HOUSE OF LORDS

Select Committee on COVID-19

Corrected oral evidence: Living online: the long-term impact on well-being

Tuesday 24 November 2020

10 am

Watch the meeting

Members present: Baroness Lane-Fox of Soho (The Chair); Lord Alderdice; Baroness Benjamin; Baroness Chisholm of Owlpen; Lord Elder; Lord Hain; Lord Harris of Haringey; Baroness Jay of Paddington; Baroness Morgan of Cotes; Lord Pickles; Baroness Young of Hornsey.

Evidence Session No. 3 Virtual Proceeding Questions 25 - 36

Witnesses

I: Dr Ruth Chambers, Staffordshire Sustainability and Transformation Partnership; Dr Farah Jameel, the British Medical Association; Chris McCann, Healthwatch; Dr Pritesh Mistry, The King's Fund.

Examination of witness

Dr Ruth Chambers, Dr Farah Jameel, Chris McCann and Dr Pritesh Mistry.

Q25 **The Chair:** Good morning, and welcome to the House of Lords COVID-19 Committee. I am looking forward to hearing from our witnesses and thank them very much for coming to talk to us about this important topic. As you are aware, we have been tasked with looking at the long-term implications of Covid for the economic and social well-being of the UK, so we would appreciate you keeping those two frames of reference in mind: both the long-term implications—a two to five-year horizon—and that word "well-being". It is sometimes hard to unpick what we are all thinking about the current situation and to cast our minds forwards, but that is the challenge that our Committee has, and we would really like your help with it.

I am Martha; I am the Chair. We have all seen some of the areas that we are going to talk about this morning. My colleagues will be asking those questions, plus questions on other areas of interest to them. It would be great if the witnesses could say hello—no need for too long an introduction because we have all read your impressive bios.

I remind everybody that we are being recorded and a transcript will be available, so please keep yourselves muted until you speak. If anyone wants to make a point at any point, please could they use their "raise hand" function and I will come to them. I will ask people to speak and to ask questions so that it is a relatively orderly format.

Once again, thank you to our witnesses; we are really looking forward to hearing from you. Can I ask you to give a wave to the camera and say your job title when we come to you?

Dr Ruth Chambers: I work with the Staffordshire Sustainability and Transformation Partnership as the clinical lead for technology-enabled care services. I was a GP for 40 years and escaped a couple of years ago.

The Chair: Thank you for being a GP for so long. We really look forward to hearing what you say.

Dr Farah Jameel: Thank you to the Chair and the Committee for the opportunity to give evidence to this inquiry. I work as a GP in London. I am a member of the executive team of the general practitioners committee at the BMA, but today I shall be speaking on behalf of the whole profession.

The Chair: Fantastic. We very much appreciate the evidence that the BMA has submitted to the Committee.

Chris McCann: I am the director of communications, insight and campaigns at Healthwatch England, the independent champion for patients. I am representing our executive team here today.

The Chair: Fantastic. The voice of patients is obviously something we want to consider deeply, so we appreciate you being here.

Dr Pritesh Mistry: Thank you, Chair. I am a fellow at the King's Fund, an independent charity and think tank working in health and care.

The Chair: Fantastic. It is a big topic and, as I say, we are trying to cast our minds forward to the two to five-year horizon, so we would appreciate you keeping that in mind. The two big anchors for us in our work are the long-term implications of this horrible pandemic and its effects on social and economic well-being, which we are looking at through the lens of digital. One of the most indisputably clear trends from the past eight months has been the acceleration of digital. Bearing that frame of reference in mind would be extremely helpful for us.

Q26 **Baroness Benjamin:** Thank you, Martha, and hello to all our witnesses this morning. I am sure you will agree that over the last 72 years the NHS has delivered an outstanding healthcare service to the nation. During that time, it has evolved. Today, much has been reported about digital healthcare and the major role that it is playing, not just now but for the future.

The first set of questions that I would like to ask are about digital healthcare pre Covid. First, what role did digital technology play in the delivery of healthcare services before the Covid-19 pandemic? What proportion of patients were accessing healthcare services digitally?

Secondly, what impact has this had on people's physical health? Were some interventions more effective than others, for example? Were some people able to access treatment that they would not otherwise have found available? Finally, were there any negative consequences of digital healthcare? Those questions are to all our witnesses.

Dr Ruth Chambers: I must say that I have got increasingly worked up over the last few months about not including patients enough at the level at which they need to be included. Many of the long-term, annual reviews that would normally happen, like a practice nurse in general practice seeing someone with blood pressure every six months, were not happening. The problem is that most patients did not have their own blood pressure machine, so it has made it extremely difficult for practices to adapt. We have all talked a lot about video consultation, but in September NHS Digital data showed that only 0.5% of consultations in general practice in England were via video. Nearly all were done over the phone. Thus you cannot see the patient and you cannot get the body language if there are mental health problems.

Dr Farah Jameel: I might start with the numbers. My colleague, Dr Chambers, has articulated well some of the challenges we have in capturing that kind of data. What we do not have a good indication or idea about, is what proportion of the population is using digital health services. That is possibly because of how we count them or label them on our systems.

I did a bit of digging around and thought that I had found slightly different numbers, but please take them with a pinch of salt. Back in February, there was a suggestion that in general practice some 14% of

consultations were being delivered remotely, but that does not necessarily mean that they were being delivered digitally because, of course, they could simply have been delivered via the telephone. The telephone is something that most people now have access to, whereas the infrastructure associated with remote consulting via video is perhaps less easily accessed by all patients.

It is estimated that up to 85% of consultations are now being delivered remotely. I looked at some of the hospital data. Back in February, some 6% of outpatient consultations were being delivered remotely, which is perhaps a reflection of some of the behaviour change that is needed in hospitals as well as in some of the infrastructure that supports delivery of that way of working. Through the peak of the pandemic, between 44% to 46% of consultations were delivered virtually[1].

Here is a little more on the data. The latest GP appointments data suggest that just over 50% of appointments are being delivered face to face. If we try to draw an inference from that, it is perhaps that, while we have the ability to some extent to deliver consultations remotely, there is a need to see patients face to face. There is care that can be delivered only by examining and seeing a patient face to face. When it comes to framing my response to this question, remote delivery of healthcare has played a huge role over many years, but it is not the end-all.

We cast our minds to telephone and video consultations, but there is actually a whole other programme of work that has gone on behind the scenes. Electronic health records, which general practice pioneered and has led on since the 1980s, are something that hospitals are only just catching up with. The amount of data being held in electronic health records and the ability to draw insights when you harness it is quite important to the delivery of healthcare and the outcomes that we can achieve for our patients.

We have an electronic prescribing service in place which enables us to transfer prescriptions from general practice directly to pharmacies, with the patient not necessarily having to attend a GP surgery to pick up that prescription. We know that it has been running quite successfully, with more than 60 million patients and 96.8% of practices registered. We know that the utilisation rate is just over 85%.

In September alone, and I have looked back at previous months as well, 80 million prescriptions were issued through EPS. That is having a huge change and impact on our patients' lives. Looking at the pre-pandemic levels, we were probably at 60 million or 70 million. So there has been a slight jump through the pandemic but not a dramatic one. I could go on, because there are so many lovely examples specifically in general practice, such as virtual MDTs. You might remember, casting our minds back one or two years, the Axe the Fax programme—to think that

[1] The witness has since clarified that she was referring to remote, rather than virtual, consultations.

hospitals were updating their bed status by faxing the current status of their bed occupancy around.

So while we have had tools for a number of years, perhaps the NHS has been less good at picking up and utilising them to the best benefit of our patients. At this moment we have an advice and guidance programme whereby I can just send off a communication to the secondary care teams, they can respond to me digitally and I can manage that patient remotely. That is all up and running pre-Covid.

We know that NHS 111 offers decision-tree pathways: a patient rings up and a call handler takes them through a decision-tree pathway and gives them a disposition. We might sit here and debate the good and bad of NHS 111, but we know that that technology has supported and helped a wide array of our patients. That is the context. Where the infrastructure has been provided, we have utilised it. The key issue is the infrastructure being provided to the NHS.

The Chair: We will definitely come back to that topic.

Chris McCann: Prior to the pandemic, public feedback suggested that very few people had direct experience of digital appointments, but research that Healthwatch England carried out during 2019, along with our local network of over 125,000 people, showed that there was significant appetite for a greater use of technology to make care easier to access. People from rural communities, who may have long distances to travel to NHS services, and people with long-term conditions were particularly interested in this. People have felt a bit frustrated by the limitations of existing NHS online systems not allowing them to make different types of appointments.

