

Health and Social Care Committee

Oral evidence: Digital transformation in the NHS, HC 223

Tuesday 15 November 2022

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Members present: Steve Brine (Chair); Lucy Allan; Chris Green; Mrs Paulette Hamilton; Rachael Maskell; James Morris; Taiwo Owatemi.

Questions 1 - 64

Witnesses

[I](#): Pritesh Mistry, Fellow, The King's Fund; and Karen Payne, Topol Digital Fellow, NHS Dorset.

[II](#): Dr Paul Atkinson, Chair, Health Informatics Group, Royal College of General Practitioners; and John Dean, Clinical Vice-President, Royal College of Physicians.

Examination of witnesses

Witnesses: Pritesh Mistry and Karen Payne.

Q1 Chair: Good morning. Thank you for joining us. This is the Health and Social Care Select Committee. This is our first session of a new inquiry focused on digital transformation in the NHS. We will look at the current use of digital technology and examine how it needs to change, from the evidence of our witnesses, to deliver improvement in services and, ultimately, outcomes for patients.

It is a wide-ranging inquiry. For our first meeting, we have Pritesh Mistry, who is a fellow at the King's Fund, and Karen Payne, who is a Topol digital fellow at NHS Dorset. You are both very welcome. This is a cross-party Committee, with Members here who are ready to ask you questions.

I will kick off with what may be a cynical question. Many people across the NHS—staff and patients—and, of course, the media, not to mention some in Parliament, will have a half-weary eye-roll on the subject of digital transformation when it comes up with respect to the NHS. Some may think back to the infamous NHS computer programme, which has coloured some people's judgment on this, or it may come from their day-to-day experience of working in the NHS or their day-to-day experience as a patient trying to get an appointment, for which they receive two hard-copy letters by Royal Mail when they know full well that the department has their email address. Is that fair? Are people right to be cynical when you look at the subject of digital transformation in the NHS? Do you want to start, Pritesh?

Pritesh Mistry: People's experience speaks to why they may be cynical, but we need to remember that there is a lot of variation across the national footprint. We have organisations that are perhaps among the leaders globally, or can be considered in that category. We also have organisations that are barely digital at all. They do not even have electronic health records. If you consider that level of variation across the national footprint, people's experiences can vary as well. You hear very good stories. We are doing some research with people with lived experiences. People have some very good experiences, but there are some terrible experiences as well.

Q2 Chair: Karen, what are your thoughts?

Karen Payne: I agree with that. Some of the problems that we are facing come from the fact that we digitise the current process, rather than digitising to transform. We just replicate what happens on paper, which may already be inefficient, in a digital world, where it remains inefficient, but in a digital way, rather than a physical way.

Q3 Chair: Give us an example of that.

Karen Payne: When out-patient appointments are done, you get a text, rather than a letter, or you get a text and a letter, so it becomes a



duplication, rather than a single thing. You cannot necessarily respond to the text you get, so when you want to change it you still have to phone. Then you get another letter and another electronic text with an appointment. There are things like that, where we could work smarter by digitising it properly, so that when you reply and say, "I can't make that appointment," you can choose electronically, rather than working through it with someone else. There are ways it could be done better.

- Q4 **Chair:** Is there an element of weariness around just putting a stamp on a letter and sending it? What must that be costing? I had a medical appointment the other day, for which I received two hard-copy letters literally one day after the other—duplicate letters saying exactly the same thing. There were two envelopes, two pieces of paper and two stamps. When money is tight, how are we in the position of not doing something as simple as sending me an email, instead of two letters?

Karen Payne: From my perspective, there are a couple of issues. First, if we are talking about hospital appointments in this scenario, the EPRs are not always connected to the Spine. The Spine has all of your up-to-date contact details, so, although the hospital may have an email address for you, they may not know whether it is the correct one. That brings issues around information governance. Am I sending this letter to the right place and the right person?

Equally, a large part of the NHS struggles to stop what it is doing and take a minute to think, "Is there a better way?" Everybody is so busy, head down, getting the job done, that the time to think about transformation is often lost and in separate teams that are away from the people who are delivering the job.

- Q5 **Chair:** Does that play into my half-weary eye-roll? A lot of people who are at the coalface and would probably love to do what I am talking about would probably say, "Steve, get a grip. We are just trying to deal with huge demand outstripping supply."

Karen Payne: They have a to-do list as long as your arm. They do not have the time and headspace to take half an hour out to think about how it can be done differently.

- Q6 **Chair:** Finally, before we move on to colleagues, I have a question for Mr Mistry. From the time when you were at Guy's, can you give us an example of what we are talking about here?

Pritesh Mistry: What do you mean?

Chair: Give us an example of what Karen is saying, where the day job overtook innovation.

Pritesh Mistry: Luckily, at Guy's I was in an innovation hub. In some organisations within the NHS, there are embedded places where clinicians can work with researchers, which allows for water cooler moments of



conversation and co-development of technologies, tools and research that can then go into the clinical setting.

However, clinician time is very tight, as you are fully aware. Although we create an environment that allows for that to happen as much as possible, it still does not happen enough. People are too busy and meetings get cancelled because of emergency surgery or other priorities that come in. It gets worse as the workload and work burden increases. Even where you have an environment where you are trying to coalesce that kind of collaborative and innovative approach, it still has its challenges.

With the letters, one bit of information that we are missing is how patients might prefer to be communicated with. The lowest common denominator is a letter. Not everyone is digitally active. Being able to have that information in people's records, so that we can understand how they would prefer to be communicated with, would help to move that forward.

Chair: This probably leads on quite neatly to my colleagues. Taiwo Owatemi, over to you.

Q7 Taiwo Owatemi: Good morning, panel. Thank you so much for joining us. Earlier, you both spoke about the different variations within the NHS and how the situation could be improved. Starting with Pritesh, what do you think can be done to implement standards across the NHS so that we have better interoperability?

Pritesh Mistry: There are a couple of Bills that have come through—the most recent is the Health and Care Bill—mandating the use of standards. There is one coming through mandating that suppliers adhere to standards. Those are two very important things that need to happen.

In our recent interoperability report, we mention the need to look at a systems approach. Sometimes you find that there is procurement of a technology for a particular part of the NHS, which adheres to standards within that framework. The same happens in another part of the NHS, but those standards are not within the same framework categorisation. With these technologies, we need to start thinking about how they work across organisations, breaking down some of the silos, instead of thinking, "This is what we need for our organisation." Digital transformation is not just from a single organisational perspective. I suppose there is a division of risk, resources and reward across organisations and professions. That is how it needs to be treated.

In the report, we specify that it is not just about the standards. The standards and the technology are not quite good enough, but it is also about how people work together. It is about having the time to understand and get to know one another, so that you can work collaboratively, and about having a supportive environment—things like informational governance and workflows and processes around that.



Q8 Taiwo Owatemi: Karen, do you think that we will benefit from having a national framework to guide clinicians better on implementing digital transformation?

Karen Payne: I think we will. The interoperability piece is the key to that. At the moment, clinicians are sometimes involved in procuring digital solutions, but sometimes they are not. What they often lack is the ability to talk to other systems that are already working. As a clinician, you need to be able to access all the information in one place, not to be logging into various systems that do not talk to one another to get the answers that you need.

Q9 Taiwo Owatemi: What national policy or support do you think that the Government can provide to help us to reach that point?

Pritesh Mistry: I mentioned the two Bills that are going through. That is a good start. There are supportive changes that we could do to make sure that the standards are representative across different organisations.

We need to think about how we digitalise other bits of the system—having highly digitalised hospitals and GP practices, and moving towards highly digitalised social care. There are still digital deserts in people's journey, such as dentistry and optometry—all the other bits where people touch healthcare, in the broad sense. We still need to think about how we digitalise those. That involves standards, making sure that standards are being developed and that they are maintained, as a kind of product.

