

Chapter 3: The national and wider social context shaping virtual consultation services (macro level)

The macro element of the study was geared towards identifying the national-level drivers for virtual consultations, as well as potential blocks to development and implementation. Analysis of our data set indicated a significant policy push for technology-supported new service models between 2009 and 2017, including virtual consultations in both secondary and primary care. This has been matched by interest from industry and (to some extent) from professional organisations. However, as our detailed analysis below shows, national-level support for rolling out virtual consultations to the wider NHS has met significant challenges, especially in relation to reimbursement through the national tariff system.

The following themes were evident in our macro-level data.

National policy on the digitisation of health and social care

The context for technological innovation in the UK public sector is currently extremely challenging. Analysis of our macro-level data set highlighted a significant policy push to develop the UK's digital economy^{181–185} and digital government,^{186–189} as well as digital health.^{4,5,15,182,190–196} However, constraints imposed by ongoing financial austerity have meant that there has been little slack to support either technological innovation or the piloting, organisational learning and extensive groundwork that is often needed to routinise new technologies or practices within the NHS and the wider public sector.

In health care, spending plans for the NHS set out an average real-terms increase per year of 0.75% above inflation between 2017–18 and 2020–21.¹⁹⁷ However, with costs and demand for health care rising faster than funding (as a result of treatments becoming more expensive, and people living longer and hence needing additional care),¹⁹⁸ there are already significant overspending problems for the vast majority of NHS hospitals.¹⁹⁹ As set out in [Figure 2](#), this means that there is a significant projected gap (£12B by 2022–23) between existing spending plans and the funding required to keep up with the rate of increase in NHS costs and demand, and little slack in the system to enable technological innovation.

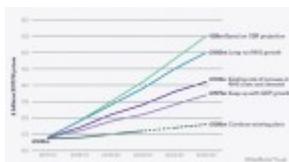


FIGURE 2

NHS spending scenarios. Reproduced with permission from Appleby J and Gainsbury S. *NHS Funding Choices and the 2017 General Election*. London: Nuffield Trust; 2017.

At the time of writing, shortly after the general election in June 2017, and in the wake of the UK's referendum decision in June 2016 to leave the European Union, there is significant uncertainty about the future direction of public spending. Spending plans indicate a decreasing share of gross domestic product (GDP) being devoted to the NHS (from around 7.3% in 2016–17 to 6.9% by 2022–23¹⁹⁹), representing the largest sustained fall in NHS spending as a share of GDP in any period since 1951.²⁰⁰ Compared with other countries, the UK is a relatively low spender on health care, and has already slipped into the bottom half of the Organisation for Economic Co-operation and Development's health spending league¹⁹⁸ and may well slip further.²⁰¹ Based on manifesto pledges ahead of the election, it seems likely that the projected decline in health spending as a proportion of GDP is set to continue.¹⁹⁹

Our analysis suggests that the low growth in NHS spending combined with sustained increases in demand are taking their toll on providers.²⁰² NHS trusts face significant challenges in meeting financial and performance targets (as evidenced, for instance, by the rising number of trusts missing the 4-hour target in A&E and the downgrading of the 18-week referral to treatment standard²⁰³). NHS finance directors are sceptical about the chances of the NHS delivering the required productivity gains over the next 5 years.²⁰⁰

Against a background of worsening austerity, both the *Five Year Forward View*² and the *General Practice Forward View*²⁰⁴ encouraged local health and social care economies to develop novel ways of working to deliver efficient, person-centred, cross-sector care. This was also a major focus of the Wachter Review,⁴ which centred specifically on the implementation of information systems across the NHS and social care, with particular attention given to the use of electronic health records and the ways in which digital health tools might support an (implicitly more efficient) 'paperless' NHS. Of the 10 recommendations made by Wachter, several addressed the need to train a national cohort of CCIOs in both primary and secondary care, who would have a dual role in supporting the digitisation of records and services and supporting the development of local improvement plans linked to new information systems. The Wachter review called for 'new national funding to help Trusts go digital and achieve maximum benefit from digitisation' (contains public sector information licensed under the Open Government Licence v3.0).⁴ This led to the appointment of 12 NHS hospital trusts as 'digital exemplars',²⁰⁵ each receiving up to £10M to enable the use of digital technology to drive improvements in the care of patients (e.g. using real-time video links between ambulances and emergency departments to support better care during journeys to hospital).