Obviously there were clear concerns about some groups potentially being left behind. There is a belief that a switch to digital could deliver new exclusions. One counterintuitive example that came up is that young people might be comfortable with technology but not in using it for interactions with the NHS. The key thing that we note is that technology is not as important as people receiving personalised care.

On the issue of data sharing, we commissioned a poll in 2018 about data sharing in the NHS. We found that, overall, most people are positive about sharing their patient data. Some 73% of adults told us that they would be happy for the NHS to use their information to improve healthcare treatment for themselves and others. However, we know that the key thing here is public confidence, and that any missteps involving the use of personal data really negatively affect public trust in data sharing.

In terms of the move, we know that, as Dr Jameel said, before Covid-19 roughly 95% of GP appointments were carried out face to face and that during the pandemic that has moved towards 85%.

Dr Pritesh Mistry: Before Covid, the digitalisation of the health and care system was already happening, but the pandemic brought a dramatic

change in scale and pace to that digitalisation. Many colleagues on the panel have already mentioned some of the numbers. It is important to note that the numbers differ depending on the actual locations and the digital maturity—I suppose that is the phrase—of the organisation in question. A recent Health Foundation report shows that in digitally enabled practices in 2019 between March and June approximately 40% of consultations were held face to face, whereas during the pandemic the figure for the same period was 8.5% of appointments.

However, as some of my colleagues have mentioned, the national data show dramatically different numbers. In February 2020, before Covid, 80% of GP appointments were carried out face to face, so you can see that there is a dramatic difference in those numbers depending on location and organisation. Digital providers were potentially disrupting primary care with digital-first services catering to specific demographics and potentially providing better access to specific individuals, tending to skew towards well-informed, educated and potentially younger demographics. Digital was also increasingly being used for health and care services at a slower pace in niche areas in isolated patches.

We have talked a lot about remote consultations and how there may be a confusion about low-tech—telephone compared to video—and how much of that is actually digital. Across the ecosystem, before Covid there were a lot of high-tech developments in robotics for surgical interventions, VR for mental health, apps for health tracking and improving health, and the NHS app development. There was a lot of isolated development; some of it has not progressed and indeed some may even have regressed during Covid, whereas other areas, such as video consultations and prescribing platforms, have accelerated.

As for the impact on people's health, the data pre Covid was very much focused on digital service provision, and a lot of that showed that there was a lot of risk of double contacts, especially in primary care. The medium used, phone consultations and video consultations, had tended to be less information-rich. There were infrastructure issues, with people feeling quite confused or frustrated about connectivity. There is also a potential for high rates of prescribing for antibiotics, with lower-risk thresholds in clinicians.

The Chair: That was a very interesting point about how take-up may have accelerated but innovation and structural transformation may have slowed down. That is an important point to come to. Floella, I do not know if there is anything else you want to ask as part of your question.

Baroness Benjamin: No, thank you, I think they have covered everything.

Q27 **Lord Harris of Haringey:** Thank you very much for those answers. You have addressed some of the points that I wanted to raise about what has changed during Covid in terms of digital technology. In preparation for this session I logged on to my own GP's website last night, partly because the evidence that we have received talks about all these wonderful things

that are available in most GP surgeries, and I was not aware of any of them in mine. Apart from a very stern warning that they were not doing any physical consultations whatever, there was still no indication as to how you might book an appointment online or anything else. I might change my GP.

There were very many interesting points in your answers. I want to get at the extent to which there is a real barrier here to some of the diagnostic things that you might otherwise be doing. If 85% of consultations are delivered remotely, does that lead—I think one of your answers suggested this—to more transactional arrangements whereby essentially this is a communication, and you end up with a prescription that is sent to the pharmacy?

Secondly, how important are the things that you cannot do remotely? Presumably you cannot palpate a lump or listen to someone's chest. There must be a whole number of such things. Is there a concern that things are being missed as a result of this process? I do not know who wants to go first; perhaps Pritesh, because he made me think about the transactional relationship that may grow.

Dr Pritesh Mistry: There are concerns that something will be missed depending on the medium. Ruth mentioned this. There are fewer indicators, depending on the modality of engagement. If it is a phone consultation, you have the audio information. If it is a video consultation, you can see the individual. If it is face to face, you have a different interaction. My clinical colleagues on the panel can expand on that.

There are risks, but the technology also has the potential to improve particular aspects. E-stethoscopes, for example, are now coming into play in healthcare services and are transforming the analysis of some of the indicators that may previously have been audio and which can now be visual. Where there are shortfalls, technology also enables better access and convenience, which means that people who may not be able to access healthcare or who feel isolated from accessing care can now access it. We need to think about the benefits as well as the failures of the technologies.

Dr Farah Jameel: You are right to draw out the anxieties about things that might not get picked up or that might get missed. What do we not see that is not visible in the room because the patient is not with us—the way they have walked, who they have come in with, what the interactions are like, what sort of domestic violence picture is going on behind the screen, what sort of safeguarding issues there might be? Those are all important aspects to take into consideration as part of training, but they are also some of the risks that we need to ensure we address.

I go back to the point that this is one consulting method, but it is not the only one. Clinicians must choose the right consultation method based on patient interaction and transaction and the patient's needs. I can cast my mind back to my clinical experience and remember the number of times I listened to a chest and spotted a mole that I just did not like the look of

which I then sent off for specialist review. The patient never walked in with that and would never have come to me about it. So it is absolutely right to draw out that sort of anxiety and risk.

The other thing to mention is the whole patient behaviour change piece that has taken place through the pandemic. Some of that is purely to do with the pandemic and the public health message that it is dangerous to go out, because the chances are that you might be exposed to an infection. People are scared to go out and to walk into a healthcare setting, so there are delayed presentations. That is not a direct effect of moving to remote consulting methods; that is a Covid effect. We have certainly seen that in the number of cancer referrals, which are slowly creeping back up again but dropped through the peak of the pandemic. A&E attendances also dropped down through the peak of the pandemic, as did admissions into hospitals.

Those are stark figures that we cannot get away from. However, we also have the experience that I have had of sitting with a broken printer with paper stuck inside it and unable to make it work. When we talk about digital and technology, we need to consider the wider implications of ensuring that the right infrastructure is in place. There is a lot that we can deliver remotely, but for the right patient.

Dr Ruth Chambers: What has not been talked about much is patient empowerment. That is done through shared management plans. It has not become universal, but in general practice quite a lot of people have entered into that kind of arrangement—for example, a general practice nurse with a patient with asthma or with chronic obstructive pulmonary disease. If the patient has a device like a pulse oximeter, which is what the Government are offering all areas across England at the moment, it is agreed at what level of their oxygen they take what action. A lot of the patients love that sort of thing.

Along with Pritesh, I got Covid funds across Staffordshire for digital stethoscopes, but they need the skills of the general practitioners or nurses who will operate them, and for you to leave it somewhere. It is all right to have one in your desk, but actually you need it to be where the remote patient is. That means care homes. We have done an awful lot of work across the country, especially in Staffordshire. We have upskilled 100 of our care homes specifically for video consultation, and doing a lot more as well. NHSX did a marvellous pilot of Facebook portals in care settings.

A lot of these things have helped, as we have gone on through Covid, to get us using digital transformation and making it happen in a few months, rather than in a few years as is usually the case. I particularly go for the patient empowerment end of things.

Lord Harris of Haringey: Farah made a point about all the other things that you pick up, including some of the social signals about the circumstances of the patient or other issues in the background. Is there a way of replicating that technologically?

Dr Ruth Chambers: Yes. I am at the moment doing a video consultation module for GPs with the Royal College of General Practitioners, because there is so much that needs to be in the background, such as whether the patient gave consent. In a consultation with someone who lacks cognition, for example, if things start to go wrong during that consultation is it okay for a carer to answer for them? There is so much of that.

Very much at the beginning, in April, Trish Greenhalgh from the University of Oxford, with the digital transformation leads for NHSE, wrote fantastic materials for general practice, and one has just come out for patients. There is all this digital literacy. I have worked locally with refugees, too. We have to be so careful that we do not just go with the easy pickings and that we help patients, and the patients who need the most help are the most difficult to bring on with their digital literacy.

Lord Harris of Haringey: Could I ask Chris to comment from the patient's perspective? What feedback is local Healthwatch getting about how patients have reacted to this? Some people will like it, because it is a lot less trouble for them; they do not have to go somewhere, they do not have to wait, and so on. But at the other extreme there might be people who do not feel that they are getting the service they need. Could you tell us how that has gone, and any other things that have come from the patient's perspective?