Q10 James Morris: Karen, I was struck by what you said about the fact that hospitals are doing all their work and that it is all very hectic, with lots of pressures, but somewhere else somebody is sitting and coming up with ideas about digitalisation. Best practice would suggest that the way to get adoption is to involve staff and clinicians very early in the design process, so that they own it. To what extent are we doing that? What are the areas where we might need to improve doing that? Is it not happening at all, or is it variable?

Karen Payne: It is inconsistent. We have areas of good practice, where clinicians are in at the start. They have come up with the problem that needs solving and are exploring with their digital teams the solutions that might be found or suggesting ways that someone else is doing it that we could adopt. In other areas, there are times when digital teams are coming up with solutions on their own, without speaking to the clinicians. That is generally when they fail.

For me, there is a big hole at the moment with regard to clinical digital teams. They are not mandated. Some organisations have good, strong clinical digital teams, and therefore these things do not tend to happen. In other organisations, they may have no digital clinicians, or very few, who are spread very thin and are just doing the clinical safety officer work, not getting into the bigger picture.

Q11 James Morris: What do you think is the solution to that? One of the



weaknesses of national frameworks is that they impose a modus operandi on local organisations. On the other hand, if you just let local organisations get on with it, there will be inconsistency. What do you think needs to happen in order to get greater focus on that sort of clinical involvement?

Karen Payne: Digital clinical teams should be mandated in some form for organisations, to make sure that clinicians are there at the start of every project and understand how it might work. The digital clinical teams are really good at going out to meet frontline staff and saying, “What is your problem? How is it going? What can we do to help?” They are good at buffering when a solution has been implemented but people may not have the time to attend the training session that shows them how to use it properly. They will go down to the wards to work with clinicians and say, “This is how you can use it. This is what you can do.” At the moment, the digital clinical team is hugely undervalued. Even within my area, there are some organisations where the team is quite small and therefore struggles to make an impact. Something along those lines would really help.

Q12 **James Morris:** Pritesh, do you have any reflections? It strikes me that we talk about different aspects of digital transformation—patient records or letters. That is what IT strategists would call a key operational thing that needs to be got right, but there is other stuff. How do we manage all of these different cycles of digital transformation, the different elements of it? How can we get better at dissemination?

Pritesh Mistry: It is a combination of organisational readiness and psychological readiness. Something about culture change and leadership comes into that as well. How do we enable organisations to pull in technology? The response to the pandemic was the first time on a national level that we saw technology being pulled into the system because it was seen as a solution, not technology being pushed into the system because we had national-level targets, for example. Unfortunately, when you have national-level targets, the focus is on installation of technology. As my colleague rightly says, installation of technology is not transformation. That is just digitalisation. You need to have the technology there, as well as the transformation of people’s job roles, workflows, processes, the environment in which they sit and their skills. All of that stuff needs to change. We need to make sure that there is enough space for that to happen. We need to make sure that it does happen.

By comparison, in the financial services, for example, 50% to 75% of their project budget is spent not on the technology itself but on change activities. It is a bit different in the NHS. It is not just about having organisational capacity to identify problems and give permissive environments for change to happen—for people to test and try technologies; it is also the psychological readiness, when you have a national-level initiative, to ask, “Why is it happening? What is the responsibility of the staff? How are we going to support the staff to



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engage in it? How are we going to help them to make the change happen?"

Chair: Chris Green is the newest member of the Committee; he just joined today. He wants to come in on this point. Welcome, Chris.

- Q13 **Chris Green:** Thank you. A big question is over leadership. From the outside, many people look at the national health service and think that it is one size fits all: everyone will have the same service, no matter where they are. On the question of letters being sent out to people twice, presumably there are parts of the country that have a system that works efficiently, and you get one letter or one notification to come to the appointment. Would you say that is right? Are there pockets of excellence?

Karen Payne: Yes.

- Q14 **Chris Green:** One of the lessons from covid ought to have been about leadership, about decision making and people saying, "I am accountable. I am going to make this decision." Has that culture really been adopted by the national health service?

Karen Payne: It is variable. During covid, there was a lot more permission for teams to make decisions swiftly. As we are coming out of the pandemic, normal governance routes are coming back. There is a place for that, but it needs to be slicker in places.

- Q15 **Chris Green:** This is quite a danger. The lessons learnt can easily be washed away with time, so that a year or two years later they will have pretty much all disappeared. That is inevitable, isn't it?

Karen Payne: It is not inevitable. As an ICB, we are certainly working to make our governance process slicker than the previous CCG process, which had a lot more layers. We are trying to make decisions faster and to get the right people to make them. It may need to go to a senior committee, but it does not need to go through three first.

- Q16 **Chris Green:** A senior committee in NHS England or a senior committee in the ICB?

Karen Payne: In the ICB or within providers. Local ICBs and providers will be able to make their own decisions about how they interpret national guidance and how that fits for them. There is not one size that fits all. It is the same as we were saying with the letters. There are some teams that will have it sussed, and it will be running amazingly. There are others where there are problems, for whatever reason.

- Q17 **Chris Green:** The question then comes down to data, digitalisation and the adoption of these technologies. With the ICBs taking this leadership role, in many ways, we are going to have an incredibly variable system around the country. You will have pockets of excellence and pockets of leadership, and you will have pockets where those qualities are not so strong.



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Karen Payne: I agree. I have to say that that is a concern of mine. I am a health visitor by background. Very early in your health visitor training, you learn about health inequalities and how you do it. There is a danger that ICBs can create those differences.

Q18 Chris Green: Do you know what straightforward mechanism there is for the Secretary of State for Health to intervene in an integrated care board to challenge leadership if it is failing? Is it a straightforward process?

Karen Payne: I don't think so. I don't think anything is ever a straightforward process.

Q19 Chris Green: That variability in adoption of digitalisation, data and everything else is something for the system as a whole to look at and address.

It comes on to another aspect as well, if you are looking at the adoption of new technologies in a broader sense—wearable devices and technologies of that sort—by companies and organisations. As a normal British citizen looking from the outside, you would expect the national health service to be an almost perfect organisation to be able to adopt those technologies in a uniform way, right across England. I appreciate that Scotland, Wales and Northern Ireland will be different, but, right across England, it should be quite straightforward for these technologies to be adopted once a decision has been made. Is that the case?

Pritesh Mistry: Unfortunately, no. As I mentioned, there is a lot of variation across the national footprint. Organisational readiness across the NHS is variable. That impacts the scalability of technology and whether it can spread. As I just mentioned, the national agendas have tended to focus on the installation of technology. If you are a highly digitally mature and capable organisation, you will meet that milestone much more easily and quickly than a less digitally mature organisation.

Q20 Chris Green: Again, this will lead to a postcode lottery. We represent all sorts of different parts of the country. In terms of the treatment available—the adoption of new medicines or new devices—that variability is embedded in the system at the moment.

Pritesh Mistry: It is. Because of the scope of the national activity—electronic health records, virtual wards, AI, apps and the NHS website—there is huge scope, and the huge variation feeds into that. You need to reduce the variation to be able to do more and to be—

Q21 Chris Green: Can I pick you up on the point about artificial intelligence? That requires good-quality data uniformly across the national health service. If we want organisations in the private sector, institutes, universities and medical research charities to engage with the national health service to improve patient care, they need good access to good-quality, consistent data. Is the health service at the moment ready to provide the data they would need? How much extra money would it require to free up the time of medical practitioners to make sure that



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they input that data in the right way and then the system works to enable it to be a useful resource?

Pritesh Mistry: To the money question, according to an NAO report in 2020, 2% of trust spend is on digital. The target is around 5%.

Q22 **Chris Green:** The target is 5%. They are spending about 40% of what they need to spend.

Pritesh Mistry: It is much less than we should expect it to be. As I mentioned, the scope is huge, so there needs to be more focus. On a national level, that variation needs to be reduced. Then you can scale in technology.

Finally, to nail down the point about variation, there are people who are struggling in the healthcare system with wi-fi issues and webcams on their computers, whereas other places are charging ahead with AI. There are some really basic issues that affect some of the culture around whether digital will be adopted and can be embraced.

