Embracing virtual clinics and assessments

#6 of the Responding to Covid-19 Series

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Learning from Community Paediatrics in Southwark and Lambeth

The Community Paediatric service in Southwark and Lambeth is a large service with high-referral rates for EHCPs and developmental assessments. They have managed to maintain their clinics throughout lockdown, including the innovative EHCP health assessment clinic which enables children and young people who are going through the EHC process but who have not recently been seen by the community health team to have contact with health professionals.

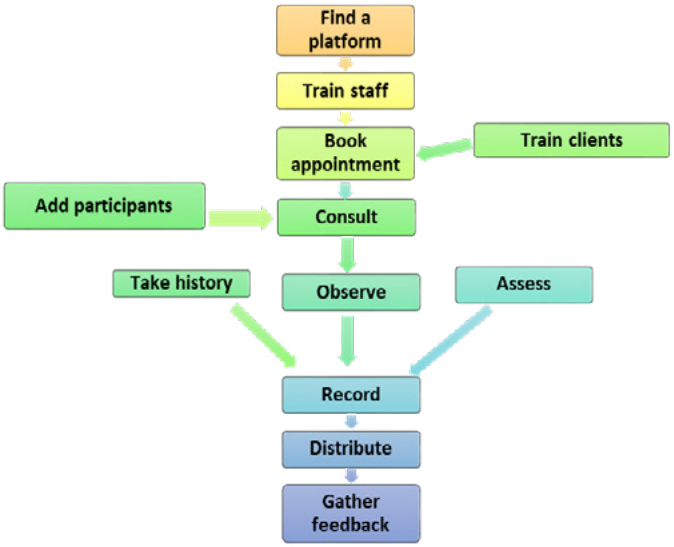
From March to May, the team ran 146 Paediatric consultations virtually which were broken down into the following assessments: 81 General developmental clinics, 24 Looked After Children clinics, 20 EHCP medical assessment clinics, and 14 MDT Neurodisability clinics. The numbers are now over double that and the service has been learning and adapting along the way.

At beginning of the Covid-19 lockdown, most clinicians moved to working from home, with a small number of doctors remaining on site on a rota. Almost all community paediatric clinics moved to remote delivery, other than Child Protection medical assessments or for urgent assessments for very vulnerable children where it was not possible to quickly set up virtual appointments.

The service uses Attend Anywhere and, despite initial concerns that it would not be possible to run developmental clinics through this platform, they have found it has worked well. A process of skilling-up was required, particularly for admin staff who have taken on the additional role of training patients and families with how to use virtual software, but remote working is now functioning well.

The service has been able to adapt a range of developmental tools for virtual use, including Raven assessment and Griffith's III Developmental Scales which have been used through screen share options. The team have also used different screening questionnaires, including around possible ADHD or Autism.

The Flowchart below summarises the process for setting up and delivering virtual clinics:



Key enablers of successful virtual delivery

Ensuring the right technology is in place - The children's community health service in Southwark and Lambeth was fortunate in that it had previously undergone an agile working programme in 2019. This programme ensured all staff who work in community children's services, from admin staff to paediatric doctors, health visitors and school nurses, had been provided with laptops or tablets that had camera and video functions. This also gave them remote access to electronic health records, a secure email, service folders and EPR, the hospital electronic system, which meant there was no lag time to acquire the technology needed for virtual assessments.

Skilled admin staff – Investing in skilled admin staff was seen as crucial to the success of this work as they were able to up-skill parents, train them on how to use the remote platforms and explain what would be involved prior to their appointment.

Develop a bank of resources – The service developed a list of up-to-date resources they could quickly share with families when needed whilst many families were unable to access the range of face-to-face services they may usually rely on. This included advice on foodbanks, income support, autism support and more.

There were also a number of practical requirements and expectations which were communicated clearly to practitioners and their families. This included:

- A requirement to use Google Chrome at the provider end and the need for a good connection at the patient end
- The need for a second screen for practitioners to be able to work comfortably. Often a clinician will need to deliver a video clinic, make notes and access previous records at the same time and this is not easily done on one small laptop screen. This was seen as important for long-term implementation of virtual delivery
- Professionals should wear a head-set to improve sound quality and to help the patient and family feel that what they are saying will remain confidential
- Practitioners need to carefully consider their video set-up and background. Staff were given advice on this including to:
  ⇒ Use a quiet space
  ⇒ Centre themselves