Chris McCann: We have done some in-depth interviews on this, and we have found that, for many people, remote consultations offer a convenient option for speaking to a healthcare professional. They appreciate the quicker and more efficient access, not having to travel, less time taken out of the day, and the ability to fit an appointment into their general lives. Most people have felt that they have received adequate care, and more people than not said that they would be happy to continue with consultations being held remotely in future.

I suppose the thing is that it is not one size fits all. Some people would have liked their consultation to be in a different format, and people tended to highlight the need for choice and guidance and setting expectations in advance of appointments, as well as respect for people's boundaries and time in arranging appointments.

Something that is really important is the quality of communication, with a clear message. People were happy with a virtual appointment as long as it did not compromise the quality of the interaction. We have produced texts for healthcare professionals on the kind of things they need to keep in mind when they make virtual consultations or appointments.

It is stuff that might seem common sense, but it includes: making sure that you provide a precise time window; checking that the person will be in a confidential and safe place to have a phone call or a video appointment; understanding that person's level of confidence in using technology; giving people a choice of how to communicate; proactively checking if the patient needs clarifying what happens next and who is

responsible for the next stages of care; slowing down the pace of consultations when they are being done virtually to make sure that you can demonstrate active listening, which can be missing when you are not in the same physical space—that sense of connection; if it is a video call, using the chat function to make the appointment more interactive; potentially sharing links to useful information or summarising the next steps.

Patients are also keen not to be asked to provide information which the healthcare professionals should already have access to, and to be given guidance on how the appointment will work, and offered a demonstration providing an opportunity for a test run or some training if necessary.

I suppose the key thing at the end is to close the loop to make sure that providers seek feedback about people's experiences and use that to continually refine and improve the service.

The Chair: We have jumped forward a bit with the questions. We continue on the theme of patients with a question from Baroness Jay.

Q28 **Baroness Jay of Paddington:** I thank the panel for those very interesting answers. I want to go back to the issues of infrastructure, which some of you raised in your initial answers to the first question. I speak from bitter experience about this, because at one stage I had the unhappy role of Minister in charge of upgrading NHS infrastructure. The problems that were always raised as barriers—I note that you, particularly the BMA, have mentioned barriers again—were patient data, problems with local commissioning, questions about confidentiality and GP management and so on, and particularly the interface between primary and secondary care.

Listening to you, and looking at some of the evidence that we have had, it seems that those are still some of the main problems. How are we going to solve all this? It almost sounds as if we have to have a really direct attempt at trying to nationalise the infrastructure of NHS IT. I think we should start with Farah, because the note the BMA helpfully sent us yesterday raised this issue as a major barrier to improving things.

Dr Farah Jameel: I think it was Pritesh who talked about digital maturity and how experiences are different depending on which part of the system you are in. There are some really positive examples of excellent digital maturity across the NHS and colleagues being able to offer services quite seamlessly, but the majority of our members tell us that simple things like speed, bandwidth, outdated hardware, not having the right software or having outdated software are just not being prioritised, because funding that has been put aside for a rolling upgrade of infrastructure gets taken up by other priorities, as it is not particularly well ring-fenced so does not go on things like training or timely IT support. I talked about my frustrations with a broken printer. Can you imagine me as a clinician every day—this was most days—stuck there, usually with the patient in front of me, I am profusely apologising and saying, "I'm sorry this is

taking so long"? These are not problems that we should be spending our time with, and it is because of outdated IT and outdated infrastructure.

You helpfully pointed out the primary/secondary interface. I will describe what it might look like from a patient's perspective. I have seen a patient in general practice and referred them on to secondary care. Their referral should be with the secondary care team, because now we have a lovely electronic referral system. My understanding is that in some trusts the team responsible will download it off that system, PDF it and upload it on to a different system, and then the consultant might print it off at their end and review the referral. That sounds like an awful lot of steps and a waste of time for a lot of people.

Then the patient is seen in clinic and assessed, and plans are made for them, but the infrastructure in the hospital is such that if my colleague in the hospital wanted to organise prescriptions for them to pick up outside the hospital, they could not. I got stuck like that myself; it took five visits to the hospital to pick up my prescription, which I refused to go to my GP about because I know how busy they are.

Those are some of the wider challenges. Through the pandemic my secondary care colleagues have struggled to organise blood tests electronically, so they have ended up sending letters to general practices saying, "Please could you organise for this patient to have their blood test and this prescription, because I am unable to do it? I've spoken to them remotely or seen them on video, but I'm unable to do it." That is purely down to lacking infrastructure.

Baroness Jay of Paddington: Can we therefore agree that there are terrible problems and that we are trying to think about what the solutions might be? For example, we are hearing about £3 billion more for the NHS in the reorganisation of the public expenditure budget. Should there be a national ring-fenced budget for IT improvement, in which national guidelines are set down so that local hospitals and local commissioning groups are in a sense forced to join in a national programme?

Dr Farah Jameel: That goes without saying, although the response we might get is that some of that already happens. Unfortunately, getting a temperature check from the ground, from staff working, might be a better barometer for the actual infrastructure that is being delivered on the ground. We have colleagues on obsolete Windows 7 systems and we have situations where, as I said, we are still PDF-ing, uploading and downloading documents, which seems absurd when we are talking about interoperability.

We need to go back to the patient. The patient's expectation is that the relevant people within the healthcare system will know what to do and will have access to their records and referrals, and timely information is being shared about them. If we just view it from the patient's point of view, it is obvious what we need to do on funding assignment and priorities.

Baroness Jay of Paddington: I wonder if Pritesh has anything to add, because I know the King's Fund has done work in this area.

Dr Pritesh Mistry: I have a few thoughts. It depends on how you view infrastructure. As Dr Jameel mentioned, infrastructure can be your hardware and your physical kind of plumbing, but it can also be your skills and the capabilities of a system.

There is a definite need to continue to invest in infrastructure, and infrastructure was a problem before Covid. During the pandemic we have seen a lot of simple tools being used for remote consultations, such as telephone and messaging, and that has been particularly impactful. Video consultations have been tried but have not been the majority of contacts that have been made. That is because some of the underlying issues within the system persist; infrastructure has not been upgraded during the pandemic, as you might imagine.

We need to consider how to continue to improve the infrastructure, including skills, at the same rate at which we want to progress the technology uptake. We know what technology road maps will look like. We know what the future, maybe through the global digital exemplars, might look like. So how do we start pulling all these into the same direction of travel to make sure that our infrastructure, skills and capabilities match what our patients expect and what the technology is enabling us to do?

There are potentially other ways in which we can view this. If we look at how estates are upkept in the NHS, we see that they are not particularly well maintained across the healthcare system, and infrastructure within IT needs to be viewed in the same way: it is underpinning architecture, so it needs to have investment and it needs to be maintained. You do not just create the capacity and leave it there; you also need to maintain your systems, otherwise you accrue what we term "technology debt". Effectively you have archaic systems that need to be maintained, and that increases your costs.

One last point: we can continue to invest in NHS infrastructure, but we also need to think about connectivity for the patients. If we have good connectivity within the system but patients cannot connect, that capacity will not be used.

Baroness Jay of Paddington: Does your analogy with architecture involve national budgeting?

Dr Pritesh Mistry: That would need more research. There is infrastructure that is provided by commercial organisations. I am sure there are parallels with the supply of water and electricity, for example. How do you make sure that your regulation and your free market apply to that kind of infrastructure as well?

Dr Ruth Chambers: One of the most important things is for us to have an integrated care record that all the trusts, local authorities and general practices share. In Staffordshire, as an example—we are possibly behind

the times; I think this has been going on across England and the UK—we now have an integrated care record. It has taken two years to get there, and all the different leads in the trusts, the clinical commissioning groups and so on had to agree what data we were sharing. We also have a data-sharing agreement between each practice centrally. That means that more or less three-quarters of anyone's record can now be seen in any of the trusts, which makes an immense difference. So you need the IT that we have been talking about and you need the skills, but you also need that data integrated care record.

We also need the protocols to be shared. I have one local example that I have been the creator of: pulmonary rehabilitation for people with chronic obstructive disease through virtual reality. In Covid times, we cannot go face to face, and they are very needy people who usually need to shield. Now they can have a consultation and access that service with the headset on. We have managed to get the community trusts that normally produce that face-to-face service and the general practices to agree a shared protocol. Again, I see these Covid times as having driven us to start getting more interaction and shared care between trusts and local authorities, and we do the same with the Alexas in general practice.

Q29 **Baroness Jay of Paddington:** My next question follows from what Dr Chambers was just asked. We have heard a great deal about how enthusiastic the medical profession is about expanding IT, but obviously we do not have the same evidence about patients' experience, although I think Chris referred to some of it in his first answer.

