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Capturing clinical innovations - BMA Submission

Dear Ms Hassell,

Further to the letter published by Prof Stephen Powis and Hugh McCaughey on 27th May, please find attached a submission from the BMA in response to the four questions asked on capturing clinical innovations.

Unfortunately, our answers were incompatible with the online form but I hope that this format is also acceptable and can be taken into account.

Yours sincerely

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Capturing clinical innovations: The BMA's emerging thoughts

This submission is not intended as a comprehensive list of the changes and innovations, both positive and negative, that have arisen in response to the Covid-19 pandemic. Rather, it is an overview of the emerging findings of the BMA's own research and the initial thoughts of our members and the BMA's Patient Liaison Group. The points made here reflect that and do not represent our final views on the merits and demerits of respective innovations and changes, which remain subject to change as the pandemic progresses and further analysis of the responses to it are carried out.

We hope to continue a constructive dialogue on this issue and to be involved in any future conversations relating to it.

1. What beneficial innovations/changes have occurred in your specialty and within patient pathways?

Telephone and video consulting technology

While not seen as an ideal solution for all patients, the rapid increase in the use of telephone and video consulting technology has largely been accepted by clinicians as a positive change in response to Covid-19. It is seen as a necessary step taken in order to both protect patients and staff and to support social distancing in the short term, and one which has the capacity to provide potentially significant advantages in the long term. However, our members are clear that remote consultations are not necessarily faster or less time consuming than face to face appointments and that, therefore, they should not be considered as a more efficient model.

This change has been especially prominent in general practice, where use of remote consultations was adopted at pace following the outset of the pandemic. Practices moved to a 'digital front door' model and to delivering a significant number of consultations by telephone or online (asynchronous or video). Face-to-face consultations, either in the practice or at home, have only been undertaken when clinically necessary. Remote access to GPs has been beneficial to patients who would struggle to attend GP surgeries and has been key to ensuring continued access to care while reducing the risk of transmission for both doctors and patients.

Hospitals have also utilised video and telephone consultations to positive effect, most prominently in order to provide remote outpatient appointments. This approach has been welcomed, where considered clinically suitable, as a means of reducing the need for patients to travel to hospital.

Online learning

Our members, including junior doctors, medical students and clinical academics, have fed back that the fundamental structures of medical education have been affected as the use of online learning has expanded rapidly. This has been broadly beneficial for many of our members,

enabling them to learn from home instead of at regional centres as before - which often requires significant amounts of travel.

Integration of clinical academics into practice

The integration of clinical academics into practice has allowed for the development of new protocols which, in turn, have managed to mitigate some of the impact of Covid-19. One area, where academic respiratory physicians and academic geriatricians were integrated into the local response to the pandemic, saw a particularly low mortality rate per admissions and was able to avoid many of the severe problems faced by nursing homes seen in much of the country.

Regulatory or contractual requirements

The reduction in, and absence of, much of the regulatory or contractual requirements that were previously placed on GPs has enabled them to lead the fundamental changes to way general practice operates. The removal of layers of bureaucracy have empowered GPs and allowed them to work in an environment that has actively encouraged problem solving and the use of clinically led solutions to the problems posed by Covid-19. This is one of the core points highlighted in the BMA's General Practitioners Committee recently published [*Trust GPs to lead: learning from the response to COVID-19 within general practice in England.*](#)

One such example is the founding CCR (Covid Crisis Rescue) by one London out of hours GP, after they felt local CCGs and NHS bodies were not responding quickly to the needs of local clinicians and patients. A voluntary initiative, CCR has spearheaded a number of programs within the capital designed to support both doctors and patients during the pandemic since it was launched in March. These include sourcing and distributing 40,000 pieces of PPE - including masks, gowns, visors and gloves, as well as partnering with a taxi firm to set up a dedicated 'COVID cab service' to allow patients without personal transport to attend Covid 'hot hubs'.

Doctors' wellbeing

The overall impact of the pandemic on doctors' wellbeing has been significant, with a recent BMA survey in June 2020 finding that when asked if they are currently suffering from any of depression, anxiety, stress, burnout, emotional distress or other mental health condition relating to or made worse by their work, 32% said "yes, and worse during this pandemic than before", with another 13% saying "yes, but no worse than before the pandemic". This makes it especially important that we identify and where possible retain any positive changes that have taken place over the last few months.

Several positive changes have been identified in respect of support for doctors' wellbeing in response to the pandemic, some of which we believe ought to be retained. These include the provision of free parking for staff, which has been a longstanding issue for NHS workers, as well as the availability of free meals during shifts and the issuing of scrubs to all doctors. These three changes have been cited by our members as important steps to help improve morale and the daily working lives of staff.