⇒ Zoom in, minimise any background distractions and turn the camera away from any personal items in the background e.g. pictures
⇒ Dress for work
⇒ Use good lighting and avoid having a lighting source coming from behind

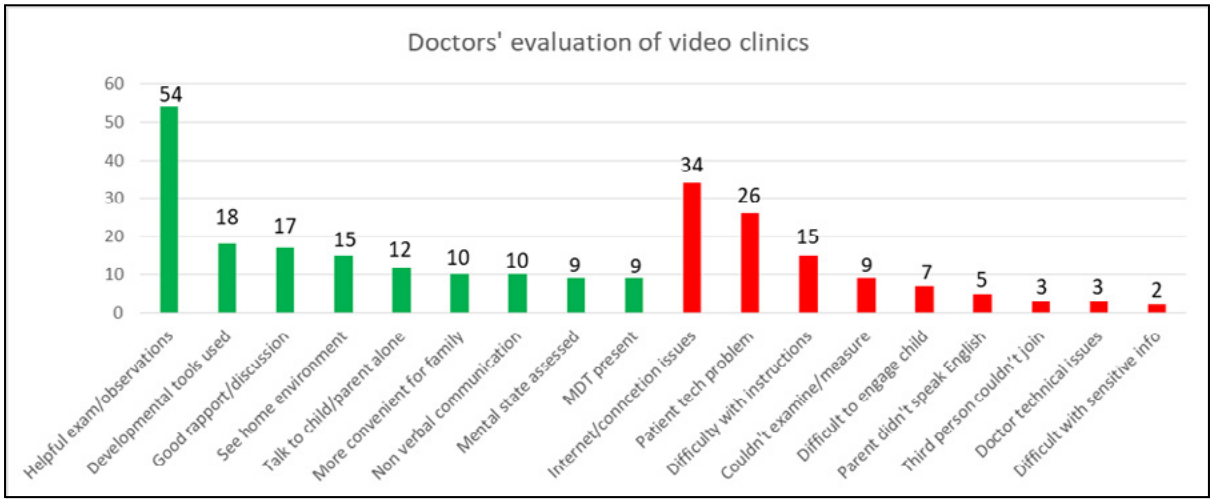
Challenges

Technical set-up and infrastructure – Although staff had access to the necessary technology due to the agile working programme in 2019, many patients and families did not. This included a lack of devices, such as a laptop with a webcam built-in, no Wi-Fi, insufficient data or a poor quality connection. The very families the service want to be in contact with the most are the families who are likely to be under-resourced and may not have access to the equipment and data needed to engage well in remote assessment. The team heard of parents who used all their data for the month on a one-hour video consultation, for example.

Clinician fatigue – Clinicians were enthusiastic at the beginning of the move to virtual services but have found that it is very tiring to deliver in this way, particularly given the sensitive nature of conversations and the need to read body language, focus more closely, and overcome any technical problems and delay. The assessments have also taken longer since they have moved online. A different level of concentration has been needed and this has been tiring for all practitioners.

Impact

Overall, Doctors across the service felt they had been able to make helpful observations, have good discussions with children and families and had been able to use developmental tools effectively. The findings of a survey into Doctors#' evaluations of these video clinics can be seen below, with the strengths in green and challenges in red.



Likewise, patients and families gave very positive informal feedback and expressed gratitude that they were able to remain in contact with the service during this time and have access to assessments they may have been waiting on for some time. Some felt particularly happy with video delivery and felt that it was more convenient than face-to-face discussions. Only two families chose not to have a virtual clinic session.

Next steps

Overall, the service found virtual assessments useful but acknowledges it cannot wholly replace a face-to-face assessment of a child's neurodevelopmental presentation. In particular, they have struggled to undertake autism diagnostic assessments over video (*please see resource #3 on this topic*). However, virtual assessment has worked well for many purposes, including initial assessments and record-taking and they are likely to continue with a mixed approach in the future.

Learning from Speech and Language Therapy, Physiotherapy and Occupational Therapy in Enfield

At the beginning of the Covid-19 pandemic, children's specialist health services across Enfield used a pyramid ranking system so they could quickly understand which children needed to be seen as a priority. Each case load was stratified, including assessments and referrals. Face to face consultation was only an option when *essential* needs could not be met through remote consultation, which was only the case for a small percentage of children within level 1. The 3 levels of priority were:

- Level 1 – urgent priority. This was made up of children and young people with fluctuating or deteriorating health conditions, those on child protection plans, children with post-operative needs, children on continuing health care packages, and/or those involved with admission avoidance and discharge planning teams
- Level 2 – medium priority. This including children and young people with EHC plan provision
- Level 3 – low clinical priority. These were children and young people whose health needs could be safely managed without accessing urgent support. They continued to be monitored for any changes and could move up the priority list if needed. A patient advice line was established for those with long-term conditions or housebound in this group.

