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Quality assurance of remote clinical assessments in the NHS

COVID-19 has accelerated the proportion of digital patient consultations across community and hospital settings, bringing both challenge and opportunity to health-care organisations and their staff. Within our own work, one such opportunity was the increased ability to record and review consultation audio, benefiting not just organisational quality assurance and complaint and incident investigation but also providing meaningful feedback to support clinicians' continuous professional development.

In England, the COVID-19 Clinical Assessment Service (CCAS), a flexible workforce of about 1500 practising and recent retiree general practitioners (GPs), was created to support the National Health Service (NHS) COVID-19 pandemic response. Patients with possible COVID-19 symptoms who contacted NHS 111, a national telephone and online access point for urgent care, were triaged and their details passed to CCAS if further clinical assessment was required. CCAS clinicians then assessed and advised these patients via telephone or video consultation, with the option to remotely prescribe, book local appointments for further assessment, or directly request an emergency ambulance. Across the duration of the service (March 28, 2020, to May 23, 2021), 603 269 calls were received and more than 500 000 patients were assessed by CCAS.[1]

During CCAS's operation, a proportion of each active GP's audio and written records were regularly reviewed by one of a central team of about 30 active clinical peers. This process was formative, based around the principles of coaching and appreciative enquiry,[2] and utilised a COVID-19-specific adaptation of the urgent care audit toolkit from the Royal College of General Practitioners,[3] which incorporated public health considerations, patient safety, and best practice use of the software interface.

Our reflection on this experience, during which more than 5730 calls were reviewed, is that consultation audio review provides a unique insight into a clinician's practice that is not otherwise afforded once they have completed clinical training. Aspects of the consultation, such as its structure, the building of rapport, proportionate data gathering, shared decision making, and best practice with technological processes, can all be reviewed and fed back on an individual basis, reinforcing best practice and supporting clinician development. At an organisational level, this supports quality assurance, transparency, operational safety, and the convergence of clinical practice.

We now question whether the metrics commonly used for clinical performance review in unscheduled care, such as average call length and peer-referenced referral rates, meaningfully reflect quality and safety within individual consultations or the wider service as a whole. From a perspective of continuing professional development, we also question the developmental utility of exclusively quantitative feedback metrics for most clinicians.

In the era of digital consulting, we believe consultation audio and notes review by experienced and distant clinical peers as a formative and appreciative enquiry has potential beyond unscheduled and primary care settings.[4] Provider organisations investing in consultation audio review can add value to patient care by both assuring quality and continuously improving it.

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Beyond COVID-19: scaling up and sustaining mobile health in Africa

In their Perspective,[1] N Hélène Sawadogo and colleagues highlight the challenges of mobile health care in Africa with the MOS@N project, which provided medical support to pregnant women but ran out of funding 3 years into operation. Securing longer-term funding to sustain mobile health is a challenge in Africa.[2] Social innovations such as BIMA (Ghana), AccesAfya (Kenya), Idocta (Cameroon), and Healthforce (South Africa) use telemedicine to improve access to

quality health care but have not managed to scale up.

Most Africans live under the poverty line and cannot afford to pay for health care. Thus, it is critical to remove financial barriers to ensure that telemedicine reaches all people. There are a number of innovative financing mechanisms that should be tried to scale up telemedicine.[3] These mechanisms include health-care impact bonds that have leveraged US$25 million to tackle malaria in Mozambique[4] and $2 million in Cameroon to provide 18 000 cataract surgeries over a 5-year period.[3] Patton and Joseph, in their *New (not-so-Oxford) Dictionary of Innovative Finance*, suggest another alternative is the use of diaspora bonds, which allow Africans living outside of their home countries to invest in local projects. Similarly, they suggest charity bonds are opportunities to provide start-up funding by financing medium-term debt to support project implementation.

Scaling up telehealth requires strong political will to drive innovation by partnering with the private sector and the diaspora to facilitate increased sustainable funding opportunities in African countries to ensure greater health-care access equity.

I declare no competing interests.

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Authors' reply

We thank Yap Boum for taking the time to respond to our Perspective.[1]

Boum focuses on one particular dimension of our argument, namely that scaling up and securing long-term funding poses a considerable challenge for mobile health projects in Africa. It is indeed the case that the vast majority of mobile health interventions in sub-Saharan Africa are being designed as experimental, pilot infrastructure for care or surveillance. In response to this challenge, Boum calls for the creation of innovative financing mechanisms and strong political will. He appears particularly optimistic that more sustainable financing would lead to more viable mobile health infrastructure.

In our own experience, however, long-term financing is only one among many conditions that need to be gathered for scaling up to be made possible. As we suggested in our Perspective,[1] a project such as MOS@N could not be durable without a series of improvisations in the face of challenges of all kinds—including crucial changes in the role of godmothers.

The way that MOS@N has evolved over the course of 3 years was not anticipated. Although financing is certainly an important part of the story, MOS@N was held together by labour, commitments, and relations of care that do not easily translate into predictable features. In other words, while we agree with Boum that sustainable funding solutions are key to integrate mobile health into health-care infrastructure in sub-Saharan Africa, the work it takes to create scalability is messy and capricious. Funding is important but it is only one part of the story. Addressing the other parts entails rethinking our approach to mobile health projects altogether, perhaps insisting less on expectations of scalability and paying more attention to projects' capacity to transform and reinvent themselves as they expand.

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COVID-19 and myocardial infarction

Ioannis Katsoularis and colleagues[1] found that COVID-19 is a risk factor for myocardial infarction and stroke through self-controlled case series evaluation, a method that has been used to establish the risk of myocardial infarction associated with influenza infection.[2,3] Regarding myocardial infarction, as the investigators recognised, one of the possible limitations of this research is the inaccurate diagnosis and codification of myocardial injury or myocarditis as myocardial infarction, particularly because the current myocardial infarction definition (and diagnostic methods) differ from the definition at the time of the registry outcome validation study.[4] In this context, we would like to stress that it is important to report either the risk estimates for ST-segment elevation myocardial infarction similarly to previous influenza studies,[5] or the risk of coronary revascularisation procedures after COVID-19, to decrease the potential bias and increase the robustness of the data and conclusions.

We declare no competing interests.

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For **Patton and Joseph's *New (not-so-Oxford) Dictionary of Innovative Finance*** see http://insideoutpaper.org/the-new-not-so-oxford-dictionary-of-innovative-finance/

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