Care pathways and improving patient flow

Our members have highlighted innovations which could improve flow through clinics. One has been the widespread use of the Hear Glue Ear app for children with glue ear, to help patients while grommet operations have been unavailable. A fast tracked COVID research study has also been introduced in one area to provide bone conduction headphones to support children with hearing loss from glue ear. These headphones can be sent by post to families with follow up support offered by video consultation. Research outcomes will look at long term acceptability and quality of life but, if suitable, this approach could be adopted to support children who are unable to access grommet operations for long periods.

2. Please describe the impact of these innovations/ changes (e.g. population health outcome, patient outcome, safety, wider system, efficiency, productivity). How did you measure the benefit?

The full impact of innovations taking place since the beginning of the pandemic are unlikely to become clear until more time has passed, but in relation to the points made above we would point to the following:

- Measuring the overall effectiveness of **telephone and video consultations** is pivotal if they are to be adopted at-scale. It will be important to assess whether remote consultations are effective for the majority of patients and how they impact outcomes for potentially vulnerable patients - including those who may be less adept at using technology, have limited health literacy, or are less confident in asking questions of clinicians.
- Assessing the impact of any innovations on the **quality of patient experience** is essential and should be central to determining their efficacy and long-term suitability.
- Both examples cited for **paediatric audiology** were established as research studies in order to answer a clinical question and to measure and report on outcomes, therefore their overall benefit is still being measured.

3. What is needed to sustain the change?

- Wider adoption and endorsement are needed if many innovations are to be embedded in the long term. This requires a concerted and proactive effort on the part of health and care systems, NHSE/I's regional teams, and national bodies to share good practice and positive change.
- Changes and innovations should not, however, be embedded without further evidence of their efficacy and proof that their **benefits can be sustained** - measured by, for example, clinical efficacy, equitable impact assessments, patient experience, patient feedback, and others, over time and in more typical working circumstances.
- Throughout this pandemic NHS staff have shown that, when empowered to do so, they can deliver fundamental change in very little time. Clinicians need to be given the **freedom to innovate** without artificial targets and central micro-management, so that they can continue to develop new solutions to the various crises presently facing the

NHS. This freedom should include a revised approach to **regulation and bureaucracy** that frees up clinician time to both care for patients and to innovate.

- It is essential that **digital and technological support** for practices, hospitals, and community services is increased if widespread use of remote consultations is to be a successful long-term innovation. This means additional investment is needed in software, hardware, and other equipment, as well as in training and support.
- In respect of **online learning** and **telephone and video** consultations, adequate provision of equipment and/or access to the appropriate online facilities – for patients and their families, as well as for the doctors – is essential.
- If any innovations are to be sustained, the **confidence of the public and patients** in them is essential. Without public confidence either in knowing how to access the service, or in being comfortable with their experience of care, the healthcare system is unlikely to function effectively.

4. What, if anything, hasn't worked so well?

- It is critical to remember that many of the innovations seen during the pandemic have been developed by clinicians carrying out research on top of their existing and pivotal role of providing care. Relying on the goodwill of dedicated staff wanting to answer an important clinical question is neither a sustainable nor a desirable approach. If innovations are to be captured and embedded in the long-term, **incentives and funding** must be made available for the necessary research and studies.
- National **Covid-19 guidelines**, relating to testing, PPE, and public activity, have understandably changed several times as we have learnt more about the pandemic and its transmission. However, the timing, nature, and communication of these changes has often made it difficult for NHS staff and the public to keep up with and implement current guidelines. Many guidelines also had updates which contradicted previous versions, generating further confusion amongst the public and, in some cases, NHS staff. In future, guidelines must be as consistent and thoroughly planned as possible.
- In practice, **PPE** arrived significantly later than promised by governments that have frequently been out-of-touch with the realities of the pandemic on the ground. Moreover, the distribution of that PPE often appeared not to be informed by the data being collected.
- Issues with the **technology and IT equipment** provided have hindered the roll out of new practices in some instances. For example, laptops provided to some GP practices had screens too small to load an entire eKIS summary at once – meaning that clinicians could write notes but not save them. This rendered the laptops effectively useless for this purpose without the additional purchase – and expense – of additional auxiliary screens. General practice was also not able to make full use of locum GP capacity owing to the fact that they are not registered to a practice and thus did not always qualify for the hardware and software needed to carry out remote consultations. Even

where they had adequate personal hardware, it was difficult to configure the necessary permissions and software needed. In future, ensuring that the equipment provided is fit for purpose will facilitate its appropriate use and avoid unnecessary future spending to correct deficiencies.

- Potentially **vulnerable patients** who may struggle to use remote consultations, may have been disadvantaged by the wholesale movement to phone/video consulting. GPs have done all they can to continue to offer in-person appointments to these groups but, given that many may have been sheltering as instructed, or reluctant to travel for other reasons, the overarching system has failed to provide equitable opportunities to all patients.
- **Test and trace** processes have been implemented in great haste, with confusion and frequently poor processes. Outsourcing data gathering and management to large private companies has hampered effective and timely local response to new cases and increased the likelihood of disease spread and local outbreaks.