Q23 **Chris Green:** This is my final point. The health service is in a very difficult position already. It will get into a more serious position over the winter. The waiting lists are going up. We need more resources to be pulled into the NHS, and there are organisations that can invest in it in one way or another, especially with innovation, but the health service is not really geared up in the way it should be to make full use of that in a global marketplace. Should one of the targets be to make the digital and data side of things in the NHS compatible with and complementary to a research or innovation-rich environment?

Pritesh Mistry: There needs to be both a top-down and a bottom-up approach. In answer to your question, the issue is how we enable the healthcare system to work with various partners—researchers, innovators and start-ups, as well as incumbent companies—to develop solutions that work for them. There is a 2011 paper on how medical device companies work with healthcare systems. The answer is not very well. Typically, they work with senior consultants, not actual users, and do not talk to patients. From initiation of idea through to implementation, that needs to happen.

Q24 **Chris Green:** Device manufacturers might have to have a separate relationship with every integrated care system around the country—all 42 of them.

Pritesh Mistry: That is why we need to reduce the variation, so that we can have more scalability.

Q25 **Chair:** I want to pick up on that. It happens in hospital pharmacy, doesn't it? I have seen the robots in hospitals. There is one at Winchester hospital that I opened earlier this year. That interaction with the medicine suppliers is really smooth and is making a real difference to discharge, because one of the big blocks to discharge is that if you do not have your



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meds ready you cannot leave. There are exemplars of service that you must have picked up, aren't there? That would be one of them. Would it be fair for me to say that?

Pritesh Mistry: There are exemplars of practice in very different technology areas. Parts of the NHS are using drones, for example. We have already mentioned AI. There is a maternity unit that is developing a mum and baby app that will help to reduce inequalities. There are definitely centres of excellence. There is amazing expertise.

Q26 **Chair:** Which unit is that?

Pritesh Mistry: I think it is in south-west London. I can get back to you with the details.

Q27 **Chair:** Please do. It will be really interesting.

Pritesh Mistry: There are centres of excellence, but that is the problem. It is not national. That is the variation that we need to try to address.

Q28 **Chair:** Parliament created integrated care boards. The national health service is in many ways a misnomer, isn't it? We have lots of different health services that come under the NHS. We created a sense of difference, didn't we?

Pritesh Mistry: In some ways, the incentives in the way in which technology is purchased and the fact that organisations work in silos have impacted the way in which technology can scale, move and shift. There are different demographics and different staff, as well as different technologies being pulled in, different skills and different ways of working, which means that there is a lot of variation that impacts on technology—

Q29 **Chair:** One of the witnesses on our second panel specialises in diabetes care. In an area where there may be a greater prevalence, the ICB can shift its focus and its work. You are saying that, when it comes to IT, there really isn't that difference. It is needed everywhere.

Pritesh Mistry: When it comes to IT, there should be a basic level of infrastructure that technology can sit on. As I mentioned, that is missing to some degree.

Chair: It is missing.

Pritesh Mistry: As a final point, we need to think about the patients and the public. It does not matter how digital and how whizzy the technology in the NHS is if people cannot connect. What we saw during covid was that the pace of change rapidly outstripped patients' expectations and experience. When that happens, the technology does not get absorbed.

Chair: "Whizzy" is an excellent word that we do not hear enough.

We have just talked about the pandemic. My colleague Lucy Allan is going to explore that.



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- Q30 **Lucy Allan:** Pritesh, I want to take you back to what you were saying about the pace of change having really accelerated during covid. Could you set out for the Committee how progress is being made, building on the transformation that occurred during the pandemic?

Pritesh Mistry: As I am sure you are fully aware, there was a massive change during the first few months of the pandemic. My understanding is that after that the rate of change dropped rapidly, as service delivery became the priority.

Following on from that, there have been national initiatives and funding around some of the technologies and approaches that were trialled during covid: things like NHS @home, virtual wards and online consultations. Technology and the ways of working and processes around that have continued to develop and be embedded.

Unfortunately, in some cases it has been very much from a single organisation perspective. Virtual wards, for example, have implications for staff in the community or in primary care, but the money, the workflow and the changes generally happen in a hospital, going by the recommended model of NHS England. There have been changes, but patients' expectations have moved on as well. They may no longer understand or want just online consultations. If you look at the data, the proportion of online consultations compared with face-to-face consultations has now shifted again. I hope that that answers your question.

- Q31 **Lucy Allan:** Are staff positive about some of the transformation that happened during covid? Do they see it as something that will be part of the future? Perhaps this is for you, Karen.

Karen Payne: As with everything, it is very variable. There are some clinicians who have embraced it and see the benefit of it. There are others who trained expecting to see patients face to face and still want to do that. If they are just on a screen all day doing virtual appointments, they struggle to get the same relationship.

I think it is developing. It is about clinicians and patients going on a journey together. As Pritesh said, a lot of the time patients are now saying, "I want to see my doctor. I want to see him face to face," but actually the clinician does not need it. How do we bring the patients on the journey? How do we bring reluctant clinicians, who still want to see patients face to face, on the journey? That comes back to a big piece we have touched on all over the place about winning hearts and minds about how technology is changing and how we can have better interactions with the use of technology, using face-to-face consultations in a complementary manner when we need them, rather than them being the default.

- Q32 **Lucy Allan:** Was your personal experience during covid that you were able to use it effectively, with patients not resisting it?



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Karen Payne: At the beginning of covid patients were very different. Patients were very understanding and were just happy to get a service and to see their GP virtually. As time has gone on, patients have got weary and are less accepting: "Covid is over so let's move on." That is a challenge. The balance is shifting, and we need to redress it a bit. Some of it is around public messaging that the best way to meet your needs may not be a face-to-face appointment; there may be other ways to do it.

I have seen some good examples in primary care in my area of nurses using technology to do a lot of pre-work with patients. Rather than them coming in for their annual diabetes check, or their COPD check, they do a lot of their inputting at home. The nurses are then able to flex the appointments. Rather than it being a 45-minute appointment, you might get five minutes because everything is great, and you can just have a phone conversation. Another person might get an hour face to face because lots of problems have been identified. I think there are nurses who are seeing the benefit of being able to flex and to spend the time with the patients who need it. Those who are just running along nicely and are self-managing just get a quick check-in. I think there are lots of benefits with that.

Q33 **Lucy Allan:** Presumably, Pritesh, there was more than just the remote working element to the advancements that happened during covid. There were other digital changes. Could you tell us about some of the beneficial ones that happened that were not just about remote consultation?

Pritesh Mistry: As I mentioned, virtual wards, keeping people safe in their home and able to recover outside the hospital environment, have been very beneficial. We have seen advances in AI, with the AI chest database, for example, and the use of AI to analyse images and to be able to support changes in how medical imaging is being used. There are home monitoring systems as well to keep people out of hospital, when they can recover at home and have the support of their family around them. There are a lot of different technologies.

It is not digital on its own and it is not physical on its own. It is how we combine the two. There is some interesting work happening in east Lancashire, I believe, where they are trying to develop three different pathways that patients can come in and out of. There is the high-tech one; there is the middle one, where you might go to a GP practice or a pharmacy and have support but using the technology there; and there is the traditional low-tech option. Being able to have patients coming in and out, depending on clinical need and preferences, is where we should be trying to get to.

Chair: Thank you. My colleague Paulette Hamilton wants to come in on the back of this.

Q34 **Mrs Hamilton:** Thank you so much for what you have just talked about. I am going to flick the switch and talk about poor-quality equipment. You



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talked quite a bit about that in the stuff that was submitted to us.

The question I would like to ask is this. Because people have tried the digital realm, staff do not trust it and people feel that they are not being diagnosed quickly enough. You talked about winning over hearts and minds. What is being done to ensure that the equipment that staff are using and being trained to use does not lead to catastrophic failures, which is what is being talked about and said in the workplace? How are you including NAs—the lower grade of staff—nurses and health visitors and the whole gamut? How are you working to ensure that they are trained to a certain standard so that they are not the ones creating the catastrophic failures that have been highlighted? I will start with Karen and then Pritesh.

