**Video Consultations / Virtual Platforms in Direct Clinical Practice during the COVID-19 Pandemic**

**Standard Operating Policy (SOP)**

The key messages the reader should note about this document are:

1. Our services should be using video consultations as part of our service offer at the present time.
2. Staff should be clear about the safe effective way of using this technology.
3. Staff should be operating with understanding of the platforms available and in a professional manner, paying attention to self care.
4. Video consultations should happen in accordance with core principles which are outlined in this document.
5. Individual services may in addition develop their own local working instructions to reflect their own specific assessment/therapeutic needs.

This policy/procedure may refer to staff as qualified/registered/professional or other such term to describe their role. These terms have traditionally referred to individuals in a clinical role at band 5 or above. Please note that the use of these terms **may or may not** include nursing associates or associate practitioners (band 4). For clarification on whether a nursing associate or associate practitioner is an appropriate person to take on the identified roles or tasks in this policy/procedure please refer to the job description and job plan for the individual, or local risk assessment.

**DOCUMENT SUMMARY SHEET**

ALL sections of this form must be completed.

|  |  |
| --- | --- |
| Document title | **Video Consultations / Virtual Platforms in Direct Clinical Practice during the COVID-19 Pandemic**  **Standard Operating Policy (SOP)** |
| **Document Reference Number** | TBC |
| **Key searchable words** | *Video. Consultation. Digital. Guidance* |
| **Executive Team member responsible (title)** | Claire Kenwood |
| **Document author (name and title)** | Sophie Roberts, Clinical Director |
| **Approved by (Committee/Group)** | Trust Wide Clinical Governance |
| **Date approved** | 2/7/20 |
| **Ratified by** | Silver command IRT |
| **Date ratified** | 3/7/20 |
| **Review date** | 26/8/20 – updated |
| **Frequency of review** | Initially 6 months for v1.0, thereafter annually |

**Amendment detail**

|  |  |  |
| --- | --- | --- |
| **Version** | **Amendment** | **Reason** |
| 0.1 – 0.4 | Various | Development drafts |
| 1.0 | Transposed to Trust policy document format | Finalised for approval and ratification |
|  |  |  |

**CONTENTS**

[1. The Policy 4](#_Toc44507723)

[1.1 Context 4](#_Toc44507724)

[1.2 Purpose of the Policy 4](#_Toc44507725)

[1.3 Duties and Responsibilities 5](#_Toc44507726)

[1.4 Key Principles 5](#_Toc44507727)

[1.4.1 Service User Consideration and Choice 5](#_Toc44507728)

[1.4.2 Deciding if Video Consultations is Appropriate 5](#_Toc44507729)

[1.4.3 Video Consultations may not be Appropriate for 6](#_Toc44507730)

[1.4.4 Start of the Consultation 6](#_Toc44507731)

[1.4.5 Communication issues: 7](#_Toc44507732)

[1.4.6 Closing the Consultation 7](#_Toc44507733)

[1.4.7 Documentation of the Consultation 7](#_Toc44507734)

[1.4.8 Risk Assessments 8](#_Toc44507735)

[1.4.9 Safeguarding Concerns and Issues 8](#_Toc44507736)

[1.4.10 Interpreter Involvement 8](#_Toc44507737)

[1.4.11 Looking After Yourself 8](#_Toc44507738)

[1.4.12 Evaluation 9](#_Toc44507739)

[1.4.13 Practical Considerations 9](#_Toc44507740)

[1.4.14 Professionalism 9](#_Toc44507741)

[2 Appendices 10](#_Toc44507742)

[Appendix A – A psychological survival guide for working from home in the midst of the Covid-19 crisis. 10](#_Toc44507743)

[Appendix 2 – Suggested Rules for Group Working through Video Platforms 13](#_Toc44507744)

# 1. The Policy

# Context

COVID-19 creates an unprecedented situation. Many NHS trusts are introducing Video Consultation as a matter of urgency to reduce the risk of contagion when bringing service users or relatives / friends of service users into Trust premises. The use of video consultation has rapidly been adopted across the Trust, with face-to-face consultation recommended only for specific circumstances based on the individual service user. This document defines the Video Consultation Standard Operating Policy for Leeds and York Partnership NHS Foundation Trust (the Trust) during the pandemic. The document has encompassed information taken from documents already in circulation across the Trust and nationally. This is an evolving document and remains subject to further review.

