally, the current lack of telehealth policy and user-based understanding of health needs are among the biggest barriers to making telehealth a viable means of service delivery.

Wherton J and Greenhalgh T (2020) Evaluation of the Attend Anywhere / Near Me video consulting service in Scotland, 2019-20

The Equality Impact Assessment (EQIA) for Near Me identified the following barriers:

- Attitudinal barriers resulting in limited use of Near Me for certain groups where clinicians or organisations may make general assumptions about video appointments not being appropriate for

certain cohorts (e.g. assuming all older people are less technologically literate than other cohorts).
- Lack of a safe and confidential space to conduct a video appointment, particularly for younger people in a house with others, carers or those with disabilities and situations where domestic violence occurs.
- Lack of inclusive communication of Near Me information and patient resources limits use, especially for people where English is not their first language, have a learning disability or low literacy skills.
- People who are digitally excluded for whatever reason. Particularly for younger and older people, minority ethnic populations including gypsy travellers, homeless people, rural and remote communities, and those from low socio-economic backgrounds (see also the Iriss Outline on Digital Exclusion - Sanders, 2020).

Ethical considerations in video consultations

Digital consultations currently require both service users and practitioners to find a private and undisturbed place for sessions. Both parties also implicitly agree not to make any kind of recording of sessions conducted by phone or video-link. This however, is complicated by a range of issues:

- Security

Different organisations might use different tools. The security of devices, including password-protection and virus-checkers and firewalls installed, could affect video consultations negatively - lack of adequate security could compromise both parties. In selecting an online communication platform, practitioners might use different tools like Telegram and WhatsApp which offer end-to-end encryption, which means others cannot intercept or view your message or communication. However, using platforms like WhatsApp might mean contacts will see your phone number. Popular online apps such as Zoom have also reported security breaches (BACP 2020).

- Limited relationships

The reduced non-verbal cues can affect the practitioner's ability to make full use of self and establish and maintain a more in-depth emotional and

empathic professional relationship. On the other hand, for some young people and their families, online conversations and relationships may facilitate ease of connection, more open communication and greater self-disclosure (BACP 2020).

- Recording

Recording is a complex issue in video consultations. On one side, service users might want to record sessions to have the information presented to them more readily available and some GPs have been in favour of this (Near Me: Public engagement, 2020). However, some highlight the ethical issues of recording and some guidelines for this eventuality (The PCFSW & Social Work England Best Practice Guide for Video Call/Contact and Virtual/Online Home Visit, 2020, p10) :

“Video conversations could be recorded without your knowledge or consent. Therefore, as part of the ground rules at the beginning of the call, it is important to clarify whether the call is being recorded and, if it is, explain why. Also, if you believe that attendees may be recording the call, discuss this with them and ask why they are recording the video call. Remember that most apps allow recording of calls and recordings will include the video, audio and the chat content. In general, act as if the call is being recorded.

If you decide to record the call, it is important to note that this may have implications under the Data Protection Act 2018 (incorporating the General Data Protection Regulation (GDPR)). Therefore, before recording a call, check organisational policies and agree with your manager about recording. Once agreed, practitioners should follow their organisational policies and relevant procedures regarding how to record the call and how to manage the recording: this may include, who to inform, whether you have all required consent, where to save the recording, who will have access to this material, how long it will be kept and for what purpose, and who can view or use this material (access is different from use, viewing or listening) and who is responsible for managing it, and so on.”

Recommendations

Smith, A.C. and Gray, L.C., 2009. Telemedicine across the ages. Medical journal of Australia, 190(1), pp.15-19.

This is an article which summarises telecare in Australia. It reflects on certain clinical contexts like telepediatrics and telegeriatrics and gives the following broader recommendations which apply to technology enabled care more widely:

- The focus of telecare should move beyond simply the provision of equipment and network connectivity.
- Telecare services should be designed according to clinical needs and complement conventional outpatient services.
- Once the appropriate infrastructure is established, the success of telecare depends on the administrative and clinical systems that support it.
- Telecare requires simplicity of use, ease of access to facilities, and at least financial parity with live consultations.
- Coordination of referrals and remote management of sessions are key factors in the success of telecare.
- The potential savings for government health departments are significant. These are predominantly related to reduced travel costs, and should be redirected into the operational costs of telecare services.
- Technology enabled care should be developed in conjunction with a robust research program to ensure clinical and cost-effectiveness.

Smith, Anthony C., et al. "Telehealth for global emergencies: Implications for coronavirus disease 2019 (COVID-19)." Journal of telemedicine and telecare (2020): 1357633X20916567.

The authors argue that some reasons for the low uptake of telehealth globally are multifaceted and diverse, but factors such as clinician willingness, financial reimbursement and (re)organisation of the health system may be to blame.

The limited uptake of telehealth services is mostly because of clinician's unwillingness to adopt telehealth. A timely telehealth response to emergencies, such as the COVID-19 outbreak, calls for a health workforce that is skilled and capable of switching delivery modes, as required. Relying just on sporadic uptake of telehealth, as in times of emergency, is problematic.

Appropriate remuneration is needed for all telehealth services. Traditionally, the lack of funding has been blamed for the slow uptake of telehealth. Constraints for funding associated with geographical location and service type have also limited expansion of telehealth in city locations. For example, in Australia, funding is predominantly focused on medical consultations delivered by videoconference for patients in rural and remote locations.

