

BMA Northern Ireland response to *Turning the Digital Dial*

For the attention of Eddie Ritson and Claire Buchner

Introduction

BMA Northern Ireland is pleased to respond to Digital Health & Care Northern Ireland's green paper *Turning the Dial: Enabling Technology Enabled Care*. Whilst noting that the green paper is not a formal consultation, given the importance of the topic and the BMA's views on this issue, we determined to submit a substantive response.

The British Medical Association (BMA) is an apolitical independent trade union and professional association representing doctors and medical students from all branches of medicine across the UK. Our mission is we look after doctors so they can look after you.

Our response focuses on three main issues: using a common assessment framework to help identify the problems we are trying to solve with technology enabled care (TEC), the question of the primary/secondary care divide and care pathways, and the issue of innovating within already strained IT infrastructure. The response reflects in particular the contributions of the Northern Ireland GP committee and the 2022 BMA report *Getting IT Right: the case for urgent investment in safe, modern technology and data sharing in the UK's health services*.¹

¹ <https://www.bma.org.uk/media/6578/bma-infrastructure-2-report-getting-it-right-dec-2022.pdf>

National director (Northern Ireland): Claire Armstrong

Co-chief executive officers: Neeta Major & Rachel Podolak

Registered as a Company limited by Guarantee. Registered No. 8848 England.
Registered office: BMA House, Tavistock Square, London, WC1H 9JP.
Listed as a Trade Union under the Trade Union and Labour Relations Act 1974



Defining the question: the need for a common assessment framework

Discussions of technology enabled care are not new. No clinician would dispute the role that digital technology will have in healthcare in the future. The 2022–2030 digital strategy,² succeeding the 2016 eHealth and Care Strategy,³ demonstrates this in defining ‘intelligent use of data [which] will optimise performance and harness population health insights, whilst ensuring robust data protection standards’ as one of its 6 core strategic outcomes.

We feel that the emphasis in the green paper is the wrong one to enable a productive conversation on the topic of TEC’s role in healthcare in Northern Ireland. The paper posits TEC both as an inevitability and as an end in itself. Although it states its aim to be that of ‘a catalyst to thinking differently about the needs of patients, clients and their carers’, we find the patient (and clinician) curiously absent in the paper’s discussion of the role of remote monitoring and technology in care.

We do not argue that TEC *does not* have a role but we strongly urge DHCNI to frame questions around the role of technology squarely in terms of the problem that is being solved. We do not mean this solely on a system level as the paper clearly articulates – self-management of conditions, reducing hospital admissions, enabling data-driven clinical decisions – but also on a case-by-case basis: how will TEC enable better care of a patient or better management of their health?

To do otherwise risks identifying a solution in search of a problem. We have seen this approach fail before in the HSC: unused cardiac event monitors and iPod touches for dermatology patients are only two recent examples. If we don’t take a problem-centred approach to determining the direction of travel on TEC, we risk wasting further capital investment on technology that is not yet tightly knit into existing infrastructure and care pathways.

A guaranteed feature of technology is that it evolves continually. Many GPs will have had their first experience of remote consultations as a consequence of the coronavirus pandemic, but many will also be familiar with this technology through a private company’s business development strategy. Software providers have for some time issued free licenses for clinical software solutions on a ‘freemium’ model, with other features or elements of the software family only available with subscription. It is worth considering whether DHCNI risks promoting technology that GPs would not pay for themselves.

Therefore, an important question to pose – which is not posed in the green paper – is how to assess new technologies for health (including those mentioned explicitly in the paper) for suitability. In any discussion of TEC, we call first for the development of a common assessment framework by which to judge each initiative on a case-by-case basis before routine implementation. Some technology is unequivocally useful; for some the case is less clear. A common assessment framework will allow the health service and clinicians to make informed judgements about TEC alongside other options for care in a robust, methodical manner.

Primary care, secondary care, and care pathways

The green paper does not explicitly set out DHCNI’s thinking on the different application of TEC in primary and secondary care settings. However, this will be a vital area to examine as the role of monitoring equipment, to take one example, increases in patient care. Will blood pressure and heart monitoring data be sent directly to the consultant cardiologist for a patient with a heart condition or

² <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-hscni-digital-strategy-final.pdf>

³ <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/interactive-ehealth-strategy.pdf>

will this be sent via their GP? Which doctor will be responsible for monitoring the general health of the patient via these metrics and recommending appropriate action when data shows issues of concern?

Without exploring and defining the different roles of primary and secondary care in the use of TEC we risk duplication of effort, conflict of responsibility and, worse, mistakes in patient care. Other areas we address in this response – ePrescribing and interoperability – play a role in mitigating this but so too does clearly defined areas of responsibility and care pathways, particularly in areas where the data collected may be wide-ranging, as in the example of wearables in the paper.