I suppose what I really want to ask is whether, although the example that Dr Chambers just gave is very encouraging, you are confident that there will be the sort of personalised developments that will enable shared care, as you explained it, and other offers to patients to be developed technically in a way that will not disadvantage the people who are already the most disadvantaged.

Chris McCann: We are looking into concerns about the risk that a move towards digitisation could lead to the exacerbation of existing inequalities. We know that some people struggle to access virtual appointments, prefer face to face for the rapport and have concerns about getting a correct diagnosis. We also heard about issues of long delays in receiving callbacks or waiting for health professionals to contact them despite having a specific appointment time. We also know that those with mental health concerns in particular have stated that digital support does not always work for them, as they feel it can be a little impersonal and it does not have the same therapeutic effect as face to face.

Through some research that we carried out with National Voices and Traverse during the pandemic, we heard concerns about the risk of people without access to technology receiving poor-quality care and of seeing existing inequalities exacerbated; concerns about that lack of face-to-face time compromising the quality of care and leading to what one patient referred to as concerns about a call-centre approach; and concerns about patients being frustrated when they have to tell their

story multiple times or fill in lengthy forms with information that seemed to be irrelevant.

To hark back to a point that I think Ruth made, National Voices has also highlighted that we need better data on inequality in the digital tech space. We need to know who is using it and how, and who is not and why. This has all moved incredibly quickly during the pandemic. We cannot afford the risk that people will fall through the cracks, so a substantial piece of work needs to be done to investigate this and make sure that that is not happening.

People who we interviewed also told us that they felt that further work was required to engage with people who are not confident with technology or do not have access to it. We are undertaking a follow-up project to better understand the experiences of these groups. We are looking specifically at groups that have previously been identified through research as being at risk of digital exclusion: those from areas of social deprivation, the over-65s, people with disabilities and people with language barriers. We are working across 10 separate areas in England to investigate that, and we hope to publish some findings in April 2021.

Baroness Jay of Paddington: That will be extremely interesting. It is a pity that we cannot see it today, because obviously it touches all the points that we are concerned about.

To go back to what Dr Chambers was saying—you might have something to add, Dr Chambers—what is concerning is that the people who have the worst health problems may be the worst treated in a digital situation.

Dr Ruth Chambers: I agree with that. The recent Ofcom report shows that only half of 75 year-olds go online. Of course, quite a lot of those will go online with their younger children alongside to support them, and that is the kind of thing that we have had to do. We have deployed 400 Alexa Echo Shows to needy people. We have mainly used people like social prescribing leads, which we have not mentioned, who are now set up in primary care networks. They are sometimes called link workers and they are very good at linking between general practice, the voluntary sector and social care. They will often help "buddies". I have a call tomorrow with a befriending service that needs our help with tablets and so on, but they will need buddies to help them. Usually the older people, or people who do not speak English, welcome that help with a carer.

Another example is Facebook. I know that Facebook does not always have the positives that you would expect, but we have set up three-quarters of our general practices—that is, three-quarters of 150 practices across Staffordshire with 1.2 million patients, so 800,000 are covered—with public Facebook pages on general practice sites. We put up animations there on how people with diabetes or high blood pressure could self-manage during Covid, and we have had tens of thousands of views of those animations.

We have to work with people and see what they are prepared to do, rather than dismissing them because they do not have a smartphone. We need to try to find some way around that; usually there is a friend, a loved one or a buddy in their voluntary group who will befriend them and really try to bring them on.

Baroness Jay of Paddington: I do not know who I should ask—perhaps Pritesh—about whether there is any hope that that sort of very careful system could be developed nationally. Is the King's Fund doing anything about the way in which patients' involvement and education can be improved?

Dr Pritesh Mistry: Digital exclusion is a real risk. I refer you to the latest Good Things Foundation report on digital inclusion. They have been doing a lot of work on the ground about how to enable and widen access, particularly in deprived populations.

There is a lot of nuance in this kind of area. We might think of "elderly population" and "socioeconomically deprived" as umbrella terms for these potentially excluded populations, but there is a lot of nuance within them that needs a deeper dive. There are people who are perhaps capable but unwilling because of aspects like data and trust and what these technologies and tools are doing. As we have seen in the pandemic, there has been an erosion of trust, which is particularly important if we want these tools to be taken up at a national level.

There is also the risk that digital exclusion is perpetuating some of the exclusion that we find already in the health and care system in physically delivered care. Chris mentioned language barriers; there are also cultural sensitivities and other such issues that may be replicated in the digital space that have the potential to hardcode some of these challenges in accessing care.

Baroness Jay of Paddington: I think other members of the Committee want to ask specific questions on this issue.

The Chair: We have jumped topics a bit, so I hope colleagues will forgive me. I will come to them, but I will come to Baroness Young first because her questions fit neatly here.

Q30 **Baroness Young of Hornsey:** My question has been partially answered, particularly in Dr Mistry's last response. We were talking about groups that were not necessarily able to engage or access the benefits of digitisation in the health service. You talked about umbrella terms, so I wonder whether we can dig a bit deeper into some of the terms that we are accustomed to using, like "people with disabilities". That covers a huge range of differently abled people and often but not always includes people with learning disabilities. Again, there is a huge range of people in black and minority ethnic groups. How do we get to a stage where we are able to analyse the groups under these umbrella terms and think deeply about how to deliver services principally through digitisation in the future, given what we have learned during the pandemic?

Dr Pritesh Mistry: A lot of this needs to be done through working with the public and our citizens. I am sure that colleagues, especially Chris, will agree that there is a lot of value in co-developing our tools at a local level. How do we start bringing together national procurement and other such levers alongside local-choice, co-development and development in our particular community? It is important to think about local demographic needs, the potential to upskill local citizens to a certain level, and the potential complexity of health conditions, asking how the demographic will progress in the near and long-term future so that we can start planning what the tools need to look like.

We need to be careful about the digital and physical care balance in our healthcare system. Digital will be accessible to some, physical care to others. By bringing them both alongside, we should be able to blend a healthcare system that works for more people than just a physical or digitally enabled system. It is important that we do not have one that is higher-quality, the default or the only care provision approach. We need to think about how we enable pathways to work through both modalities.

There are some things that we may want to have more focus on, such as accessibility features in digital care; for example, enabling people with visual impairment or hearing loss to have at least basic accessibility or good-practice accessibility reinforced by how we procure and ask for technologies to be developed for the healthcare system. To be honest, that can cut both ways. It is not just for patients but for our staff well, and how we can improve accessibility for them.

Baroness Young of Hornsey: I do not want to summarise you falsely, but I take from what you said that we need to think much more about what in other areas we call co-production for staff and patients, wherever they are on the spectrum of accessibility, and perhaps to resist an exclusively top-down solution to these issues.

Dr Pritesh Mistry: I agree. I think it needs a balance between top-down, as in what happens at the national level, and freedom at the local level to work with your local population and demographic. There can be on-the-ground upskilling and community work, but there also needs to be an understanding of your demographics, the proportions of your community, the complexity and how care will be delivered to make sure that the right tools are available.

Baroness Young of Hornsey: Perhaps this is a good moment to ask Chris McGann to say how he sees that working out.

Chris McCann: The focus needs to be on people receiving a personalised service. It is things like making sure that, when we are dealing with a patient who has hearing impairments, we are able show subtitles on video platforms. Things like that are really helpful. When services are designed, commissioned and delivered, the key thing is to ensure that the patient voice is engaged during that process. That happens quite strongly locally.

There is also quite a strong patient voice nationally. An area that we really need to look at is the intermediate area, particularly at the ICS (Integrated Care System) level, where commissioning might be taking place, to make sure that the needs of patients are taken into account through that patient voice to ensure a people-centred approach to care. That is the key to delivering this: making sure that the mechanisms are in place so that those voices can be heard at that level.

Baroness Young of Hornsey: And presumably to get the resources together, because not everybody will have the kind of resources that are needed or even have thought about them.

Chris McCann: Absolutely. As I said, some areas of the country are very strong in integrating the patient voice, but in other areas there is probably a need for extra resource and extra focus on making sure that the voice and the experience of patients are at the centre of how new digital systems are scoped, commissioned and implemented.

Dr Ruth Chambers: I wanted to add a bit of extra colour to what Pritesh was saying. I would call it co-design. The Good Things Foundation report that has just come out, which Pritesh mentioned, describes 25 pathfinders, of which we were one in Stoke-on-Trent. That is what drove us to do the work with refugees and asylum seekers, 1,000 of whom belong to a local organisation. We worked with them to understand the kit they needed as well as the skills, and how they were going to translate five or six different languages. All they needed was a big screen on the wall that could translate into five or six languages while the person was giving their upskilling. We just have to find what is right for the population.