Karen Payne: To begin with, there are standards around some of the digital technologies. There are digital clinical safety standards that equipment, apps and things need to meet before they can be implemented.

I am aware that our acute providers are well aware of those, but in primary care they are not so well aware of them. A piece of work we are trying to do now is understanding which apps have been implemented over the last couple of years in primary care that we may not know about, because they may not have known about the digital clinical safety standards that they needed to meet.

There is a bit of an issue in getting the word out about understanding how we assess that the technology we are implementing is safe. People in my world, working in the digital world, know about those standards. We know what we have to look for, but many colleagues do not, and they just say, "Oh, this looks good," and do it. We talked a little bit about the slickness of governance going and they just implement something. There is a big education piece out there.

Whenever technology is implemented, there is a big bit about education that we quite often miss. Quite often technology is implemented and the nurses on the ward, as I say, and the NAs—the actual on-the-ground staff—are too busy to attend the training. Clinical staff are bad at looking at emails. You might send them an email that says, "Here's an online video that you can watch on how to use it." When I was working clinically, if I checked my emails once a week it was a good week, whereas in my current job I could not manage without it. We are not very good at engaging clinicians where they are, and that is what we need to do. When new technology comes in, we need floorwalkers coming down, saying, "Do you know how to do this? Do you know what this is for?", and showing them and spending time with them.

I talked about the digital clinical safety teams earlier. It is about having those teams on the ground, working with the frontline staff as things are implemented, so that they stop some of the issues happening. What happens is that when it does not work, or they cannot find a way around,



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they find workarounds and then they become a problem. That is when it does not work and you have issues.

Pritesh Mistry: I completely agree. There is the work that MHRA have been doing. They have been developing the evidence standards framework. That helps to understand when technology is acceptably a risk. There is the evidence base around that which sits on top, and that is the governance. Ultimately, those are the ways that we ensure that technologies are suitable for use.

When technology goes wrong, it is how we recover from that as well. About 8% of GP time is being used on IT errors and IT going wrong. That can cause patient frustration and issues. It is about making sure that things are safe and that we have a structure in place to be able to do that and to make sure that people are adhering to governance structures, but also, when the technology goes wrong, about how we make sure that it is reliable for use.

Q35 **Mrs Hamilton:** I was not going to go into governance, but I will just push you a little bit. Do you mean governance at a national level or at a trust level—ICB-type local level? What sort of governance are you talking about? Like Karen, I was a jobbing nurse. If I checked my emails once a month it was quite a lot; it was good. At the end of the day, who provides the governance? Who then polices that governance? Who then ensures that it is monitored as we go along? At the moment everything is about digital IT. I am worried that we are talking one language in places like this, but when you get to the workplace they are not with us. When you trained as a nurse—I am not sure about today because I trained yesterday—you did not get anything around IT. When you trained as a physio or what-have-you, I did not know of anything being included as being absolutely IT based. Where does all this fit in when you talk about governance?

Pritesh Mistry: There is a national-level responsibility for governance, to set the vision and what frameworks people should be working to. Then there is the adherence to governance that needs to happen closer to the frontline. As you mentioned, there are skills as well. We are seeing some ICSs setting up training hubs to support staff, to make sure that staff have protected time to do training, as well as academies within their own region to make sure that all the staff have the acquired level of training in digital skills as well as awareness of information governance and what technologies should be doing and looking out for in terms of assurance.

Chair: Your floorwalkers point is really well made. We have made a clear note of that.

Q36 **Rachael Maskell:** I want to start with you, Pritesh, and ask how innovation is stratified. Clearly, a digital solution that is found could have national application, yet it is often a clinician who is saying, “I need a solution to this.” It certainly seemed, from your response earlier, that this is looking more at a local level rather than escalation to a national scale.



Could you talk me through how that could be brought forward? I will give you an example. I had correspondence from a constituent, a physio—my own clinical background—who said, “People do their exercises with me and then I want them to continue doing their exercises back at home, but they don’t. I want a digital solution so that they can do their exercises alongside somebody, and a tool to do that.” How does that get scaled up? There will be physios across the land saying, “Ah, we need one of those.” How do we make that happen?

Pritesh Mistry: We need to reduce the variation across the country. How do we make organisations closer together in their digital capability? We need to support staff to have permissive environments to start addressing some of their frustrations with technology, identifying the tools that work for them and working within governance structures to implement those tools when they are assured.

In doing that, we can reduce the cap gap in the variability and create cultures that will be receptive towards technology. That then allows us to start scaling things up. With this level of variation your challenges might be wi-fi or skills. There is such a huge gamut of issues that could come out of it that it is difficult to scale things.

We try to scale things in the NHS. There are centres of excellence around robotic process automation, for example. Being able to have a technology stack that the technology sits on of equal functionality across the country helps. Having people being able to support each other—peer support—across organisations, being able to change workflows and having the time to do that is what is needed to be able to scale up technologies.

Q37 **Rachael Maskell:** Taking that scenario, or another, a clinician knows what they know, but they do not necessarily know the extent of, and how far to push, digital innovation, whereas, clearly, somebody working in the digital world does not know their clinical knowledge but understands the scope of digital. How would you get conversations so that you get the optimum innovation delivered?

Pritesh Mistry: We absolutely must have problem-led development of solutions. Clinical need must be understood and then matched against the digital solution to that.

I was speaking to Iain Hennessey, for example, at Alder Hey Hospital. He is the lead for their innovation hub. They have a special space in the hospital so that clinicians do not need to go far. It is in the basement, but it is nicely kitted out. It feels like it is far enough away from their work environment that it is a neutral space. They also have technology companies come in. They create a space for clinicians and junior doctors. It does not matter about hierarchy. Anyone can come in. They can identify a solution and talk to companies. They have tech expertise around them. The team is not expert in AI. They are not looking to apply AI to everything. They have broad, expansive knowledge of that



technology and links to companies that they can then talk to about how they start thinking about a solution.

- Q38 **Rachael Maskell:** Karen, I want to ask you a question from a slightly different angle. It is around the inequalities that we know exist across healthcare, but that obviously extend into digital connectivity and engagement. How are you seeing inequality addressed through this? What are the ethical considerations behind that?

Karen Payne: Something that has come up for us recently is that our maternity units have introduced Badger Notes, which is an app. The patient has all their records and the hospital staff can access them, but it relies on somebody having a smartphone that can use it. They are working with our local council around reuse of devices, recycling just for that purpose.

The problem with that solution is that you can have a paper one, but it negates the benefits that we have of a digital solution. We need to ensure that all our pathways are not digital only, because then, by default, you are excluding people. I live in Dorset, which is a very rural county with lots of blackspots with no wi-fi, and no broadband full stop—no phone signal, no nothing. We have to ensure that we do not create inequality by creating digital-only pathways. We need another way that works just as well, so that you do not get a second-class service just because you cannot access. Equally, as an ICS, we need to look at digital issues in rural communities and what we can do to support them.

- Q39 **Rachael Maskell:** Pritesh, do you have any observations on that?

Pritesh Mistry: I completely agree. There are ICSs developing initiatives. They are donating devices, donating data and providing support. There is great voluntary activity in communities, supporting people to understand how to use digital and improve their digital skills.

We need to have digital underpinning, so that people come in and out of physical care to digital care and back again, with digital pervasiveness. As I mentioned, for me it is not about one or the other. It is how you marry the two. People can be physically excluded and benefit from digital, and vice versa. Digital can do a lot to overcome inequalities, with video and audio instead of text, for example. There are various ways that digital can help; it is about applying it to help people to use it in ways that work for them.

Chair: Interesting. Taiwo Owatemi wants to come back in.

- Q40 **Taiwo Owatemi:** You have spoken a lot about the use of AI in healthcare. You have also spoken about how, obviously, we are gathering a lot of data now. We talked about the varying trust levels, of patients and members of the public, in some of this technology. How do we get to a point where we can improve the relationship and trust of patients and healthcare professionals with the use of data and AI?