The Trust uses a variety of video consultation platforms however the principles within the document can be universally applied. The Trust permits the use of the following platforms: (ensure the latest version is downloaded):

* **Attend Anywhere** – NHS Digital approved platform that mimics an outpatient experience.
* **Zoom** – Can be used for video consultations and for sharing confidential information, e.g. via screenshare.
* **Microsoft Teams** – Can be used for video consultations and for sharing confidential information, e.g. via screenshare.
* **WhatsApp, Skype, Apple FaceTime and Google Duo** – These programmes can be used for video consultations from Trust mobiles / PCs / laptops to service user devices.

Users must ensure that they are using the latest version of the app / software to be assured of information security.

This document: -

* Sets out the Trust policy for the protection of the confidentiality, integrity and effective use of video consultation platforms for use within service user consultations.
* Establishes the Trust’s and user’s responsibilities.

# Purpose of the Policy

This SOP sets out the steps that must be taken to ensure that the interests of service users are protected and gives clear guidance to Trust employees in understanding their responsibility and accountability when conducting video consultations and using video consultation platforms for service user consultations. It outlines the Trust-sanctioned use of video consultations. This SOP forms part of the Trust’s overall approach to information security and governance.

The purpose of the Video Consultation SOP is to: -

* Ensure staff who use video consultation platforms are aware of the purpose and proper use of video consultation platforms.
* Make staff aware of what the Trust deems as acceptable and unacceptable use of video consultation platforms.
* Ensure that systems, personal, and otherwise confidential data are not put at risk.

This document is to be used alongside local working instructions which clinical services may develop for their specific service areas, and existing Trust ICT and IG policies and procedures.

# Duties and Responsibilities

Heads of Operations and Clinical Leads will ensure dissemination and implementation of the SOP within the service lines. Operational Managers, lead clinicians and practice development staff will disseminate and implement the agreed SOP. All staff employed by the Trust who use video consultation will familiarise themselves and follow this agreed SOP.

# Key Principles

The clinical service must have a collaborative discussion with the service user about the use of video consultation and provide written supportive accessible information. This will need to take into account:

* Service user access to technology / appropriate space.
* Service user preference of a particular video consultation platform.
* Service user ability to focus on the session – this might depend on cognitive abilities or issues, acuity of mental state, nature of interaction required to complete assessment.
* The clinical presentation and task / focus of the video consultation.
* Ensure there is a clear collaboratively developed plan for managing risk.
* Support service users in having a carer / friend / family member present during the consultation, or conversely being assured that the service user has adequate privacy.
* Clarify what support particularly vulnerable service users have available and when you would pull them in.
* Be aware that video consultations can be more emotionally and physically draining for the service user and staff.
* The agreement about use of video consultation and practicalities of arranging appointments should be shared by the clinician and the administration team.
* Where a series of therapeutic sessions is being set up, it is good practice for the clinician to have the first point of contact either by phone (or face to face if safe/appropriate) to discuss the practicalities of video consultation and go through the contingencies outlined below.

# Deciding if Video Consultations is Appropriate

**Specific COVID-19 factors:**

* The clinician working from home.
* Where an outpatient-based face-to-face appointment is not possible.
* Where multiple professionals need to be involved in referral assessment / care planning meetings for current in-patients.
* The service user is COVID-19 positive, has mild symptoms or is self-isolating (e.g. a contact of a known case).
* The service user is in a care home with staff on hand to support a video consultation.
* There is a need for remote support to meet increased demand in a particular locality (e.g. during a local outbreak when staff are off sick).