We also use case studies. For instance, we found that an Alexa Echo Show enabled somebody based in Stoke to interact with their daughter based in London. One of them was deaf, so they could sign. She had not spoken to her daughter throughout Covid, but now, just through that cheap screen, she was able to sign, and it made all the difference to their lives. You can show a case study like that to lots of other people around the country and they will do it too. We just need to have these visual ways.

Again on co-design, we are trying to use Alexa Echo Shows at the moment to help a school that has children aged eight to 16 with disabilities—by that, I mean all sorts of disabilities, whether it is learning difficulties, autism or whatever. We have used a couple of children—who happen to be my granddaughters, aged 10 and 12—to do the flashcards that Alexa could use to remind them to do things or to help them to reduce stress. That is another example of co-design.

Dr Farah Jameel: It might be helpful to break it down into things like the ability to buy the tech, the ability to use the tech and the ability to understand the tech—the language piece. I am thinking back to an example, pre Covid, of some web-based delivery of diabetes care. They looked at that platform purely because they were having too many

DNAs—too many patients who did not attend. That was for a variety of reasons, including caring responsibilities and others. By that simple change, there were fewer missed appointments and there was an improvement in overall outcomes and markers of diabetes.

There is something about recognising which pathway might be best supported in being delivered remotely. A lot of what I was hearing was, "Let's get out there, let's test, but let's learn as well and let's ensure that we're utilising the views of the end user in informing and improving the final product". The point was really well made in the last question about social media and its role in amplification of the right key health messages.

I want to go back to something that I saw two years ago. A visually impaired colleague delivered a presentation, and I was moved by how technology allowed him to deliver perhaps one of the best presentations I'd ever heard. He articulated clearly the sort of value that the Alexas were having in his day-to-day life, allowing him to run his business, to seek healthcare and to keep on top of things without looking to somebody else for support. I thought that was an excellent example of technology being an enabler.

The Chair: It is very interesting to think about some of the more positive use cases here. We have focused a bit on the negative, and it is great to hear some of those positive examples.

Q31 **Lord Hain:** Pritesh, as I interpreted it, you said that there had been a big jump in antibiotic prescriptions as a kind of easy resort, which worried me. If you could divide patients between the healthy, the semi-healthy, those who are a bit obese and so on, and the ill, I suppose most of the attention would be on the third category.

However, if we are thinking five years ahead and the big kick that Covid has given to the health system and the care system, what do you think would be best delivered digitally? What will the system look like, and what should it look like? Might you get more GP home visits, for example, to the people who cannot use the service digitally? Might you get a better integration of GP work with the care system, and so on? What would you like it to be like in five years' time, using the digital opportunities but also making sure that the non-digital ones are properly utilised? Where do you think we are going?

Dr Ruth Chambers: One of the big points to remember is the skills mix. When you talked about more GP home visits, I immediately thought, "Oh no, you could need a practice nurse or an advanced nurse practitioner who has a digital stethoscope or a dermoscope with them". The GP would still be in their base because they were not needed, because the nurse, or even a healthcare assistant, could take the biometric measurements such as temperature, and the person could be seen live through a video consultation.

We have too few GPs. I am not trying to protect them, but GPs cost three or four times as much as a nurse, so you need a nurse out there for this

to be doable. However, along with the kit they need the skills and the live streaming, or however they are going to record the interaction. The nurse who is out there at that moment might guess whether someone should have a flu vaccination because they have a cough, but if they have a digital stethoscope on the person's chest, the GP can say, "Oh no, stop there. I can hear phlegm. They have a temperature. I can give them an antibiotic"—I just said "antibiotic" to get you going. Then the person can have their flu vaccination in a couple of weeks.

We have to be very careful with the skills mix and what we can afford in order to make sure that this is sustainable in future. That was just one example.

Lord Hain: Are you saying that there should be a better interaction and mix of skills in local health provision, with nurses being more proactive and patients having direct relationships, or what?

Dr Ruth Chambers: Yes. If doctors cost four times as much as nurses, we need to make sure that the nurses act up to the top of their skills. If, to make it safe, they can do that only on remote live streaming with a supervising consultant if in hospital, or with a GP if at home, that will make our service much more sustainable. It would also stop people being seen twice.

We can also do more rapid care. About three years ago, I did a paper using Flo Telehealth, which is interactive texting. We gave standby medication, which is a steroid and antibiotics, to patients who were ill with chronic obstructive pulmonary disease (COPD) and who had been in hospital a couple of times in previous years. It was very clear, through their plan and the interactive texting they did, when they should start that medication. The results showed that they started two days earlier than they would have done if they had waited to see a GP or a nurse. We found that only two of the 25 people who had been in hospital in winter before went into hospital the next winter, even though they were older and their COPD was worse.

We just need to find the right modes of digital to empower people, whether that is nurses empowering them or healthcare assistants who work for social care, and to have the right oversight so that it can be sustainable.

Lord Hain: Thank you, that was really fascinating. Chris, you mentioned a significant impact on inequality. How would that play into my question about five years ahead?

Chris McCann: The key thing for me is that when you are designing systems you are designing them for everyone. You need to make sure when designing any new digital system that it is as inclusive, legible, readable and accessible as it can be. It is about building towards the user's need, the patient's need. As we know, the people who need the services the most are often the people who find them the hardest to use. That, for me, is a key factor at the very earliest stage, when you are

scoping and designing any sort of new processes or applications that you are intending to implement.

Lord Hain: Farah, can I ask you to respond to Ruth's points about a better mix of the different skills in a GP's surgery using different digital opportunities?

Dr Farah Jameel: I was struck by that, because there is an assumption that using digital models of delivery will free up time, but there is a big if about whether it does. The key thing to bear in mind is that we are currently working in an environment where there are staff shortages, we have fewer hospital beds, and the funding afforded to healthcare is perhaps less than in most other countries around the world. We are feeling that impact in recruitment.

It is exceptionally important to maximise the value of who in the team can best support our patients' care, and even more so now. Our tracker surveys have been telling us that a lot of our colleagues are feeling quite anxious about the coming months, let alone the coming years, in the wake of the pandemic: fatigue, exhaustion, concerns about well-being and morale, concerns about what the staffing shortages will mean for combating waiting lists that have been building up as a result of the pandemic, the ability to cope with just the now—the current non-Covid acute deteriorations and the Covid deteriorations.

Again, it becomes extremely important that we use these tools to allow us to make decisions about triage and where the patient's healthcare needs might best be supported. That could be by directing them to things like self-care, to emergency rooms in hospitals where there is need, to pharmacies, or to another member of our team in general practice.

Over the last few years in general practice, we have been rolling out an expansion of the primary care team. The original aim was to have about 26,000 new members of the workforce by the end of the five-year period—we are in year two and a half at the moment, but the pandemic sort of skews the time continuum—eventually getting up to over 30,000 new members of the workforce team, each of whom, when appropriately supported, trained and kitted out with the right tech, will have the ability to add further value to a patient's care pathway.

Lord Hain: You mentioned pharmacy. I go to Spain quite a lot on holiday, and its pharmacists seem to be much more empowered to be proactive in advice and so on. Do you think we could do that? Would a digital perspective help on that?

Dr Farah Jameel: At the moment, there is a programme called the Community Pharmacy Consultation Service, which has just been rolled out across England. If a patient rings up the general practice setting and it is thought that they could be dealt with appropriately by a pharmacy, they are now triaged back into pharmacy. There is that handing over of responsibility to and upskilling of the pharmacy teams—they are exceptionally skilled, by the way; we have just not tapped into that

resource—recognising the additional value that they can bring to meeting a patient's healthcare needs. Some areas are going further and empowering them with the right policy piece and paperwork to ensure that they can prescribe medication in certain conditions.

So in a very controlled environment with the right support, absolutely, yes. I need to look a little more into the Spanish model, but it sounds intriguing.

Dr Pritesh Mistry: I do not have the figures to hand on the prescribing of antibiotics, but we can provide those. I would not say that it is a dramatic increase, but it is still an increase.

Five years hence, we have the potential to revolutionise how we deliver care. Dr Jameel rightly mentioned some of the challenges that we had before Covid and which perhaps are exacerbated by insufficient numbers of staff, low morale and so on. We may need to rethink how we deliver care and how we use digital to do so.

Lord Hain: What do you think?