For example, I am a pharmacist. We have had an increase in the number of AI platforms that are checking prescriptions and making sure that things are clinically safe. There are conversations within the profession as to how it is regulated. We know who is regulating it, but what criteria are they using to regulate it? How can we have trust in the platform? Essentially, how do we ensure that we are developing trust between patients and healthcare professionals in the increased use of data and AI in healthcare?

Pritesh Mistry: I can give you a live example. In the North Yorkshire and Humber ICS, they are going out to talk to people. They are going to pubs and marketplaces. They are talking about shared care records. They are talking about how their population are comfortable with using data, how they expect it to be used and how they continue to keep them informed on how it is used.

Building that bridge to people and into communities and talking to people about how data is being used and how they are comfortable with it, giving them control over it, is how we start building trust. We saw from the GP data planning research initiative a couple of years ago what happens when we do not communicate effectively with patients. That erodes trust. That is one way. We need to continue to converse with people, communicate with people and understand what their expectations are.

There is also the bit around how we assure them that the technology is working as we expect it to work. A BSI standard around AI and the use of data that is currently being developed should, hopefully, help with that. It is about checking where the data is processed and how it protects people's privacy, and about making sure that it only uses the data it needs to use. It does not need to use personal identifiable data, for example.

Q41 **Taiwo Owatemi:** Do you think healthcare professionals should be involved in some of this regulation? I know that MHRA is in charge of regulating it, but as a pharmacist I do not think they have reached out in consulting. Given the fact that it has transformed the way the profession operated, do you think that healthcare professionals should be involved in that discussion?

Pritesh Mistry: I think healthcare professionals should be involved in the discussion with patients and the public around how they expect their data to be used. In terms of technology and transformation, I think staff and patients definitely need to be involved. Technology will impact people's roles and responsibilities, and how people work, and staff absolutely need to be involved in that.

Taiwo Owatemi: Karen, do you want to add anything?

Karen Payne: I agree. I think some of it for me is around conversations and sharing the information for patients to understand what is going on behind it when they get a text saying, "Can you share your data?" What



does that mean? That is what we need to do. I worry that a lot of the time, as clinicians, we are pushed for time, but we need to spend time with patients so that they understand and make informed decisions. Unfortunately, time does not always happen, but for me it is always about the one-on-one conversation. That is where you win the trust. Then you forget that, but they tell their mum, their auntie and the lady down the road, and the message starts spreading. It is about spending time and helping people understand.

Chair: Karen Payne and Pritesh Mistry, thank you very much. That was a very useful first part of the first session. We will take a two-minute break while we change over the panel. Thank you for joining us.

Examination of witnesses

Witnesses: Dr Paul Atkinson and John Dean.

Q42 **Chair:** We continue our evidence on digital transformation of the NHS. We have had a very interesting first panel. We now have with us Dr John Dean from the Royal College of Physicians and Dr Paul Atkinson from the RCGP. Thank you for joining us. We are very interested in hearing what you have to say.

I want to open by, hopefully, gaining an understanding of the current level of digital skills that is out there in the clinical setting. Dr Atkinson, starting with you, could you open the surgery door for us on how widespread digital skills are out there in GP land?

Dr Atkinson: Good morning, and thank you. I think primary care has often been held as a centre of excellence in terms of digital. We have often been quoted as perhaps being a few years ahead of some of our secondary care colleagues. We are at the stage now where I very rarely use a pen. I consult with an electronic record in real time. I make my notes electronically and have done for over a decade. We now have electronic prescriptions. I am not sure of the latest stats, but over 99% of prescriptions now go electronically from myself to the chemists. They are securely signed with a digital signature. We are saving bits of paper from floating around.

It was interesting listening to the earlier panel's conversation about letters. In general practice, because of the way we are structured and the way that expenses are felt by the practice, we sometimes move earlier on some things. There was a comment about letters and the cost of stamps and envelopes. Most of the surgeries I work with have largely given up on writing to patients. Most surgeries now text patients, usually as a first preference, or use email or send a letter. In most primary care we record patients' preferences for communication.

Q43 **Chair:** I agree. The example I was giving was actually in the acute sector.



Dr Atkinson: I agree. I was trying to show some of the differences between where primary care is and where secondary care is. We have learnt some of those lessons. One of the things I find quite enjoyable, working with my secondary care colleagues, is with an organisation near me that is just rolling out electronic prescriptions on their wards. What are the lessons that we have learnt and that we can help share with them as they follow us on their digital journey?

Q44 **Chair:** Welcome, Dr Dean. What are your thoughts on the digital skillset out there in the general setting?

John Dean: It is a question of what we mean by digital skills. Digital is so broad. It is like saying healthcare clinical skills. You have to break it down. Digital is part of everybody's clinical day job and what they do. The question is how well it is integrated into that. The previous speakers were raising the issue of its just replacing current workflows rather than changing current workflows.

From our point of view, if you break it down for physicians, we work in three main areas. We work in wards looking after patients and in 80% of hospitals we use electronic patient records to varying degrees, and electronic prescribing in a number of those. There are devices delivering medicines to patients, for example.

In out-patient services, again there are different scenarios. The use of information in an integrated record is the most important thing there. We have heard about the variation in remote consultation that has become a significant part of out-patients. Then there are people doing procedures that increasingly use technical devices.

When you talk about skills, there are very different levels of skill. Generally, there is not a mature level of knowledge of the risks and benefits of digital solutions, particularly around technologies and applications. They are testing their safety because, basically, they are black boxes. There are things that we might have understood before and could assume were giving us the right answers, but there are many examples where that is not the case. There is a level of understanding that needs to be greater.

There is huge variation in use of electronic records or electronic prescribing, but that is largely because we have replaced a paper-based system with an electronic system, rather than actually changed. People's typing is slower than them writing. If they were dictating, it would be quicker. I am sure there is variation in typing skills across this Committee as much as there is in our clinical teams.

It is the same with out-patients in terms of the ability to bring all the information together. Some people will be very good at that. Some people have systems that help them to bring information together to inform the consultation. Similarly, people have different levels of knowledge and skill around remote consultation. Generally, people have



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not been trained in remote consultation in secondary care, which is different from primary care. That is a big gap, and it is a big risk. It is a clinical risk, and it is a risk because we do not understand it from the patient perspective as well as the clinician's perspective.

When it gets to the technologies of intervention, I think those are better understood because there is a closer relationship between the clinician and the technical providers on investigations and the use of technology there.

Q45 Chair: You mentioned safety. Obviously, you have an interest in the quality and improvement of patient safety, as it says in your biog. Where are the risks in that from your experience? You have an interest in diabetes.

John Dean: Yes.

Chair: You specialise in diabetes. People often say that, from a patient's interaction with digital NHS, that is an area where there have been quite big leaps. Is that real? Can you talk about that for us?

John Dean: It is real. For people with long-term conditions, and we use diabetes as an example of that, there has been a sea change in the ownership and management of the condition. Technologies have enabled that.

Q46 Chair: For those watching, could you set out a couple of examples of that technology and how it has helped people, particularly with type 2?

John Dean: The biggest example in diabetes will be patients with type 1 diabetes—people who require insulin to live with diabetes and need to moderate or adjust the amount of insulin they use, based on their blood sugars. You will all now be aware that continuous monitoring using technical devices attached to the skin can give people real-time data on what their blood sugar is. It can give real-time adjustments to insulin administration related to that. That has fundamentally changed, and the patient is in control of that. The patient is doing that, whereas previously they might have come to a healthcare professional every three months with a set of readings that are written in a book, and get guidance.

Q47 Chair: The patient becomes quite expert in understanding the condition.

John Dean: The patient is the expert. You see that in other areas as well. Where it is regulated and integrated into healthcare, it is safe. The danger that we have, however, is that if you look at applications for self-management, for example, the majority that are used by patients across the board for their health or their wellbeing are not regulated at all. Indeed, awareness among the public around the safety of these applications is very important, as well as among professionals. How we guide our patients, understand what applications they are using and integrate that into our clinical practice is most important. I think that has



been done well in some areas like diabetes, and there will be other examples, but there is a risk for patients and a risk for staff.