# Video Consultations may not be Appropriate for

There might be situations which may not be appropriate for video consultations:

* Assessing unknown service users with potentially serious and high-risk mental health presentations
* The service user’s ability to use the technology is affected by co-morbidities or they have serious anxieties about the technology (unless relatives/carers/support are present to help)
* There are known safeguarding concerns which need further exploration not possible through video consultation.

If there are any concerns or doubts seek guidance and support from the wider clinical team.

# Start of the Consultation

* At the start of the consultation, confirm the service-users identity by name and DoB.
* Confirm the sound / visual quality and overall stability of the connection.
* Request that the camera and microphone remain on during a 1-1 consultation.
* Confirm the location of the service user. Video consultations are not recommended in public areas. Staff should not routinely conduct a consultation if the service user is abroad, although some interactions may be appropriate, depending on an appropriate risk assessment by the service involved.
* Discuss the limits of confidentiality:
  + Service user to consider their location and surroundings.
  + Discuss reducing volume of speakers.
  + Consider use of headphones.
* Ensure there will be no interruptions, if unavoidable, agree a plan if the service should be interrupted. If the technology fails, consider:
  + Potential move to another platform
  + Agreement to continue by phone if possible
  + Rescheduling of consultation to a different time.
* Provide a statement that the consultation will not be recorded and request that the service user does not record the consultation.
* Take contact details early in the proceedings (ideally prior to the consultation), so that you can re-establish contact if the connections or technology fail. Agree to contact the service user in the event of a lost connection. Agree who would be an emergency contact if needed.
* Introduce everyone in the room (even those off camera), and ask patient to do the same or confirm that they are alone.
* Clarify the aim of the consultation and expected length of the session.
* Reassure the patient that the consultation is likely to be very similar to a standard consultation, and that the consultation is confidential / secure.

# Communication issues:

* Video Consultation works the same as face-to-face, but it may feel less fluent and there can be glitches (e.g. blurry picture, freezing etc.).
* You do not need to look at the camera to demonstrate that you are engaged. Looking at the screen is fine. Inform the patient when you are otherwise occupied (e.g. taking notes).
* Make written records as you would in a standard consultation.
* Try to allow for as much non-verbal communication to be captured as possible.
* Slow the rate of speech to allow for problems with slow connections and pause between sentences longer than you might do face-to-face.
* Use clear language - again this may be shorter than in face to face to ensure clarity of expression across the video call.
* Process considerations:
  + Beginnings and endings – it is good practice to follow a structure to contain the consultation. Much as you would collect and return a service user to the waiting area in a face-to-face visit, which allows helpful ‘human-to-human’ conversation, allowing time for this in the video consultation is helpful. Starting and ending with some general social pleasantries can help.

# Closing the Consultation

* Be particularly careful to summarise key points.
* Ensure the service user knows their ongoing support plan.
* Ask the service user if they need anything clarified.
* Confirm (and record in the notes) if the service user is happy to use video consultation again.
* To end, tell the service user you are going to close the call now, and say goodbye (before actually closing the connection).

# Documentation of the Consultation

* Document the contact as usual, noting that this was a video consultation.
* Document the service user’s location and all individuals present.

# Risk Assessments

Assessing risk during video consultations can be more challenging than face-to-face however the same principles would apply. Clinicians should take part in a collaborative safety planning process with service user:

* Ensure you know the location of the service user during the consultation. This would be important if a welfare check needed to be arranged for a service user with acute / imminent risks.
* If a service user terminated a consultation, following a disclosure of plans or intentions to harm themselves or others, follow the individual risk management plan for the service user.

# Safeguarding Concerns and Issues

* As with any clinical interaction if the clinicians sees / hears something which causes concern then this needs to be assessed in terms of immediacy of risk and discussed with clinical supervisor / manager and Safeguarding team.
* Gather details of all children present within the home (names and DoB) and determine parental responsibilities.
* Domestic Violence – Cinicians need to be aware of signals / signs a service user might use which might indicate this is happening. Ensure the service user is alone and able to talk without putting themselves at risk.
* If there are known Safeguarding concerns (including issues around neglect), clinicians need to assess whether video consultation is appropriate and potentially make alternative arrangements.