The overall strategic terrain is thus characterised, on the one hand, by intense and worsening financial pressure, but on the other hand, by a ring-fenced funding stream for developing new structures and cross-sector linkages supported by information and communication technologies. In this context, technology appears to be seen as a logical route towards achieving cost-savings (e.g. by reducing staff time, supporting caring for people at home) and increasing quality (e.g. through monitoring care), and industry is depicted as an important partner in achieving this. Our data suggest that the stance taken by government and industry assumes that the digitisation of health and care services is the de facto option that needs to be engaged with across the public sector. As one GP involved in national-level debate about digital health put it, 'The assumption is that if you don't [engage with technology], you jolly well should.' Although there was widespread acknowledgement of the need to train staff, few documents or informants mentioned the limited access, skills or motivation of the target patient population, 21% of whom (and a

disproportionate number of poor, sick and elderly people) cannot use the web and 14% of whom are estimated to have no access to the Internet.^{182,187,206}

Despite the drive to digitise the NHS, we could find no formal national policy documents and limited guidance that explicitly related to virtual consultations. Guidance appeared to be restricted to a two-page guide on the use of remote consultations in the NHS produced by the Health and Social Care Information Centre (now NHS Digital; see [Appendix 1](#)), and focusing largely on issues of IG.

As indicated by the following extract from an interview in May 2016 with a senior decision-maker in NHS England, the push for virtual consultations was linked to the overarching theme of ‘telehealth’ and has come through a range of announcements and initiatives:

Interviewer:

Would you say that there’s a coherent picture of what [telehealth] might look like?

Interviewee:

No, there isn’t, not that I’ve seen. And I’m quite actively involved in this space. There might be some small documents floating around.

The policy of digitising health appears to be folded into other programmes – for instance, the ‘New Models of Care’ programme stemming from the *Five Year Forward View*² that commenced in January 2015 and included the NHS ‘vanguards’, 50 local innovative services focused on delivering the ‘New Models of Care’ programme and supported by a dedicated tranche of innovation funding.²⁰⁷ Although it is arguably commendable that policy has been programme focused and not technology focused, it has meant that virtual consultations (and/or the infrastructure, staff training and organisational development underpinning them) have not been actively commissioned or funded centrally. Rather, when technology-based new service models have emerged, they have arisen through local initiatives.

As the senior decision-maker quoted above went on to say: ‘There are pockets of success, and there are certain vanguards exploring it, there’s bits and bobs. But there’s not actively a digital fund for telehealth’. At the time of our fieldwork, this looks set to change, with a new NHS Digital Academy under development following the recommendations of the Wachter review.⁴ The aim of the Academy is to develop a workforce of trained ‘clinician-informaticists’ in NHS trusts, give them appropriate resources and authority, and improve both capacity and capability in the health and care system. The Wachter review⁴ called for approximately £42M (1% of the £4.2B to be spent on digitising the NHS) to support workforce development and deployment. However, no confirmation has yet been given on the amount to be invested in the Digital Academy or the wider NHS.

Transformation, telehealth and innovation

Since the early 2000s, there has been a strong policy emphasis on the need for the ‘transformation’ of health and social care provision in response to the problems faced by the

rising incidence of chronic illness and with growing pressures on services.^{2,191,208–210} Telehealth (i.e. remote transfer of data and/or communication between a patient at home and a health-care provider) has been promoted as a key part of this ‘transformation’ agenda. There is strong policy support for ‘disruptive innovation’ (i.e. services transformed rapidly and radically through technology), on the assumption that change that is sufficiently radical to be experienced as uncomfortable in the short term is more likely to achieve the long-term goals of improved efficiency and effectiveness than more incremental approaches.