In addition, the patient safety framework in Northern Ireland is not fit for purpose and is unable to capture even the basic necessary metrics. We are concerned that slotting in TEC with no clear accountability or clinical governance frameworks in place will not only increase the risks for patients but will expose doctors to unnecessary risk as well.

Failing to adequately address these points also leads to a real risk of an industry based on data collection with very little clinical application. We are not working within a system that has that luxury and although this model of care may be in the interests of private healthcare companies that wish to sell the technologies that would be used, it does not directly follow that this is in the interests of clinicians or patients, nor that it delivers higher quality care.

Crucially, it must be clear in the use of TEC how the use of the technology will result in different care choices or lower workload than traditional methods. It cannot become the responsibility of clinicians to trawl through data provided by an at-home medical device to spot a possible concern – this is not a good use of specialist time. Although we note that the paper does not mention the role of artificial intelligence (something which surely now must be part of any discussion of future technology) it is also doubtful that it would be acceptable to outsource this data monitoring to AI, even when this is possible. Appropriately defining the role of data monitoring and resourcing this task are important considerations that are lacking from the green paper. Equally, if the conclusion of any concerning data is simply ‘refer to GP’ then it is unclear how technological interventions have improved patient care.

Priorities: interoperability and ePrescribing

Discussion of ambitious new technology without a plan to address the creaking digital infrastructure already in place in the HSC is akin to attempting to repair the roof during a downpour. Indeed, TEC will not function as intended, and may cause harm, if the chronic underinvestment in general IT systems and in interoperability, particularly between primary and secondary care, are not addressed first.

The BMA’s report *Getting IT Right* sets out our detailed views on the role of digital solutions in the health service and sets out what we think needs to urgently change to enable better digital implementation, infrastructure and care. In that report we note that

offering remote consultations – and wider digital transformation – has been more feasible for some parts of the system than others. [...] Whilst digital transformation in health continues at pace [...] the scale of transformation within healthcare services is impeded by an outdated, archaic IT estate. [...] So, while the majority of secondary care doctors responding to our survey agreed that the remote monitoring of patients will be a key feature of delivering care in the next 10 years, the majority also said that the IT and digital infrastructure at their hospital was not at all or not very adequate to enable them to remotely monitor patients safely.⁴

⁴ *Getting IT Right*, p. 7.

Our members cite the number of different systems and system interoperability as the two biggest barriers to digital transformation in the NHS.⁵ Our members told us very clearly that the biggest improvements that can be delivered are in reducing clinical time spent on inefficient IT systems and improving interoperability. 73.8% of respondents in our survey said interoperability of IT between primary and secondary care systems was a high priority. In a different survey conducted by the BMA in 2020, doctors 'significantly' (11%) or 'slightly limiting' (35%) barrier to providing remote consultations.⁶

Equally, it has been clear for some time that one of the biggest digital asks, particularly in primary care, is ePrescribing. This remains the most important single technological advance to improve clinician workload, patient experience and safety and yet does not feature in the green paper. The farce of a system of sophisticated wearable technology continually monitoring patient health metrics resulting in a paper prescription faxed to the local pharmacy does not need explaining.

There are greater digital priorities than TEC facing clinicians in Northern Ireland at the moment – and these must be addressed first. We cannot roll out remote consultations whilst patients have better and more reliable internet connections than doctors, or where existing data sharing is dysfunctional or inoperable. To do so will undoubtedly result in the failure of such systems or, where they are relied upon to make critical decisions, actual harm to patients.

Conclusion

We do not want to appear averse to the growing role of digital technology in healthcare, nor do we want to be overly critical of this paper's focus on patient-oriented technology. Indeed, there are clear areas where this approach is already used, works effectively, and improves outcomes. Insulin pumps supplied by trusts with flash blood glucose monitoring are commonplace for diabetic patients and more advanced self-funded continuous monitors also work well.

Importantly, these successful examples require motivated patient input and allow the patient control of data upload. Putting patients at the centre of their care in this way is not only empowering and allows self-management of conditions but also avoids overburdening health professionals.

As in any emerging area, there are currently more questions than answers. As the sector matures, questions around standardisation to better allow interoperability between primary and secondary care systems, as well as of procurement and the role of the GMS contract, will all become relevant.

At the current time, our focus should be on orienting the discussion properly. Whilst providing a valuable starting point in detailing the current state of technology and its possible applications, ultimately we believe that DHCNI's focus following this green paper needs to be more towards the areas we have outlined in this response: what value is a technology-enabled solution adding? How do we ensure that our wider IT infrastructure is ready to cope with new technology? How do we introduce technology-enabled care in an evidence-driven, joined up way that doesn't overburden clinicians without improving outcomes?

We very much welcome further conversation with the DHCNI regarding the contents of this response. Please contact Merlin Gable, senior policy executive (mgable@bma.org.uk) for any further information.

⁵ Ibid, p. 9.

⁶ BMA, 'Covid-19 Tracker Survey Wave 5', June 2020.