# Interpreter Involvement

Most video consultation platforms allow others to join. Therefore, both spoken and sign language interpreters can be on the call. The usual best practice for working with interpreters should be followed including:

* A pre-brief to let the interpreter know key details and the purpose of the appointment.
* A discussion at the start about the rules of turn taking and working with interpreters.
* A post-brief to get relevant feedback from the interpreter.

# Looking After Yourself

Video consultations can be challenging and exhausting, take time to care and look after yourself.

* Aim to have a structure to your day with scheduled breaks.
* Ensure that you have regular supervision and communicate with colleagues.
* Allow time to debrief following particularly difficult consultations.

# Evaluation

* Routine use of a service user experience questionnaire should be embedded into the process.
* It is recommended for clinical services to periodically review and evaluate their processes and seek team member feedback.

# Practical Considerations

* Ensure the chosen video consultation platform has been approved by LYPFT (approved platforms detailed above).
* Make sure both parties are using the latest version of the platform software / app.
* Make sure both parties have the necessary technology.
* Consider use of headphones / earbuds to optimise sound and enable confidentiality.
* Make sure both parties have the skill-set to use the system.
* Cabled or WiFi connections may be used, but you should use the connection method which, by experience, gives the most stable & usable video consultation connection.
* Close any additional tabs during the consultation to prevent slowing of the connection.

# Professionalism

# 

* Consider the environment beyond the video camera. Always try and conduct the consultation in a location with a neutral background and ensure no service user or other person identifiable information remains visible.
* Ensure familiarity with the video consultation platform prior to the consultation.
* Send the invitation for the consultation from a generic team email account when possible, providing the Trust protocol for e-mail contact with service users has been followed. (Please see the Trust E-Mail Use Policy IT-0003).
* Turn off / put on silent smart phones and disable any voice-activated devices.
* Ensure appropriate professional attire is worn and your staff ID badge is visible.
* Avoid eating during the consultation, unless it is part of the therapeutic intervention.
* Be mindful of the lighting in the room to ensure you are clearly visible on the camera.
* Be aware of your position and posture during the consultation. (It can be helpful to ‘hide self-view; to prevent distractions).

# 2 Appendices

# Appendix A – A psychological survival guide for working from home in the midst of the Covid-19 crisis.

During the Covid-19 outbreak, our primary work tasks have not changed but *the way in which we go about achieving those tasks is unrecognisable* from just a few days ago. We recognise that all the things we may experience in response to the crisis, including the ongoing uncertainty, may impact upon our capacity to deliver our services, predominantly *the doing of* the clinical work.

The face to face contact with colleagues in our various ways of meeting up, *keeps us clinically safe, feeling supported, motivated, capable and on track with treatment.* However, our working practices are changed with remote working now being the expected norm not a more infrequent event.

Remote working with each other and our service users means that we are understandably vulnerable in practice, as we begin to adopt new ways of communicating and managing ourselves in the work, with the usual *protective factors as described* being diminished or absent.

This document aims to help and support all staff as we face new and ongoing challenge.

1. **Working at home**

Make yourself a space to “do” the work if you haven’t done so. You may have something organised already for the less frequent times you work at home for admin etc. However, we are now at home mostly all day and every day. Make your work area organised and comfy to be in. Get it set up with all you need around you and ensure privacy for your calls and any video calling. Use of ear/headphones will help confidentiality of service user information in relation to others that you may live with, (and most likely reduce their irritability levels in not having to hear your meetings).

1. **Pretend and dress like you are going to work**

Keep the same routine that you’ve always done to *maintain* *the mental and* *emotional association* with being at work. Put your usual work wear on or very similar. Don’t work in your PJ’s! You will behave differently! Being dressed for bed or “lounging” will permeate in to the way we communicate, especially on the ‘phone to service users.