Chair: There are so many things we can come back to, and we will, but we are going to bring in colleagues now.

- Q48 **Taiwo Owatemi:** Good morning, both of you. Thank you so much for joining us. I want to build on the fact that there is variation in the skillset of NHS healthcare professionals. Do you think that we would benefit from having a clear national or local framework for the skills that each particular healthcare professional should have in being able to access some of the new technologies that are coming?

John Dean: We need to integrate within training standards the use of technology. I don't think we can separate it. One example in my area of interest is how most professional ward rounds happen in hospitals. Electronic patient records and computers on wheels with the patient are an integrated part of that.

You could train the individual in the digital element of the electronic patient record, getting information together, prescribing and giving patients information on that, but what you need is to train them how to work as a team with technology and involving the patient in that. What we have to do is integrate the digital elements of skill development with our broader elements of skill development at all stages of careers. If I am training further in diabetes or acute care, I do not go to train in the technical elements. I go to train in the care of patients, and the technical elements are brought into that as part of my normal professional development.

- Q49 **Taiwo Owatemi:** Dr Atkinson, I am a cancer pharmacist. If I work in one hospital, I am on ChemoCare. If I work in another hospital, I am on Aria. When the clinician comes into that hospital, you have to spend time getting to grips with how the whole system works. Obviously, that takes clinical time that the professional could be using to look after a patient. How do you think we can speak to the companies who are creating that technology so that there is better interoperability? Also, how do we get our healthcare professionals to have a general standard so that, wherever they go, they are able to use whatever the system is in that trust?

Dr Atkinson: I would argue that there are a couple of solutions. As John said, and as has been said before, one is that there is a certain minimum digital skillset we would probably expect of all health and care staff now. There is a certain baseline. I know that a lot of organisations put that into mandatory training, in the same way that you might have fire processes or information about information governance. There is a certain minimum baseline we need to have.

The need for a half-day training, or more, on some of our applications is a failure. What would be better is to have applications that were more mature and had better user interfaces so that we do not have to take clinical staff away to go and sit in a classroom for three hours to learn



how to use them. There is something about our suppliers becoming better and getting to a point where our day-to-day tools are more innovative and more intuitive.

When I upgraded my phone recently, it did not come with a manual. I did not have to spend half a day in a session and be signed off by someone on the clinical systems team to say that I had attended to be able to use it. We need to get some of that consumer level of intuitiveness into our clinical systems. It is not easy. They are complicated systems, and with very good reason. It is very important that a radiotherapy machine is working correctly.

Some of the systems that we use in primary care, and across other sectors as well, look like they are from an earlier decade or two. Some investment there would release time. As we are working towards integrated care systems and staff move around the system more, I do not need staff to spend time on how to use three different systems. They need to be able to come in, get on and see the patient in front of them. That is the way I would deal with it.

There is a separate part about training that is important. There is a need for a small workforce who are experts in these systems, who can get under the hood and can understand the cyber-security, the information governance and the digital clinical safety so that we can assure the products and know that they are safe to use in our systems, and that we have installed them correctly. We do not have enough of that workforce, but it does not need to be everybody. We do not need every nurse, every RN or every GP at that level. We need enough at that level to be able to do the installation and the maintenance of these systems.

Q50 Rachael Maskell: Thank you for your answers. I am interested in the whole area of clinical innovation and how that can drive forward. In itself, obviously digital produces opportunity for innovation but also for the training of clinicians. Starting with you, John Dean, to what extent do you think that innovation is being driven and that there is skills training? I was given an example by a professor who was using a platform to train people on knee replacement surgery, with a global community. The surgery was occurring in one country and there was a global seminar here. There were papers from another land. What opportunities are there for driving forward clinical practice using technology through the skills and learning platforms?

John Dean: From a skills perspective, yes. There are many entrepreneurs and innovators who are clinicians. Many of them will do that within healthcare if they are given the opportunity. Again, there are increasing opportunities for people to do that in fellowships or working with health science networks or innovation developments. There are many opportunities for people to develop those skills. What we are not good at is then sharing and spreading those innovations.



From the training point of view, using digital for training, we have seen much more remote training by connecting people virtually to sessions, either locally or globally. That means many more people are accessing training, not necessarily about digital but about whatever. What we have to do, in the same way as we do with clinical consultation, is to try to make sure that we have the balance right, because some of that was driven by the pandemic and where people were. When it needs people to be in a room together, interacting and learning together, that should happen, but when we can do it at greater scale and with greater accessibility, we can do it using more remote means. I think that is happening very widely. The example you gave is a good one.

- Q51 **Rachael Maskell:** Dr Atkinson, I would like to ask about patients' involvement, and the training and skills that they require. If we are to have the expert patient and people using digital tools in their self-management, how does that training occur? I was very interested that you talked about the interface of the digital platform with the user, but how can that be expanded to ensure that inequality is not driven and that the maximum opportunity is driven with that piece of technology?

Dr Atkinson: There are a couple of ways to answer that. The person who has the largest self-interest in the disease management process is usually the patient. Expert patients are already there. We just need to tap into them.

There is something about ensuring that there is safety. I do not think it is reasonable to expect patients to go on training courses or things like that, but we ought to provide them with safe options. I am doing some work locally where we are looking at creating a library of apps that we locally recommend and we can say, "Actually, these are ones that we have vetted or have paid an organisation to vet for us, and we are happy with them from a cyber-security or personal information security point of view. We are happy that the algorithm is right." If it is a diabetic app, we are happy that it will tell you the right number to put on your machine.

One of the difficulties is how we vet those curated libraries in front of patients, in preference. I do not now but I used to work with NHS England, and one of the things we did was to talk to organisations like Google and Apple, saying, "Here is a vetted, preferred set of applications. How do we get them in preference in the App Store?" We failed to have that conversation, both regionally and nationally at various levels.

We have a local app library where I work, but I do not have an easy way to put that in front of patients, to make that their default place to look. There is a real wild west. You cannot put a drug on a shelf in a pharmacy without going through the MHRA and a lot of regulation. There is no regulation to publish an app in the apps library and put it in front of millions of faces.

- Q52 **Rachael Maskell:** Thank you for sharing that. I have a final question around the whole area of public health. Taking diabetes as an example,



we often talk about tools to help manage disease processes. How much more can we use that technology to prevent those diagnoses in the first place?

John Dean: Absolutely. I think that public health self-management and general health wellbeing support and development is a big area where applications can support. There is increasing evidence around that.

We have to be sure that it is addressing those parts of the population where the biggest risks are—those in deprived areas, with the social determinants of health outcomes. We have to be really careful, not that we prevent people who can access them from having them, but that they are accessible for all. Previous speakers talked about that accessibility. I think that local government and the wider Government have a real role in making sure that those things are accessible. Yes, I am sure that one of the biggest benefits is in health promotion and wellbeing.

Rachael Maskell: Dr Atkinson?

Dr Atkinson: I have a slightly different angle on that. There is another area that is becoming increasingly mature, but we are probably at early days in this. It is about using the information that we have, be that information in healthcare, in the local authority or in other areas, so that we can be more proactive. I am talking about population health management. It is using the datasets that we have to go and find people. Some of the patients I am worried about as a GP are not necessarily the ones who are coming to me. It is the ones who are not coming to me who I know are sitting ducks, waiting for a disease process. If we can intervene now, we may have more options available than later down the road. I think pretty much all areas are starting on that work, and it will have real benefit in the years to come.

Q53 **Mrs Hamilton:** I have a really simple question. In the roles you currently sit in, what are the key barriers that you have faced from other health professionals and partners, because both of you are very proactive? Secondly, do GPs feel that they are losing anything re practice by moving more towards digital and having less physical interaction with patients? I will take John first, and then Paul.