Dr Pritesh Mistry: We have not touched upon group consultations, for example, which were getting to be quite popular before Covid, or upon how you support patients to support each other, facilitated by a clinician. How do we start to move some of the dynamics instead of having that whole resource constraint on the healthcare professional, and how do we bring in patients with lived experience and knowledgeable patients to provide care? Ruth has been doing a lot of work on Facebook groups and moderated Facebook groups, which can also support patients to support each other.

There is also a growing evidence base of research into wearables and how they enable patients, or just citizens, to know themselves better, and how that affects how people access care. A lot of what we are seeing with digital right now is a replication of what we do in the physical space. However, software can do a bit more. It can bring data together. How do we enable software that gives people a nudge here and there—"Air pollution or pollen levels are quite high today. Maybe you need to keep an eye on your asthma, because you've been prone to flare-ups at these particular times"?

These are the kinds of nudges that can help people to self-care. There is a lot of potential for self-care, but it tends to be people who are highly educated who know their own healthcare conditions and what flares them up in particular. How do we continue to support software that enables that to broaden out to people who are less health literate?

Dr Ruth Chambers: We tried the closed Facebook groups in the north Staffordshire trust three years ago. All these things tend to be pilots. They are still going strong, but I cannot get the establishment to listen, even though we have proved the case. There were a lot of socially isolated people with multiple sclerosis, for example, even before Covid.

Often their friends are at work and they have disabilities such that it is quite difficult for them to get out on their own if they are getting more severe.

The closed Facebook group really helped, with, as Pritesh said, a nurse posting health messages maybe once or twice a week just to keep it refreshed. However, you always have to have a lot of disclaimers to take care that you are not breaching information governance and General Medical Council stuff. Someone with multiple sclerosis may be married to someone who is commercial who then starts trying to advertise their goods on the close Facebook group, so you have to be very careful to bring it down.

Lord Hain: It would be interesting for us to have something in writing about this.

Dr Ruth Chambers: Yes. Sure. On the point about pharmacies, two or three years ago, and a year ago, I tried to get community pharmacies to do video consultations for medicines use reviews. It was extremely difficult because of how they are paid. A patient is reviewed once a year to see how they are getting on with their medicines, which is very important because, if they have lots of medicines, medicines that have been added on might clash. In the end, the local NHSE agreed that 5%—one in 20—of the medicines use reviews by community pharmacists could be by Skype. That was a favour; otherwise, they were doing it for free. You have to be very careful about the rules that lie behind.

The Chair: Thank you. That is an important point.

Q32 **Lord Alderdice:** I have two questions. One is on efficiency, and the other is on mental health.

On the efficiency question, I was struck by what both Chris and Dr Jameel said about there being a difference between the theory of efficiency and the practice of it. In theory, the patient can have a consultation online or by phone. In practice, they have to ring up to get a full appointment with the GP, which means hanging on. Then the GP, as Chris said, might be delayed in ringing back, so the patient hangs around for half the day for that. Then the GP cannot see the patient, so orders tests which the patient has to go into the health centre to get, sometimes more than once. Then there has to be another arrangement for a telephone appointment, followed by the potential for further tests or for prescription and then going in again to get medication. That is all when, in the first instance, they could have rung up, made an appointment, gone in, done what was necessary, and had fewer tests and fewer visits.

The first question is therefore how much this increased digitisation is creating more efficiency, and how much it is creating more work and more appointments.

The second question is specifically about Covid. There is the increasing problem of people with dementia in general. How much can they use digital systems? They do not remember things, they do not necessarily

know what is going on, and there is a problem. What is beginning to emerge with Covid is that not only do people suffer mental illness but people with mental illness have a worse health outcome than those without.

So are we going to see an increased problem of patients with cognitive difficulties who cannot easily engage with the digital systems? Quite a lot of people who have had asymptomatic Covid are finding subsequent cognitive problems, such as not remembering, not being able to manage with things. Is there an emerging problem there with efficiency and mental function?

The Chair: There was a lot there. Do you want to direct your questions to anybody to start? I remind everyone that we have 30 left but many members who still have questions to ask, so I ask you to be as brief as you can while being effective.

Lord Alderdice: I am interested in Chris's comments, because a lot of this question is about patients, but it would be good to have at least one of the other colleagues respond on the mental health problem.

Chris McCann: The message from Healthwatch is that there should not be a one-size-fits-all solution to this. The key to the successful shift to digital services will be understanding which approach is right for the individual patient. No patients should feel that they are being offered only digital solutions. It is about focusing on the need for people to receive the care that works best for them. For some people that will be digital. For others it will be a combination of communication tools to make sure that we can create a more equal space for patients. For some patients it will still be a face-to-face appointment or consultation.

It is about ensuring that, as we shift towards the increasingly digital live provision of healthcare services, the individuals and patients for whom that is not a suitable solution are still able to access care in the way that works best for them, and that any move towards digitalisation does not exacerbate any existing inequalities or create new ones.

Dr Ruth Chambers: Building on what Chris is saying, we have to find the right way for the right people. We put Facebook portals into care settings for people with dementia. I did not know about those portals before, because I am not very techy, which is very good because then I can see all these things from a naive point of view. The Facebook portals, the Alexas, followed patients around. Someone with dementia does not understand about sitting in front of a screen, like we are doing here, so they would be messing around in my study and the webcam would follow them around. As Chris says, we need to find the right method for the right people. We must be careful.

The other day I came out of a café with a cup of coffee, and a man of about 80 or 85 and not really with it said to me, "Is it cash or card in there?" I said, "Oh, I'm afraid it's card", and he said, "That's it, then. I don't want to use a card". That is in our day-to-day life. I had never

thought before about how we are excluding a lot of the people out there in their 80s from, say, going in and shopping.

Dr Farah Jameel: We cannot stress enough how important it is to get the value proposition right. What are we trying to do? What is the problem or challenge that we are trying to address? We should always have that in the back of our minds when we are designing services to ensure that we do not leave certain groups out.

We have not really talked about some of the insights that can be drawn from things like population health management tools. Again, this is tech software that can support us in identifying patients who are not engaging with services. We are beginning to scrape the surface of that. It will allow us to identify patients who would never have attended GP surgeries or accessed healthcare and are living with illnesses that could easily be supported with the right care.

Q33 **Baroness Morgan of Cotes:** Dr Jameel, that is exactly where we want to go in our next set of questions. In view of the time, I will try to ask very focused questions of particular witnesses.

Building on Peter's point about looking to the future and the adoption of new technologies, I want to start with Pritesh, because I know you have written for the King's Fund on very particular technologies that may offer future solutions. You mentioned wearables, for example. There is a headline in today's *Financial Times*—online, at least—"Smart ambulances and wearables offer route to speedier treatments".

We have talked about video calling, but there are many other technologies out there that offer potential. Could you talk a bit about them? Then we will come on to who is likely to access them and who, as Ruth has found with the cash-versus-card conundrum, would really struggle.

Dr Pritesh Mistry: There is a proliferation of new technologies that could be applied in health and care. We could look at the tools that have already been rolled out and implemented at scale. We talked about video consultations, which are currently replicating physical consultations. One avenue to explore is how you start leveraging the uniquely digital aspects of tools that have already been rolled out. With video consultations, for example, how do you start adding motion tracking so that you can track a person's mobility and quantify it? That would be a unique aspect of digital. There are also things like telephone consultations that can do vocal analysis that then signposts to the patient and takes away some of the admin activities that might happen in the healthcare system itself.

We mentioned wearables. There is a recent *Nature* journal paper on the retrospective analysis of wearable data, looking at people's activity monitoring and how the data shows changes as a precursor for Covid. There are a lot of different technologies out there. Some of the stuff that is very mature and ready for uptake is things like apps for health monitoring, what are termed digital therapeutics, which can provide cognitive behavioural therapy through digital means, and wearables that

can give you a precursor for a deterioration in well-being, which can then be supported through remote monitoring and, as Dr Jameel mentioned, can plug into population health management. The skills which the system needs to be able to interpret and action that, and the capacity in the healthcare system to be able to action it, are all issues that need further evidence and research.

Baroness Morgan of Cotes: Dr Jameel, you have rightly identified the significant pressure on the NHS, which obviously has been exacerbated in 2020 by Covid. One of the long-term agendas will be improving the overall health—the physical health, which we are looking at in particular today, but obviously the mental health too—of the nation. Could some of these new technologies help with that? Do you agree that if we were able to improve the physical health of the nation, that might help to alleviate some of the pressure on the NHS overall? With your insights as a GP, you will see people who are able to embrace these new technologies and those who will really struggle.