As described in *National policy on the digitisation of health and social care*, there is significant scepticism that transforming services and outcomes can be achieved in the context of current/planned NHS spending. Documents and interviews in our macro-level data set indicate that the NHS will struggle to meet the requirement, set by the *Five Year Forward View*,² to save £22B by 2020. In an effort to address this, the government’s sustainability and transformation fund includes additional funding (£1.8B in 2016–17, accessible subject to meeting specific financial controls) for NHS trusts, to help reduce reported deficits. However, if some or all of those funds are used to plug the deficit year on year, there will be little in the way of funding (or the organisational ‘slack’ that tends to go with it) for the service change and new models of care that are thought to be required to modernise and reshape NHS services.

In the documents we reviewed, telehealth generally tended to be associated with the goals of personalisation, integration and collaboration, and is typically presented in deterministic terms (in other words, that simply having access to particular technologies would lead to desired outcomes such as improved health status, more personalised care and reduced costs):

[We have an] unexploited opportunity to combine different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations.

Five Year Forward View .²

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NHS England

As one GP with a role in national-level discussions about telehealth told us:

It seems to be that they will take less time and be cheaper than face to face. And the very, very subsidiary thing that it might be more convenient for patients . . . hasn’t been presented as a major factor.

These findings resonate with a previous study by our team of earlier policy documents on telehealth.⁸¹

A prominent focus of recent policy has been to smooth, standardise and speed up the innovation process in order for NHS patients to more quickly access medicines, medical technologies, diagnostics and digital products, and make life sciences a more attractive prospect for the UK economy. Our analysis highlighted naïve assumptions underpinning recent policy about the innovation process, which is often situated as a linear pathway involving identification of ‘gaps in the technology pipeline’ that might be addressed simply by articulating to innovators ‘the

technology requirements that would best support [NHS] needs’ (*Accelerated Access Review*, p. 18; contains public sector information licensed under the Open Government Licence v3.0),¹⁵ and so smooth the innovation process from ‘discovery to adoption and spread into clinical practice’ (Personalised Health and Care 2020, p. 43; contains public sector information licensed under the Open Government Licence v3.0).⁵ This approach emphasises supply-side innovation, with little attention given to how demand might be mobilised, and the kinds of recognition and rewards that might stimulate adoption.^{211–213} Although meaningful dialogue with patients is emphasised in documents recommending accelerated access,¹⁵ this tends to focus on developing a shared understanding of what matters to users (e.g. through horizon scanning and evaluation). Shared understanding is important, but is not sufficient; technological advances need to be underpinned by a user-centred approach to design and delivery.²¹⁴

In documents, interviews and field notes in our macro-level data set, telehealth was widely considered to have a role in delivering changes ‘at scale’ and ‘at pace’. Our analysis indicated limited recognition that virtual consultations and similar technology-supported service innovations may not be adopted at all by front-line staff (or may later be abandoned by them). Furthermore, the potential time lag between the adoption of technology and any realisation of productivity gains was rarely acknowledged either by interviewees or in policy documents.

It is widely acknowledged that it is very difficult to innovate in the NHS and that ‘transformative’ and ‘disruptive’ innovation in a cash-limited, public sector setting is significantly harder than incremental change (see, for example, a recent book, by Fitzgerald and McDermott, summarising key empirical studies and theoretical perspectives²¹⁵). As Fitzgerald and McDermott²¹⁵ point out, a crucial precondition for organisational innovation is the ability to capture emerging knowledge and feed it into organisational learning. Our macro-level findings suggested important sectoral differences in attitudes towards such knowledge capture. Industry interviewees expressed confidence in the standard commercial ‘fail early, fail often’ approach of iterating software design to optimise the use of a technology in a particular setting. In contrast, clinicians and policy-makers’ responses reflected what might be called the ‘does it already work?’ culture of UK public-sector health care (a prevailing expectation for RCT evidence generated elsewhere, but assumed to be transferable to the current setting). Senior national-level decision-makers from different departments in NHS England clearly acknowledged that ‘the evidence is still very limited when it comes to digital offering’ and that there is a need ‘for us to be producing some evidence that things are progressing well to keep the people at the political end happy’.