They made sure that all children who were level 1 or 2 continued to be seen, ensuring enough staff were retained to meet their needs rather than being redeployed to inpatient care.

Children and young people's specialist services which moved to remote assessments included Occupational Therapy, Physiotherapy, Dietetics, Specialist Nursing and Speech and Language Therapy. Teams used Attend Anywhere and a mixture of other platforms, including phone calls, to provide remote support and assessments.

Speech and Language Therapy

As soon as schools were subject to infection control, prior to school closure, the SLT team moved to virtual or telephone assessments. Senior staff wrote

clear guidance on the best way to carry out calls, with a script to use and FAQs to boost staff confidence.

The SLT team focused on engaging the child and family as part of the assessment process. They initially spoke to parents and to some young people about what they wanted and planned the service accordingly. The team also wrote a guide and series of questions for parents to help them reflect on different areas of their child's speech and communication. These questions were accessible and were sent to parents in advance of the session so they had the opportunity to reflect and plan. Questions included: "How worried are you about your child's speech and language difficulties?" and "What one thing about their language do you think would make the most difference to them if we were to improve it?"

Parents were given the opportunity to go through the questions in their first language with an interpreter and offered a further session with professionals and an interpreter to discuss the questions and information needed, which feedback suggested was very useful for families.

The report format was also modified to reflect the reduced range of information available and to flag that more information may need to be gathered from contact with the young person in their education setting when schools reopen.

Occupational Therapy

The Occupational Therapy team previously always saw children with their families, with goals and outcomes coproduced with the child or young people and their parents. This approach has been maintained but there has been a change of process.

Previously, EHCP assessments for a new child would involve a clinical assessment with the child or young person and their parents, and then a school/nursery assessment if needed. Due to remote working, the process was adapted. The initial assessment has been replaced with phone or video calls to parents and he child or young person. As in Southwark and Lambeth, the team found that this was taking much longer: what previously took an hour face-to-face was taking at least 2 ½ hours, so this is now split over two appointments. The team also invite the school or nurseries to a video call.

Parents support the process by emailing relevant digital evidence including drawings, photos and handwriting samples. Staff then use observational tools, relevant to specific assessments to assess over video link. This has mostly worked well but there have been challenges. For example, it is very hard to observe handwriting through a video call.

Physiotherapy

There were a lot of concerns about the ability to deliver remote Physiotherapy assessments. Concerns included missing 'red flag symptoms' that would indicate conditions requiring urgent medical treatment or that may be life-threatening. They were concerned about misunderstandings between therapists and families without hands-on, tactile assessment. There were worries about the quality of assessment that could be delivered virtually and along with that were concerns about the child and parents' satisfaction with a digital process. However, the service was able

to adapt to deliver virtual assessments and these were well regarded by the families and therapists involved.

The assessments took much longer virtually and so were split into several different sessions: an initial telephone call to take a comprehensive history; a video consultation to focus on objective observations, particularly helpful for younger children; and a joint decision making session with the parents that included a discussion of clinical risks and benefits to determine the next steps.

As in other services, parents were sent materials in advance which detailed all the activities that would be observed during the assessment so they felt prepared for the appointment. Parents supported the assessment process by sending in videos and pictures through a secure email.

Whilst virtual tools worked well, the team were only able to deliver a limited Physiotherapy assessment and may need to supplement these with face-to-face assessments in education settings when possible. The service still felt that some safeguarding concerns and red-flags may be harder to spot in virtual assessments.

Key enablers for virtual delivery

Support parents and families to interact fully – Each service reported high levels of parental engagement and an improvement in the evidence submitted by families when compared to face-to-face assessments. They invested in supporting the parents and ensuring they were well-prepared in advance of the appointment, including by sending preparatory guides and questions, providing translators and utilising admin staff to help parents understand what to expect for virtual consultations and support with technological set-up.

Increase supervision - Many therapists have found remote working challenging and tiring, and many have had to deal with frustrated or angry parents and sensitive conversations. All teams therefore increased staff supervision, peer working and case discussions to ensure staff were well supported.