Dr Farah Jameel: That speaks to what I was saying earlier about the value proposition. Let us say that we have run some system analysis and we know that we have a problem in our locality with obesity and cardiovascular disease, with a high incidence of strokes. When we have identified that cohort of patients, we can start the target pathways of care that seek to identify such patients earlier, before they even develop the disease or progress further along in it, and introduce simple interventions such as dietary advice and access to health coaching and exercise benefits. That is not something that we will reap the rewards of instantly, so it is very hard to quantify, because we are projecting five, 10 or even 15 years into the future. Unfortunately, Governments and policy do not always look or review as far ahead, which is one of the challenges that we have at times.

Baroness Morgan of Cotes: The Committee is looking for practical recommendations to make to the Government. Would you say that more research and evidence is needed to enable us to look slightly further into the future to invest in technologies now, hoping that we will get those efficiencies in five, 10 or 15 years?

Dr Farah Jameel: We need to break it down into much cruder markers. We have to look at what system benefits can be gained by the application of tech, and what sort of tech. That comes down to things like your population health management tools, the sharing of records across the system and the right infrastructure being made available in all parts of the system so that one contact can do everything for the patient at that moment in time. But then we also need to look at what the proposition needs to look like for the individual. For a patient with a specific health need, what sort of support, advice and digital healthcare tools are necessary? If you start to break the question down into those sorts of stratifications, those segmented pieces will start to articulate a bit more clearly what exactly we need.

Dr Ruth Chambers: I would like to give a couple of examples of wearable technology where you will immediately say, "Oh yeah". We worked with the local cardiac rehabilitation service for people who have had a heart attack recently, and we bought them 80 Fitbits. Now we are in Covid times, so the programme has had to stop just at this very minute, but they had 20 people on follow-up, times four, in the group. They showed them exercises and how to watch cardiac exercises on video when they were at home. They had the Fitbits so they could monitor their heart rate when they were doing those exercises so they did not overstrain themselves. That was a good and simple solution. Fitbits are quite cheap and lots of people have them. They might not have been using them for that purpose, but they could use them to follow up for cardiac rehabilitation.

We have also given out 400 AliveCors to general practices, and helped local hospital cardiac nurses. The hospital would not listen to them, but we have given them some AliveCors to post to the patients who they are supposed to be following up to find out if they have an irregular heart rate—atrial fibrillation. The patients have borrowed the AliveCor for two weeks; they have been putting their thumbs on it for 30 seconds here and there to see whether they have atrial fibrillation. There has been a good take-up. I would price a stroke up as £30,000, which is common with atrial fibrillation, either because of their hospital stay and the fact that they have lost their job or because people are looking after them. That is what we have saved the country. It is easy to price up how these wearables, if we were to target them at scale, could save the resources of the NHS.

Baroness Morgan of Cotes: Thank you. Chris, you talked earlier about data gathering. Obviously, the wearables gather lots of data, as does a lot of tech. Is there anything you wanted to add about patients' attitudes to their data being gathered and, as Dr Jameel talked about, harnessed for the benefit of themselves and, one hopes, everybody?

Chris McCann: We commissioned some research back in 2018 on people's attitudes towards data sharing in the NHS. We found that, by and large, people are positive about sharing their data, with 73% of adults telling us that they were happy for the NHS to use their information to improve the healthcare of others. People are happy for their data to be used, but the big caveat is that we have to make sure that they feel confident that their data is secure, because any missteps that involve the misuse of personal data have a substantially negative effect on public sentiment regarding data sharing. As long as we have the right safeguards in place, the public are by and large happy for their data to be used.

Baroness Morgan of Cotes: Does Healthwatch think that the NHS has those safeguards in place?

Chris McCann: The NHS has done a lot of work on making sure that it has the right provisions in place, and it continues to do so, but we can never rest on our laurels. We know, for instance, that lots of legacy tech

in the NHS presents a risk. NHSX has a close eye on that. We continue to engage with it on data issues, such as the data approach to the Covid-19 app. We definitely think that it is moving in the right place.

Dr Pritesh Mistry: The data and the trust are a key issue. We need to engage patients at a local level. The King's Fund has done work with Understanding Patient Data and there is a lot of research in this area. We have collaborated on the OneLondon deliberation. There are expectations that need to be implemented in data agreements, and transparency needs to come through at public level so that they can have trust in how technology is used.

Baroness Young of Hornsey: We talked about designing a system that is good for everyone, but we also have to recognise specificity of particular groups. A key issue to come out of the pandemic was that people of west African or south Asian heritage fared poorly. As many staff in the NHS have those backgrounds, it is particularly important to be able to address that.

On digitisation and the movement to online diagnoses and so on, what are the pitfalls, and what is the potential, specifically with regard to those groups? This is not about accessibility; it is about how we can mitigate some of the damaging factors that brought about this particular situation during the pandemic.

Dr Pritesh Mistry: The underlying issue that we need to remember and investigate further is how digital tools can enable better access to the right healthcare professionals for people of ethnic minorities. With physical care at the moment, a lot of information is given out that is not culturally sensitised or translated. The risk is that we continue to do that in the digital realm. Currently in the physical realm, we find that local organisations will translate the information. However, when care or a diagnosis is delivered through an app or means of that kind, there is the potential to hardcode some of these barriers. Thinking beyond the simpler tools associated with online consultation and along the lines of diagnosis, we need to make sure that the algorithms and software for digitally driven healthcare systems trained to be representative of the population or the people you are treating and diagnosing, otherwise the errors may be higher and may cause misdiagnosis. We need more research, more evidence and more understanding of how we reinforce tools to be appropriate for the people we are treating.

Baroness Young of Hornsey: You will be aware, I am sure, that cameras in general but also things like facial recognition software are notoriously poor when it comes to black people's faces. This is of concern if we move to online diagnosis. What is happening on that?

Dr Pritesh Mistry: I am afraid that I do not have much information on what is happening to try to rectify that. I am aware that there have been a lot of mishaps, for example with Google and its facial recognition algorithms. I believe that there would need to be more research and evidence on how we quantify this in the healthcare system, maybe

through auditing tools or quality control tools. Maybe there is something about the user interface: how does the clinician know that for this patient that tool is appropriate?

There will be such a proliferation of tools. It goes back to what I was saying about what happens at a national level happens at a local level, and what happens with training to make sure that a clinician is confident that the tools that are being used are the best for a particular individual.

Dr Farah Jameel: I apologise. You might have to repeat the question because I had some connection problems.

Baroness Young of Hornsey: In summary, we witnessed horrible overrepresentation of black and minority-ethnic people among fatalities during the pandemic. What can we do in future? How can we harness some of the benefits of digitisation to ensure that that situation is not repeated? What do we need to put in place to mitigate some of those factors? This is not about accessibility.

Dr Farah Jameel: That is such a pertinent and important question, because, guess what, we have the tools to tell us these things now and provide us with these insights. What we did not know at the time, because it was a new virus, was how Covid might have a disproportionate effect on certain characteristics of a patient's demographic, on conditions that they are inherently more prone to and on their ethnic profile. We know that now, which means that we can run the right searches and provide the right advice. We can risk-assess our patients and allow them to make informed decisions. That is what tech allows us to do very quickly. The role of tech is determined by the information that we have about new, emerging diseases, and that is sometimes not apparent right at the start.

We have some examples of the scale of error that is sometimes built into digital tools. A few years ago, we had a cure risk tool which essentially allowed us to assess a patient's risk, perhaps in relation to the use of statins to prevent a disease or reduce its prevalence[2]. We know that when the tool was designed it was perhaps incorrectly programmed, so it underestimated or overestimated—it did both, actually—for different groups of patients. That may or may not have had an impact on patient outcomes.

Previously, when we relied on a clinician or a healthcare worker, the scale of error was perhaps limited to a few handfuls or a few hundred—I dread to reference Dr Shipman—but these things come to light very quickly because the scale of human error is noticeable over time. However, the scale for digital error when deploying such tools means that many

[2] The witness has since clarified that this sentence should read as "a few years ago, we identified an error with a commonly used Qrisk tool which essentially allows us to assess a patient's risk of developing a heart attack or a stroke, it supports clinicians to make decisions about the use of statins to prevent a disease or reduce its prevalence".

thousands, even millions, of lives can be impacted if it has not been deployed correctly, and extremely fast.

We need to be cognisant of the impact of error that is programmable into the use of such digital tools, but we also need to recognise that it is because of the use of these tools that we have the ability, for instance, to draw up overnight a list of shielded patients who need to shield and then later finesse that list into what is now the clinically extremely vulnerable patients list.

The Chair: Thank you, that is a great example.