Interviewees from regulators, industry and professional organisations similarly talked about the limited evidence available and the need to know more about, for instance, ‘what makes a good-quality remote consultation?’. However, the emphasis in policy was very much on generating an evidence base focused on ‘expand[ing] NHS operational research, RCT capability and other methods to promote more rigorous ways of answering high impact questions in health services redesign’ (*Five Year Forward View*, p. 34; contains public sector information licensed under the Open Government Licence v3.0).² This approach to generating knowledge has characterised a number of government-funded initiatives designed to improve the evidence base and adoption of telehealth. The most widely cited is the Whole System Demonstrator (WSD) programme, established by the Department of Health to ‘provide a clear evidence base to support important investment decisions and show how the technology supports people to live independently, take control and be responsible for their own health and care’ (p. 1) (contains public sector

information licensed under the Open Government Licence v3.0).²¹⁶ The WSD study involved a large RCT of telehealth and telecare, involving 6191 patients and 238 GP practices across three sites. The resulting evidence was viewed as ‘disappointing’, with further evidence required on cost-effectiveness, as well as mechanisms for reimbursement, and clinical buy-in, to support adoption of health care.¹⁹³

Other approaches (e.g. use of ‘test-bed’ sites – such as ‘NHS Innovation Test Beds’²¹⁷ or ‘Healthy New Towns’;²¹⁸ see [Appendix 1](#) for an overview – bringing together new technologies, new staffing models and payment for outcomes) have been promoted. However, our findings suggest that public sector knowledge capture continues to be dominated by trial design, is a poor fit with the ongoing adaptation of digital technologies and is at odds with the commercial approach. As one interviewee from industry put it:

it’s a block to innovation . . . because everyone wants someone to prove they have done it before in exactly the same sort of customer as they are. Well, how does anyone ever start then! You know, someone at some point has to give someone a break. And that’s the thing that people find really hard: to get a break into the NHS.

Challenges for industry

In the documents we reviewed, the technology industry is depicted as the innovator and producer of transformative technologies¹⁵ that can change the lives of NHS patients; policy is concerned with speeding up access to such innovations and boosting the UK economy. In relation to virtual consultation technologies, it is assumed that if developed and implemented at scale by a thriving and innovation-driven technology industry, these will generate change and thereby (at least partly) solve the uncomfortable problem of how to address increasing pressures on the NHS (particularly with regard to the growing ‘burden’ of chronically ill and dependent citizens), while also saving money and creating ‘a virtuous circle of economic growth for the UK’ (p. 44) (contains public sector information licensed under the Open Government Licence v3.0).⁵

Interviews and documents painted a picture of industry as a diverse group of companies, with some (typically larger ones) pursuing a strategy of offering a narrow range of products at scale and seeking to stifle competition across those ranges, and others [typically small and medium-sized enterprises (SMEs)] being more focused on identifying clinical or care issues in partnership with the NHS or social care, as well as users, and working to develop technologies that can help to address these issues. As one senior decision-maker said, ‘what we are seeing is a lot of telehealth organisations – small SMEs but also large-scale providers – working with large organisations, corporates, also some NHS organisations, to offer telehealth services’.

While a thriving technology industry that generates innovations is a key component of the policy vision for a more efficient health-care sector, the relationship between the technology industry and the public sector is complex and sometimes awkward, and makes health and social care a challenging market to enter and survive in. For example, procurement processes are typically long and complex; the market is known to have limited and shrinking resources; and block contracts often favour larger providers, making health care a challenging market to enter and survive in. There was clear recognition of these challenges within interviews and policy documents, for instance:

[Industry] largely recognise that a state-funded health care system such as the NHS must take issues of affordability seriously but find the approach to innovation, the slow track to reimbursement, and low prices without generating wider diffusion and volumes, all make the UK a challenging market.

Accelerated Access Review: Final Report Review of Innovative Medicines and Medical Technologies .¹⁵

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Department of Health

Part of why progress has not been as fast as it should have been is that the NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense. At times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme of ‘letting a thousand flowers bloom’.