Telehealth adoption requires a whole-system strategy. Embedding telehealth into routine service delivery, by all healthcare providers is the most effective way of ensuring telehealth can be readily used during emergencies. This requires operational telehealth networks, telehealth policies and procedures, and technology infrastructure that can be scaled-up during times of disaster. Telehealth is a disruptive process, so there is a need for effective change management strategies to support clinicians with limited telehealth experience.

Recommendations:

- Ensure that all health professionals receive appropriate education and training
- Introduce telehealth accreditation for health professionals
- Provide funding which adequately covers the cost of providing telehealth
- Redesign clinical models of care
- Support all stakeholders with an effective communication and change management strategy
- Establish systems to manage telehealth services routinely.

Wherton J and Greenhalgh T (2020) Evaluation of the Attend Anywhere / Near Me video consulting service in Scotland, 2019-20

For Improving accessibility of technology in care contexts, the evaluation of Near Me recommends the following:

- Improve digital access, both in terms of internet connectivity and access to devices.
- Consider introducing or expanding the idea of local hubs (such as those used in the Highlands), clinics or community based borrowable devices where people can access Near Me if they do not have their own device or the private space for a consultation, or they lack skills to use video.
- Ensure there is choice over how consultations are provided, so that Near Me is used where it is both clinically appropriate and socially appropriate for an individual patient's situation.
- Improve patient information about Near Me, for example, translated leaflets, awareness about how to make test calls, and clearer information about how to involve interpreters or family members for support in video calls.

For health professionals, the top five actions to make video consulting easier to use were (in descending order of importance, ie, biggest to smallest impact):

- Improving digital access to make it easier for all patients to use digital services.
- Patients requesting video consultations.
- Ability to provide mixed clinics (some face-to-face, some video) rather than all video.
- Improved internet connection at the consulting location of choice.
- Best practice guidance from professional bodies.

The evaluation also proposes the following recommendations:

- Continue to maintain choice and appropriate deployment of consultation type, including face-to-face appointments.
- Establish processes to enable interpreters to join Near Me appointments where appropriate. This would include both

service-provided interpreters and informal interpreters/support for appointments, such as from family members.

- Establish and communicate processes to enable patients to do a test call.
- Raise awareness about consultation options, including appointments by video.
- Continue to build links with Connecting Scotland, Public Health Scotland, and Scottish Council of Voluntary Organisations to understand the scope and impact of digital exclusion on use of Near Me and advise to ensure compatibility.
- Develop inclusive communication and guidance materials for using Near Me, including easy read, languages other than English, visual, and bespoke to groups as required (eg, young carers).
- Share best practice inclusive guides/ resources with health boards across Scotland.

References:

ADASS (2019) Connected social care - Adult social care leaders explore the pros, cons and challenges of tech-enabled care

Agnisarman, S., Narasimha, S., Chalil Madathil, K., Welch, B., Brinda, F., Ashok, A., & McElligott, J. (2017). Toward a More Usable Home-Based Video Telemedicine System: A Heuristic Evaluation of the Clinician User Interfaces of Home-Based Video Telemedicine Systems. JMIR human factors, 4(2), e11. https://doi.org/10.2196/humanfactors.7293

Caffery LJ, Bradford NK, Smith AC, Langbecker D (2018) How telehealth facilitates the provision of culturally appropriate healthcare for Indigenous Australians. Journal of Telemedicine and Telecare 24(10):676-682. doi:10.1177/1357633X18795764

Caffery LJ, Farjian M, Smith AC. Telehealth interventions for reducing waiting lists and waiting times for specialist outpatient services: A scoping review. Journal of Telemedicine and Telecare. 2016;22(8):504-512. doi:10.1177/1357633X16670495

Leonardsen A L, Hardeland C, Helgesen A K et al. (2020) Patient experiences with technology enabled care across healthcare settings- a systematic review. BMC Health Serv Res 20, 779 . https://doi.org/10.1186/s12913-020-05633-4

NHS Education for Scotland (2020) Near Me: public engagement the benefits, the barriers and the surprises Webinar

Peddle, K. Telehealth in Context: Socio-technical Barriers to Telehealth use in Labrador, Canada. Comput Supported Coop Work 16, 595–614 (2007). https://doi.org/10.1007/s10606-006-9030-3

SCIE (2020) Building rapport and establishing meaningful relationships using technology in social work

SCIE(2019) Digital Capabilities for Social Workers

Scottish Government (2016) Supporting & Empowering Scotland's Citizens: National Action Plan for Technology Enabled Care.

Scottish Government (2018) Scotland's Digital Health & Care Strategy: Enabling, Connection & Empowering.

Sharpe C (2001) 'Telenursing: nursing practice in cyberspace .' (Auburn House: Westport, CT)

Smith AC, Thomas E, Snoswell CL, et al. Telehealth for global emergencies: Implications for coronavirus disease 2019 (COVID-19). Journal of Telemedicine and Telecare. 2020;26(5):309-313. doi:10.1177/1357633X20916567

Smith, A.C. and Gray, L.C., 2009. Telemedicine across the ages. Medical journal of Australia, 190(1), pp.15-19

Wherton J and Greenhalgh T (2020), Evaluation of the Attend Anywhere/ Near Me video consulting service in Scotland, 2019-20

WHO (2009)Telemedicine: opportunities and developments in Member States: report on the second global survey on eHealth

Wright J, Technology in social care: review of the UK policy landscape, The author and CIRCLE, October 2020

If you found this resource useful and would like to use the Evidence Search and Summary Service (ESSS), please get in touch to discuss your needs:

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Suggested reference: Bocioaga, A (2020) ESSS Outline: Scoping the field- Video consultations in social care. Iriss. https://doi.org/10.31583/esss.20201911

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