John Dean: In terms of barriers in the way that I work and my clinical lead colleagues work, the professions come together well, I think it is fair to say, and we are getting better at doing that from an inter-professional point of view to address clinical issues.

Standards were touched on earlier. I think the standards are not so much around training as around the technical infrastructure and the technical interfaces, particularly the human technical interface and the technical interfaces. Those are the barriers. I can give you some examples. One of the things that we have led from the Royal College of Physicians is the use of early warning scores, which are physiological measurements to identify people who are at risk of becoming very unwell very quickly.



That worked well as a paper-based system. There are now electronic systems. There is not a standardised digital format of that in the way that it is presented or the way it interacts between primary care, ambulance and hospital services. We find it extremely difficult to work with suppliers or the intermediary for suppliers to agree a standard and consistency. Our biggest barrier is working either directly with suppliers or through an intermediary, informing the standards that need to be there that enable interoperability and the human technology interface to be consistent. Then the training issue is less because you are using the same systems and you are used to working in a similar way.

Q54 Mrs Hamilton: Do GPs feel that they are losing anything re practice in moving more towards digital and having less physical interaction with patients?

John Dean: From a specialist's point of view, I think we are learning. What the pandemic and the opportunity of remote contact with patients did was to open our minds to thinking about multiple ways that we could interact with patients, and indeed with our colleagues. To give you one example, on Friday I was part of a consultation about a patient with a GP and with four other specialists at the same time. We connected digitally. I have never done that in the 30 years of my career, but we were able to do that for a patient. That was the first time any of us had done it. We were very comfortable with that.

There will be other times when, actually, I need interaction with a patient in the room to understand the detail. The opportunities have been opened up to us. What we need to learn now are the nuances of those with patients and with our practitioners to use technology well when it is of benefit, but not using it primarily if it is not going to be of benefit. That is the place we are in at the moment.

Mrs Hamilton: Thank you. Paul?

Dr Atkinson: If I might, I will answer the two parts of the question with two slightly different hats. I am fortunate that I now spend the majority of my week working for an ICB. As a clinician I lead a digital team. I think probably the biggest barrier I have in working with my hospital colleagues, my GP colleagues, my pharmacy colleagues and so on is time. It is getting them away from service delivery to attend workshops and meetings—to get away from the fire to think about how we turn off the gas upstream. We are recovering from the pandemic. We are trying to recover a backlog of elective services. If there was a magic wand, I would ask for time.

I get great engagement across the professions. I do not think I have come across a sector that is not interested. If I could highlight one sector that is probably more time poor than any other, it is trying to work with social care settings. We have done a lot of work during the pandemic trying to get them on to secure emails so that they can move away from fax machines and receive information or share digital consultations with



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us. They are an even more separated small group. There are chains, but a lot of them are independent organisations. It is trying to get time with them when they are so busy. They have high turnover of staff as well, which makes it difficult. Again, we come back to my earlier point about how applications are not as intuitive as they could be if you need to train staff. If you have a turnover of staff, it is a barrier to getting them to use the systems.

The second part of your question was whether GPs are missing something. During the peak of the pandemic, I definitely was. We probably went too far into a remote consultation place. I think there were good reasons behind that. Patients did not want to come into our buildings because they were worried about what they might collect from the waiting room. In the very early days, when there was a shortage of PPE, we were necessarily concerned about seeing patients as well. There were some anxieties both ways.

I think that has gone. I don't have the latest stats to hand, but I think face-to-face consultations in primary care are at about 65% now and 25% remote. If you look at the statistics, a lot of that 25% is now telephone. I have been doing telephone consultations since I qualified. I did a telephone consultation course as part of being a GP trainee. We are trained in how to work away from patients and how to pick up clues and signs from pauses, where you cannot look at body language and things like that. When I need to see them, we do a two-part consultation. We do the first part by telephone. I say, "Actually, I need to examine you to decide what we are going to do about that." That consultation can then be faster because we have done some of it upstream.

I think we will find the right balance. I think some of what you see in some of the lay press about going to a pre-pandemic level is not necessarily the right answer. Speaking very personally as a working-age man, using my annual leave to take a half-day away from work to go and have a conversation with my GP was not the best way to use my annual leave. Access to GPs by online consultation, by messages, by email or by telephone is better now, and that is something we should keep hold of. We should not hold the 2017-18 statistics up as a high standard to attain, or we will lose some of what we gained from the pandemic.

Chair: We will move on because we are a bit tight for time.

Q55 Lucy Allan: I want to quickly pick up on Dr Atkinson's point there. I think there is a degree of resistance and fear from some patients because of the way remote care was introduced during the pandemic and because it was so sudden. Your comments reflect that.

There are also the digitally excluded. If you say to somebody, "Right, you have to go online to get a prescription or to make an appointment," that is not always possible. How do we make sure that clinical need and preference continue to be taken into account when we are delivering remote care?



Dr Atkinson: I would be amazed if any practice says you have to go online. If that was a practice in the area where I work, I would want to go and talk to them. For me, a digital route has always been an additional route. I do not know of any surgeries that have closed the front door or turned off the telephone. It is about finding ways that are more efficient for the surgery and more efficient for the citizen. That then creates space for those who need the phone or need to come in face to face. I do not think we have ever forced people into digital pathways, because there is a risk there of digital inequality.

Q56 **Lucy Allan:** When the covid period—

Dr Atkinson: During covid there were exceptional reasons.

Lucy Allan: There was a long tail after that. Certainly in my constituency, I saw old people queuing up outside their GP and somebody was standing at the door saying, "Here is a piece of paper; go online." That shocked me. That was quite recently, so there has been a long tail. Because of that there will be an element of resistance to remote care. People fear the way it was introduced, I suppose.

Dr Atkinson: I think the earlier panel said that there is variation across the country. Certainly, I do not think any of the surgeries where I work were behaving like that. If they were, I would have liked to talk to the surgery to say, "Is that actually the best way?" In a lot of the surgeries I work with if patients express a preference and say they would like to be seen face to face, we book them a face-to-face appointment. We do not ask why. We do not challenge. We do not push back. We just say, "That's fine."

Q57 **Lucy Allan:** That's perfect. It is how we make sure that that—

Dr Atkinson: That it is more universal, yes. I agree.

Q58 **Lucy Allan:** Do you want to add to that, Mr Dean?

John Dean: We are in a slightly different situation in hospital-based specialist care than in primary care. The biggest frustration that practitioners have is around the infrastructure to do remote consultation, which is not there. It can be the technology. It can be a private room, where you are not overheard. It can be having the electronic information to inform the consultation. There is a lot of resistance because the infrastructure is not there.

From the patient point of view, there is huge variation. In a number of hospitals there is still an expectation—indeed, there are national targets—around remote consultation, which may be having perverse effects, in that that might be seen as the primary method of consultation rather than actually being an option. I think there are dangers there. Building a trusting relationship between a patient and a specialist when it is a single interaction or a small number of interactions, rather than with general



practice, is likely to need some face-to-face care as well as remote consultation.

Q59 James Morris: Dr Atkinson, at the beginning of the session you said that you had been using electronic records for a long time and that the innovations were 10 years old. Why do you think there is a discrepancy between that and what goes on in secondary care? It strikes me, coming back to the Chair's issue about receiving two identical letters from a hospital, that secondary care is behind in terms of its level of innovation or adoption. Why is that?

Dr Atkinson: I think it is multifactorial. One of the reasons is probably that in many ways primary care is simpler. I work in a consulting room-based setting. I have a desk that it is easy to put a computer on to. We do not have a ward situation where you have to think about mobile devices. There is something about the simplicity of a primary care setting versus a large trust.

There is something about scale as well. For me to change something, it may need six or eight partners to agree and then we can put that new work into practice next week or next month. We are much more agile and faster on our feet. That is largely about scale.

The third reason would be about investment, the drivers behind investment and the returns on those investments. With primary care, in the independent contractor model, obviously if I can find efficiency savings that reduce the practice expenses, as a partner I will feel those benefits. We have a very deep-rooted interest in trying to be more efficient.