Five Year Forward View.²

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The extension of NHS contracts to a wider range of providers, including SMEs, marks a pronounced shift from the National Programme for IT (2007–11), in which the strategy was ‘ruthless standardisation’ and potentially highly lucrative contracts were restricted to a very small number of preferred providers.²¹⁹ Our findings suggest that the balance is still not right, and that a focus on centralised versus decentralised approaches to technology adoption does not address the whole picture. As one senior representative from industry put it when we interviewed them in April 2016:

They’re all negotiating locally . . . So, I agree that the National Programme [for IT] was wrong. But where we are now is wrong. We have gone far too far the other way. Because you do still have to think about the whole-system cost, don’t you, and the whole-system benefit. And there are some things where it just makes sense, it just makes sense.

Some larger companies (e.g. Microsoft) appear to have an evolving process of technology development and supply that (at least on the surface) acknowledges and works with health-care organisations and individuals, as well as patients and carers, in order to develop more nuanced and marketable products (though as noted above, this is not necessarily oriented to the kinds of technologies that might facilitate virtual consultations). This is, however, a resource-intensive process with no guarantee of meeting shareholder or executive expectations at the end of it. The same companies appear to be less concerned with technologies that might facilitate virtual consultations (e.g. Skype, FaceTime) and more with the ‘wellness and wearables markets’ (senior executive, industry). This is perhaps as a result of their awareness that adoption will be slow for complex institutional reasons and, hence, virtual consultation technologies offer limited potential for profit. Companies are also aware of the potential for reputational risk associated with profiting from virtual consultations in the NHS, whereas the wellness and wearables market is (or could be) effectively ‘direct to consumer’.

Our data suggest that both larger and smaller firms sometimes (although not always) struggle to engage with health-care organisations and systems. Take the following extract from a senior executive working in one multinational technology supplier:

I would like to have more of an influence, I think . . . Its very difficult for, not just for [our company], for the large suppliers, to engage with the NHS. This is one of my, this is the problem . . . because there's a kind of a disconnect between industry and the NHS, people are working in the NHS on the test beds, on the vanguards, on these pilots, but they're working within the boundaries of what they know and actually they have no idea what is possible or what is already mainstream. So they think that they're coming up with like this ground-breaking stuff and it's just like [cringes] . . . if only we could talk, if only we could find a mechanism to increase awareness about what can we do.

Our analysis suggests that the NHS does not have the 'slack' to receive industry in a way that could build the necessary engagement to support development of virtual consultations. This resonates with the wider literature that characterises the NHS as inherently complex and sees no simple solution for technological innovation.²¹⁵ Interviewees (both within and outside industry) suggested that the Department of Health and NHS England might do more to ease the process of working with NHS providers and commissioners. Interviews with NHS decision-makers indicated that significant work already occurs to engage with suppliers and to 'realistically manage expectations' about NHS procurement processes and time frames. However, this did not appear to have made a significant difference to suppliers who spoke to us about slow time frames, 'decision-making by committee', 'so much duplication', 'consultation about everything' and the 'need for everyone [i.e. all NHS providers/commissioners] to go out and evaluate every single thing'. The emphasis on one-off procurement contracts for particular technologies ran contrary to the desire on the part of industry stakeholders that we spoke with to develop mature NHS–industry partnerships, in which the latter is committed to supporting an evolving service via an evolving package of technology and support.

Interviewees (from industry and the NHS) spoke positively about some national-level initiatives (e.g. NHS Innovation Test Beds), which they felt may prove helpful in facilitating partnerships and working patterns, and so enable a less technology-centric way of working. However, most felt that it is currently unclear whether or not such initiatives can facilitate the capacity-building and articulation work (i.e. all of the tasks involved in assembling, scheduling, monitoring and co-ordinating all of the steps necessary to complete a task²²⁰) needed to enable a more iterative approach.

Both SMEs and larger companies often appeared to adopt a 'plug-and-play' model of technology. Such a model might appeal to health-care organisations seeking 'easy solutions' to the challenge of rising costs and expanding need, but as our meso-level data illustrate (see [Chapter 4](#)), a business model that rests on 'off-the-shelf' technologies that can be bought, installed and made to work, while ignoring the ongoing work required to embed, routinise and sustain them, may achieve short-term sales at the expense of longer-term problems.

The above findings suggest that providing technological solutions to the NHS will not be easy either for small, 'niche' software companies (SMEs) or for the larger providers with which the NHS has traditionally contracted. Our contact with representatives from the third-sector organisations also suggested that, although there is significant interest in engaging with

discussion about technological innovation in health care, there is currently little capacity to do so.