Challenges and mitigations

Staff access to technology – Many staff members in Enfield did not have a work phone and had to call families on their personal phone whilst withholding their number, however this led to a pick-up rate of only 50%

- As well as providing NHS phones to staff , the service began to text parents in advance to let them know they would be called soon and this led to the pick-up rate jumping to 80% within a week

Lack of confidence –_Some Speech and Language Therapists and Physiotherapists were initially under-confident in delivering virtual assessments and felt they would not receive enough information to provide a quality report_

- Teams increased supervision from senior staff, encouraged information sharing and introduced buddying schemes

Parental anger – Some parents expressed anger and frustrations about the system, current arrangements and difficulties accessing professional support

- Teams offered group discussion with staff regarding strategies for managing

anger, introduced specific case-based supervisions and provided debriefs where needed. Active listening tools enabled parents who felt angry to feel heard and to understand the process

Increase in time taken – Assessments that would have taken an hour if face-to-face were taking up to three times that

- This has now been factored into the planning and rota process

Draining for staff and parents

- All therapists supported to talk through issues with senior staff in supervision and given opportunities to meet in person, in a safe way, for support

Service-user technology challenges – Some families did not have access to the technology or data required for a remote assessment

- Services developed a clear criteria for which cohorts of children would benefit from face-to-face support which took socioeconomic factors into account. Families in this position were given a choice of how they would like the assessment to proceed.

Impact

High levels of parental satisfaction – Across all services, the feedback from parents was overwhelmingly positive. Many parents expressed gratitude that a therapist had spent so much time talking to them about their child, reported feeling listened to and were glad to be 'linked into' services during the lockdown period, and this is reflected in the outcomes monitored from March – May. Parents also reflected that they felt able to raise issues and concerns, regardless of the virtual platform. Some parents actively preferred face-to-face appointments due to the increased flexibility, scheduling control and input they were granted, as well as the ability to address concerns sooner which parents felt made a significant difference to their anxiety levels.

Significantly better quality information from parents - Therapists felt the quality of information from parents had been greatly improved in this process, leading to easier identifications and co-produced outcomes.
The Occupational Therapy service reported that whilst parents were always offered an opportunity to input into the process at school appointments, parents seldom attended these sessions or had much to say. With remote assessments, the OT service found parents contributed extensively to their reports, and the process was able to capture the parents' largest anxiety which was useful for the development of outcomes.

Improved understanding of parents – The SLT service reported that due to mediated discussions with families, some parents fed back that they could now see where the challenging behaviour they had experienced was the result of their child's communication difficulties.

Therapists gaining confidence and skills – The SLT and OT services reported that therapists had gained confidence and skills, for example with using translator services, improved observational skills, and opportunities to engage in a broader range of therapies and assessment.

Next steps

Conducting remote assessment did not compromise care to extent to which services were initially concerned about. Instead, remote working produced some additional and unexpected benefits compared to face-to-face assessments, particularly regarding improved relationships and greater information-sharing with parents. As in Southwark and Lambeth, children's therapeutic services in Enfield are likely to adopt a blended approach to assessments in the future.

There were many aspects of virtual assessment which were highly valued and which the services want to amplify going forward. This includes closer working and increased support for families, to gain in-depth information from parents about how their child is functioning at home, their concerns and to coproduce outcomes. The challenge here is the amount of additional time this will take, which will need to be acknowledged by commissioners, but it was seen as a huge benefit to the process which significantly improved the quality of assessments.

The teams will also continue to use first-language translators to help more parents participate fully. Some services are also further developing coaching approaches to support staff.

However, virtual assessments cannot be a *replacement* for all assessments, all parts of an assessment or for all children and many services have since started conducting some face-to-face assessments since June where it was needed. In particular, it is harder to fully assess Physiotherapy needs remotely and the Physiotherapy service will need to supplement virtual working with some face-to-face follow-up. Likewise SLTs will use school visits to add to assessments where needed. However, a majority of community paediatric assessments could be fully completed by virtual means, so it is variable picture. Furthermore, virtual assessment may not be appropriate where there are safeguarding concerns.

In the future there will need to be a combination of modalities with face-to-face and telehealth. This will vary for each service, but virtual methods are likely to be used for the foreseeable future in the following ways:

- For initial conversations and record gathering
- For assessments where the service already has an established relationship with the child or family
- For goal-setting, planning and follow-up appointments
- To improve availability, flexibility and access to assessments
- As one option given to parents, where it is clinically appropriate
- In order to reduce the spread of Covid-19, where needed