Q34 **Baroness Chisholm of Owlpen:** I want to concentrate on health professionals. The Topol review said that digital literacy is as important as the education and training of those at the start of their careers. Too much at present is self-taught. We certainly know that among healthcare professionals there is a saying: "See one, do one, teach one." What impact has the move towards offering more services digitally had on the staff? Is the NHS prepared for a more digital future? What needs to be done to allow healthcare professionals the confidence required for a more digital future post Covid?

Dr Ruth Chambers: I have been running a digital upskilling programme across England. NHS England's general practice nursing transformation team liked what we did in Staffordshire so much that they asked us to run cohorts across England. They tend to be about implementation, not theory, so by the end of the programme each nurse will be able to use apps, social media or video consultation.

When the data came out showing that in September only 0.5% of GP appointments were video consultations, we electronically surveyed all the 400 or so people who had been on our courses over the previous 18 months to two years—when Pritesh was at the Royal College of GPs, he helped with the evaluation—and we found that 75% were doing video consultation. That just shows you: 0.5% is the usual figure for video consultation when people do not have the skills or confidence—we call it confidence, but you could say capability—but the figure is 75% when they do.

We then offered to do the programme for social workers, which we are doing at the moment, and for social prescribers, who are just lapping it up. Health Education England is pushing on this at the moment following the Topol report—I am using a self-assessment digital literacy skill tool tomorrow—so it is pushing at it in ways that it hopes to get on scale, which is critical.

Dr Farah Jameel: Our members tell us that training is a huge problem. Training in the use of simple tech, the day-to-day stuff that we use, is put to one side: you sit in a quiet place and complete a module, and then just crack on with it. If I cast my mind back to when I was learning as a GP trainee, I had exposure to one system, but actually there are four key GP systems out there. Using it is very different from being able to draw

helpful insights, to be able to gain maximum support and advice and derive the best out of that system.

We do ourselves a disservice by not prioritising training in the use of such systems. There really needs to be a rolling programme. Again, I have so many examples; we have examples of errors because there was no rolling programme of training, so things were missed. There was a folder of letters just sitting there with thousands of letters accumulating, because there was no rolling programme of training.

We need to simplify things like standards. Every day, every month, there are new standards. Where I add most value is with my clinician's hat on, and if I am sitting there trying to keep up to date with standards because I will be held legally liable, because that is the way the system is set up, that is a problem that we need to try to tackle quickly. A takeaway for me would be prioritising a rolling programme of up-to-date training.

Q35 **Lord Pickles:** This has been an extraordinarily interesting session. I have two very simple questions because of time. The first builds on the last point about a rolling programme of training. I ask Dr Chambers, a self-confessed technophobe: will there be a basic level of understanding of digital electronic medicine for doctors, nurses and receptionists? Do you think there is a need for a basic understanding?

Dr Ruth Chambers: Usually it is about giving them the confidence that what they are already doing in their personal life they can do in their professional life. The next stage is engaging with patients in such a way that they do not put them off and can say, "Come on, let me just show you this video of how you should be taking your inhaler, and then you can match what you're doing against it at home."

They have to have the skills to engage with patients as well as to be more confident themselves. To be honest, although we have had learning sets over a two-month or three-month period, it probably needs only one hour of upskilling, but they have to understand all the information governance and regulations on getting people's consent, privacy and security if they are doing video consultation and so on.

Lord Pickles: I think that throughout this very interesting session there has been an assumption that it is about trying to coax the patient into accepting digital medicine and getting used to appearing on screen, but what about the doctors? I cannot believe that Lord Harris's experience with his surgery is unique. You cannot contact my own surgery by email; it has disconnected the ability to get hold of it on the NHS app. The only thing you can do is ring them up, and when I have to do that I have visions of my mother 60 years ago, stood in a public telephone booth for 20 minutes with a handful of change trying to get through. That raises the question: are patients entitled to a basic level of service and connectivity from practices?

Dr Farah Jameel: Thank you for that question. You are right to ask whether patients are entitled to a basic level. That is certainly something

that we have been discussing and agreeing as part of annual contract negotiations. All patients should be able to access certain minimum requirements out of their practice.

There is currently a move to go even further. Digital-first primary care is a way forward that NHS England is trying to progress: that is, if a patient wants to access healthcare, they present to their GP surgery website and are directed from there to book an appointment. Twenty-five per cent of all appointments available in a GP practice should be available for online booking.

Obviously, things are slightly different right now because of the whole post-wave 1, now wave 2, where we have had to prioritise which appointments are made available and how they can be accessed. Practices will be doing something slightly different depending on local circumstances. However, patients should be able to book appointments online—if they want to; it is not the only way.

There should be a minimum level of access to records. All patients should be able to access their detailed, coded record if they would like to. If they want to go further, they should be able to access their GP record. They need to have a discussion with their GP about what safe access might look like, depending on information contained in the health record.

Lord Pickles: I would be quite happy for people to write in about this, but I think that it is important to have a basic right to be able to contact your GP.

Dr Pritesh Mistry: We have some work that we hope to publish by the end of this calendar year reflecting on how teams were working remotely in the healthcare system. When we talk about the digital skills of healthcare staff, we need also to consider leadership skills: how do you lead and support your team when they are working remotely? The research has found a potential to revert hierarchical and siloed working as well.

The Chair: Eric, did you want to add anything else?

Lord Pickles: No, I think that time has beaten us.

Q36 **The Chair:** Unfortunately, it has. I am keen to have one final remark from all of you on a single policy recommendation that you would like to get into our heads. I am conscious that we have had a very wide-ranging discussion.

I remind you that we are trying to focus on the long-term implications of Covid specifically for economic and social well-being. Are there one or two specific policy recommendations that you would like to get into the Committee's minds in that framing around economic and social well-being? Eric spoke about the right of patients to be able contact their GP in certain ways.

I am extremely struck by the wide-ranging comments that you have

made, but a lot of you have mentioned corporates, Facebook groups, Alexa and Fitbits in particular. That is a theme that we have not quite managed to pick up, and I am interested in that relationship between public and private.

Putting that aside for a second, can you make one or two specific policy recommendations in the last five minutes? That would be extremely helpful for us. I ask you to be brief.

Chris McCann: This has happened very quickly. Covid has supercharged the speed of moves towards digitisation. More needs to be done to understand what has happened. An important message for us is that there is no one-size-fits-all solution. The key to a successful shift to digital services will be understanding which approach is the right one based on individual need and circumstance. By focusing on the needs of people receiving care, refusing to compromise on quality and using a combination of tools, we can create a more equal space for healthcare providers and patients to interact. This will always mean that a variety of options needs to be in place, including face-to-face appointments, so that people's preferences and needs are met. Healthcare providers will need to adapt to a more blended approach to communication with patients if we are to meet patient needs as we move forward.

Dr Ruth Chambers: I am not quite sure whether you would call this a policy statement. For me, it is about making shared care happen: that is, shared care between the clinician and patient so that the patient understands, can be more empowered and can take more responsibility. Shared care is also between primary and secondary care and social care. It means seeing a person holistically, and there should be a shared management plan.

Dr Pritesh Mistry: My recommendations would be digital health being considered a key component of healthcare provision and not as a replacement for traditional care. Physical and digital care should be given equal importance. There should be fair funding and equal emphasis on quality. We talked earlier about ensuring the maintenance and improvement of digital infrastructure, so a recommendation would be that this is tackled. We also need to look more deeply at how we may be exacerbating inequalities and exclusion, and how we mitigate that through digital means.

Dr Farah Jameel: Fixing the fundamentals has to be a key message. We must take stock of the digital and IT estate which the NHS is currently working with and address some of the inherent inequalities in it. I would go further and say that any adoption of the role that tech can play needs to be incorporated into and interpreted in policy. That is so important. Half the time, policy just does not follow it.

The future is already here. From this day on, we have more and more people coming online who are digitally enabled. Digital literacy is increasing. The problem is that it is not evenly distributed. That is an inherent risk that we need to address and find a solution for.

The Chair: Great. That is a really helpful note to end on. I thank all our witnesses. This has been such a wide-ranging discussion. We could have talked for another two hours. I know that my colleagues will have lots of other thoughts. As Lord Pickles said, it would be immensely helpful to have something from you in writing if you felt that you wanted to write anything in addition for the Committee.

You heard the tone of some of the questions and can see where we are going. We would certainly be interested in your thoughts about the future and what those models look like. I was struck by the fact that many of you talked about the hybrid nature of healthcare in the future, both digital and non-digital but also public and private and how that interacts. We would be interested to hear anything else that you feel you have not managed to get to today. If you have time, please submit evidence to us; we would be extremely grateful.

All that remains for me to do now is to thank you very much from all of us for your time and patience with all our questions, and to draw this meeting to a close.