1. **The importance of structure and your calendar**

Keep as much current structure in place as you can. Keeping what you are used to doing in the same place will help keep you focussed and “in frame” for the work. Start work and end it at the usual times – *no* late night or weekend working, unless this is part of your role. Your calendar is your frame of reference, keep it up to date and book all your work in it, however small. Make sure you share it with all of your colleagues (also see later).

1. **Make sure you “arrive” to and “leave” work.**

We usually have a journey to work which helps focus on the day ahead, it helps us leave home life behind and park most of our personal and domestic stuff. It helps us with the process of putting our professional “jackets” on. This is when we become the experts that we are and that jacket is the essential buffer to the challenges and demands that each service user or group makes of us. It protects us, keeps us objective and able to think.

Your current journey is totally different, a matter of feet! So, *create your own* *journey* to work, go for a walk, run, walk the dog, step outside – just something to give you more space between having just brushed your teeth and sitting down to your laptop.

*Leave* work by clearing it away in some way. Tidy it up, move it, cover it, so you don’t keep having to look at it. Switch your ‘phone and laptop OFF. We can stay on our personal ‘phones ALL we like after work but don’t add your work ‘phone to your screen day! Be mindful of the temptation to “just check” your ‘phone. We are not available 24 hours and work-life balance is even more important to try and hold on to in light of the new guidance to stay at home.

1. **Take breaks throughout the day**

We are now at home in the same space all day. We also have no travelling generally now which previously provided some breaks in the work.

Get up, have a break, stretch, make a brew, step outside – or all of these. Make sure you create frequent divisions in the day to break up what will start to feel relentless. However, stay mindful of *drifting* as our experience of time will be feeling very different. Check in on the news, we need it right now - but if you suddenly find yourself coming to the end of “Homes under the hammer” or “Bargain Hunt” etc – you’ve drifted! (This is not a suggested prediction about our behaviour and intended without judgement). If we have childcare to manage there is an even greater challenge to balancing care and work in one space. Specific and mindful reorganisation of our routines will be required while we have to look after children, manage home schooling and our work.

1. **Communication and support**

Working from home means there are now no nearby conversations with colleagues to turn round to, no office doors to knock on, no walks to the photocopier, no sitting together for lunch and no office chat! All the lovely conversation that keeps us sane and supported in the work, will be absent. So, we are all going to need to “over communicate”.

We cannot underestimate how much of what seems like more casual and informal conversation keeps us *connected*. Therefore, up to date shared calendars are going to be critical. Responding to emails or simply acknowledging them will let us all know we are still “out there”. It doesn’t need to be every single time we get one or always a “reply all” (so we avoid “inbox influx”), but a *mindful response* that acknowledges. We will really need to articulate the *subtle communication* of the office that will not be available to us by physically being present.

Stay mindful, (paying attention, in the moment, with purpose and without judgement). Check in with yourself frequently. If you notice feeling *stuck,* *unsure* and that ordinarily you would like to check in with a colleague, knock on a door or “catch” your line manager or supervisor – then do it! Pick up the ‘phone or email. We will all be adjusting to being available in a different and more flexible way. If you feel *discomfort or unsettled* about an issue or service user, then get in touch. Our feelings, intuition, counter-transference – how ever we label it, are all essential in telling us something. Pick up the ‘phone, you are not disturbing anyone.

1. **Looking after ourselves in the work and generally**

We are occupational beings who need to be with others. We are being advised to isolate ourselves to stay physically well but this is not good for our mental health and our emotional well-being! We are going to start sharing some of the same experiences as our service users as we see less and less of each other and people generally. If we are not careful and mindful, we will experience “drift” in our thinking and decision making. We are therefore going to need to adopt all of the clinical thinking, strategies and skills that we give to our service users.

We may begin to feel a bit “root-less” being away from the office and each other. We will be feeling anxious and stressed as we face uncertainty and we are feeling worried about our families and friends. Some of us have been ill, some of us will be worrying that we are ill and stressing about becoming ill. We will be stressed at not being able to buy essentials as our communities also react anxiously. We are all “coping” and therefore having to provide our clinical work from an understandable raised level of emotional vulnerability in ourselves.