John Dean: I agree with that. There has been investment in infrastructure in primary care over many years. That investment has not happened in secondary care. We are still seeing that, so people have to use five log-ons or wait 15 minutes for a computer to fire up. That creates frustration and disengagement.

The investment in infrastructure is the first thing; it is hugely variable and still a problem. The second is the size of the team. Every small team in secondary care would want to, and could, make the changes if they were the small team of 10 people that we have just been describing. Doing that across 50 teams within an organisation is quite complex. It needs the organisational support and time out that people talked about before so that, rather than filling the next clinic list, it is seen as a benefit that you take that time to redesign the way you contact patients, so that there are not missed appointments. It is investment in infrastructure, it is size of teams for implementation, and then it is the support structures that are required to do that.

Q60 James Morris: I have a quick follow-up question. It strikes me that the primary-secondary care interface is an area where digital transformation could have a lot of return. How far away are we from getting better



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digital interaction between primary and secondary care?

John Dean: There is huge variation again. I am sure that both of us know that in our clinical practice. I can see a primary care record when I am consulting with patients. I can put messages on that. Many of my colleagues in other parts of the country cannot do that.

I explained earlier that I had a virtual consultation with a GP and a number of other specialists together. We get messages from primary care and can reply in real time or asynchronously. That is happening more and more, but on the interoperability of local records, which is a key Government target, the dates that have been given are hugely challenging for ICBs. That has to include social care as well. It is doable. Chris will know from Bolton and Manchester, where the integrated record has led the way, that it is doable, but it has not been an easy process to get to that point. It is happening, but the opportunities are much greater.

James Morris: Dr Atkinson, do you have anything to add on the primary-secondary care interface?

Dr Atkinson: One of the most rewarding projects I have been involved with in recent years is an application exactly in that space. It was an advice and guidance tool that we rolled out to both primary care and secondary care colleagues. If I was with a patient and I was not sure what to do, I could use it to reach through to an on-call specialist in the hospital. It had sophisticated telephony inside, so it could find the person and if they were busy or operating it would find the next person. It engaged primary care to talk to secondary care again, which is something we have lost over time. It is something I remember as a newly qualified GP, but it does not happen as often anymore.

Then the technology comes in. What it did was to record that conversation. It sent a reminder to the specialist to make a couple of output notes about what we had agreed and what the next steps for the patient were. A copy of that came to me in the primary care system and went to the hospital, into their system as well. If the plan was to see the patient in clinic in the near future, they could see the conversation that was there. A lot of the digital in that space meant it was much easier for the specialist just to finish off the template of a letter with a couple of interactions and interventions that they wanted. Then we had a record and we both had a copy of that record. We both knew what we were going to do with the patient.

I think that has been really rewarding. In my area, we have a shared care record. My hospital colleagues can see primary care data. I can see hospital data as well. That is both rewarding and helpful. It helps with the slipping through the net for patients who may have lost their follow-up. Those systems could get better. They are good, but they are not as mature as they could be. One of the things that is very difficult with those systems is that when you connect the various parts of health and care you end up with a very large record. How do you then summarise that so



that a busy clinician can see a summary rather than a dictionary or an encyclopaedia of the patient?

James Morris: Interesting.

- Q61 **Chris Green:** I have a brief question on the integrated care boards which came to Greater Manchester first a few years ago. It is about the leadership. Sometimes the national health service itself can be seen as a bit too large and terribly unwieldy. The trusts are perhaps a little bit too small, but with the integrated care boards and the integrated care systems, by having the devolution of leadership, what scope do we have for the integrated care boards, which operate on a far more meaningful scale, to collaborate between one another in a geographically relevant area? Will that lend itself perhaps to the ability of workforces to have complementary training, but also to be able to work on systems, whether it is from Liverpool to Manchester, Preston or other areas? Can they work between areas more effectively in the future?

John Dean: I think it is a big opportunity, but we have to be realistic; these are still very developing organisations where people are not yet sure what their role is within them. They are maturing. The dynamics between the individual providers in health and social care and the ICB are maturing. The dynamic of leadership between the two can often produce tension at the moment. That will work out, but it is just the immaturity of it at the moment.

The potential is huge because it is joined up. It is sharing leadership and opportunity across, initially, the ICB footprint but then the regional footprints. Recognising the differences but also the commonalities, I think, brings great opportunity and we are starting to see that happen.

Dr Atkinson: I agree with a lot of what John says. One anxiety I have is that, despite guidance to the contrary, not all of the ICBs have somebody around the table with a digital portfolio. I believe I am unique in being a clinical digital executive. I have not found anybody else who has quite my portfolio in England. I think there are still systems where the digital leader sits inside finance, operations or elsewhere. It is about recognising a digital skillset and a set of training and learning as something that is valued and that should have a seat at the top table.

- Q62 **Chris Green:** To complete my point about having that key figure on the integrated care board itself, with that person being empowered to deliver and challenge the system and lead on it, one of the concerns I have heard is that, where that position does not work quite as well as it might, the person almost becomes another barrier, another hurdle, that the system has to work through, rather than being an asset to bring people together.

Dr Atkinson: There are two things. One is that you may have the wrong person in the role. There are also ICBs that do not have someone in that role. Fundamentally, they are going to struggle to make sure that digital is seen as an enabler of transformation of different ways of working. I



worry that there may still be parts of the system that see digital as an expense and something where we spend money on servers, computers and printers, not realising that it is probably the thing that is going to unlock new ways of working.

Chris Green: I am not expecting a reply to this. We have police and crime commissioners who are democratically elected. I am not sure that we want to go down the route of having the chairman of the integrated care board elected, but I suppose one thing for the future is to have some local accountability.

Taiwo Owatemi: I agree.

Q63 **Chair:** What a thought. Steve's final thought: on the NHS app, patients can view their GP health record. They then see a very brief summary of the conversation and interaction they had with primary care. Could you tell me your concerns or contentment with that? Does it limit your ability in what you might put down in that note, knowing that the patient will see it?

Dr Atkinson: We have to think about the majority of patients and the patients who may be an exception for various reasons. We have been sharing patient information with the patient for a long time, long before the NHS app was particularly mainstream. Various numbers of apps were doing it. There is a plan to share more information with patients.

As a clinician, I think it is a good thing. We know that evidence suggests that, a few minutes after you have finished your appointment with me, there are three or maybe four things that are retained. With that co-ordinated collaborative care plan, you can see what we talked about. We know that patients enjoy taking it home and showing it to family members: "This is what we said at the appointment." For the vast majority of patients, I would like to share more.

There are patients we need to be careful with. There are patients where we worry about distress. For example, if I am investigating somebody for cancer and the test results come back, I need to make sure that they are not seen by the patient until we have had a chance to explain them to the patient sensitively and carefully. That is why I make sure that we have our working processes in the surgery right and that we share information at the right time with the patient.

There is another group of patients where we worry about whether they are in a difficult or coercive relationship, and how private their device, mobile phone or laptop is. There may be patients where it is probably not wise for them to access their records because they cannot have privacy at home. We need to respect that and provide that space.

Q64 **Chair:** What it comes down to, and it has been a bit of a theme this morning with all the witnesses we have talked to, is the patient receiving the information that they require, and that they consent to talking to their clinician. The permissions that I give to any organisation I have an



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interaction with online are extensive, but they are not when it comes to my health interaction online. They are not personalised enough.

Dr Atkinson: We need to be able to personalise it to the individual's choices. Whether or not that is forcing people into booking online for appointments, we need to be respectful of patient choices. There is a variation in digital literacy in society. We have learnt from organisations that it is actually not always where you think. Sometimes digital illiteracy is not necessarily based on age. It might be based on deprivation or on access to broadband and things like that. There are things about personalising it and getting it right for patients. We have to be very careful that whenever we do broad strokes, we do not catch people with universal policies that have unintended consequences.

Chair: That is great. There ends the first session on digital transformation in the NHS from the Health and Social Care Select Committee. Dr Dean and Dr Atkinson, thank you for your time.