Keeping as healthy as possible, eating well, doing really good self-care and taking extra care with managing our limits will be important. If you start to feel unwell, follow the guidance from your service and don’t keep working feeling poorly because you are at home. Hold on to how you would *behave in the office.* Practice all of the things you know keep you well as far as you can, we will all need to work extra hard at this and adapt what we can’t now do because of social, occupational and building restrictions.

We are in unprecedented times. We can only do our best, keep in touch with our services in its variety of modes and not underestimate the *repeated need* of the emotional and mental discipline of staying mindful, sticking to structure, what we know works, keeping communicating, asking for help and checking in on ourselves - so that we remain as healthy, balanced and as steady as possible. Stay safe and well.

# Appendix 2 – Suggested Rules for Group Working through Video Platforms

1. Use it only in a private and quiet location and when no-one else is in the room. Inform other people at home not to distract you.
2. If someone walks in unexpectedly, turn the video and audio off, or put your phone / tablet down, until they have left and you are able to return to the chat.
3. If you are the ***only*** adult in the home with caring responsibilities for young children or others then you **cannot** attend a group and we will need to think with you about other possible times to attend a group.
4. Please ensure you cannot be overheard as far as possible and the use of headphones can help with clarity and to maintain confidentiality. Headphones with built in mic would also be useful.
5. Switch the TV and radio off at the time of the video-chat.
6. In Zoom, use first names only in order to maintain confidentiality.
7. In Zoom, click on settings, make sure “auto saving chats” are switched off.
8. Do NOT record the sessions; to do so will breach confidentiality.
9. Do NOT take snap shots / screen shots of sessions and share with others or post on social media; ; to do so will breach confidentiality.
10. Messages during the Zoom chat should only be sent to the whole group not individuals.
11. If you are opting out of the group chat, you must inform the facilitator and the group and leave the chat. There will be an agreement about how you will be contacted if this is the case.
12. If additional support is required outside of the group then you will need to use your DBT/CMHT crisis plan.
13. Group sessions via Zoom are scheduled for an agreed date and time. If you do not attend a group leader will try and contact you within 15 minutes of the start of the group. If we do not manage to speak to you at that time then the session will be counted as a missed group.

**PART B**

**3 IDENTIFICATION OF STAKEHOLDERS**

The table below should be used as a summary. List those involved in development, consultation, approval and ratification processes.

|  |  |
| --- | --- |
| **Stakeholder** | **Level of involvement** |
| Rose Mozdiak | Co-author |
| Carl Starbuck | Task and finish group member |
| Roz Davies | Task and finish group member |
| Tom Mullen | Task and finish group member |
| Sara Demaine | Task and finish group member |
| Phil Arthington | Task and finish group member |
| Jo Ramsden | Task and finish group member |
| Heads of Ops | Feedback on document |
| Clinical Leads | Feedback on document |

**4 REFERENCES, EVIDENCE BASE**

<https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians>

<https://www.bps.org.uk/coronavirus-resources/professional/psychological-assessment-undertaken-remotely>

<https://www.bps.org.uk/coronavirus-resources/professional/webinar-top-tips-providing-effective-therapy-video>

<https://www.bps.org.uk/coronavirus-resources/professional/working-children-young-people-online-video>

<https://www.bps.org.uk/coronavirus-resources/professional/effective-therapy-video-top-tips>

https://www.attendanywhere.com/

**5 ASSOCIATED DOCUMENTATION (if relevant)**

**6 STANDARDS/KEY PERFORMANCE INDICATORS (if relevant)**

**7. EQUALITY IMPACT**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure  might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I have/have not\* identified  any potential negative impacts for any of the nine protected groups.

Print name: Sophie Roberts

Job title: Clinical Director

Date: 6/7/20

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email; [diversity.lypft@nhs.net](mailto:diversity.lypft@nhs.net).

\*delete as appropriate