Rolling out remote consultations

As noted at the start of [Chapter 3](#), interviewees from both policy and industry acknowledged a general policy push for virtual consultations to spread across the NHS. However, we documented numerous concerns, particularly from participants drawn from the NHS and professional organisations, that delivering changes ‘at scale’ would be far from straightforward, as roll-out in any locality would be influenced by (among other things) differences in organisational culture, infrastructure, the nature and causes of professional resistance, IG challenges and the logistics of payment.

A key issue repeatedly raised by interviewees, but rarely evident in published documents, was how reimbursement for virtual consultations would be implemented. Our wider data set showed that, in localities that have introduced virtual consultations (including, but not limited to, Barts Health NHS Trust), payment has been negotiated with local commissioners on a site-by-site basis. However, establishing virtual consultations as business-as-usual across the entire NHS would require a more systematic plan for reimbursement that does not yet exist (and which some interviewees indicated would be problematic to implement). As one senior decision-maker in NHS England told us:

We have a drug tariff that does prescriptions very well, but we don’t have anything for digital. And I personally believe that telehealth falls under that space because the service that could be commissioned or could be reimbursed for but we don’t have the route to do that yet.

Our analysis highlighted several strands of work being undertaken by NHS Improvement (previously Monitor) and NHS England (see [Appendix 1](#)) to review payment and pricing, and indicated significant awareness within these organisations that there are specific challenges relating to reimbursement of virtual consultations. The development of an innovation and technology tariff has gone some way to addressing this, by removing the need for multiple local price negotiations (instead guaranteeing automatic reimbursement when an approved innovation is used), but is currently limited to six medical devices or apps (and does not currently include the use of virtual consultation technologies). Our analysis suggests that the current need for individual provider organisations to negotiate payment with local CCGs will continue to present a significant barrier to the national roll-out of virtual consultations, and might also compromise the long-term sustainability of existing virtual consultation services.

Some of our interviewees suggested that, in the longer term, the proposed shift away from activity-based funding and towards the introduction of capitated payments might facilitate roll-out. Capitated payments have been put forward as a long-term vision for health reform, for instance:

We are interested in learning from commissioners and providers that are implementing alternative payment approaches to enhance system-wide incentives . . . for example . . . to focus . . . on integrated care. Alternative payment approaches might include pathway, capitation or outcomes-based payments.

Reproduced with permission from National Tariff Payment System 2014/15 (p. 138)²²¹.
NHS England

At their most radical, PACS [primary and acute care systems] would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget – similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

Five Year Forward View.²

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NHS England

In this model, a lump-sum payment to a provider (or group of providers) could cover the majority of care for a group of patients across different settings and, in theory, enable funds to be spent however is thought best locally (in negotiation within/across providers and CCGs). It seems likely that moves to develop a more effective payment strategy within the NHS will combine different mechanisms, and be complemented by other levers for influencing quality and efficiency.²²² Even if capitated payments are pursued at scale, our analysis suggests that redesign of the payment system will take time and any impact would probably not be felt for several years.

Our meso-level data indicated that IG was a significant concern when setting up virtual consultations (see [Chapter 4](#)). This concern was not mirrored in our meso-level data set, with interviews or documents situating IG as something that can be sensibly addressed and dealt with (ensuring appropriate privacy and security of data), rather than as a potential block to further roll-out. As one GP involved in national-level discussions about telehealth told us: ‘I think it has to be looked at but I don’t really see it as a major obstacle . . . the main issue is the IT connection which is a security issue, not an IG issue’.

Digital participation

Our macro-level data suggested a widespread assumption that digital literacy among the general population and NHS clinicians and staff would develop in pace with technological advances. Interviews indicated that, for instance, NHS England and NHS Digital not only wanted to engage with this agenda (e.g. by supporting people from disadvantaged backgrounds, and in particular ethnic minorities, to improve their digital literacy^{182,183}), but are also taking action to do so. As one senior decision-maker in NHS Digital told us:

Quite an interesting part of the move to NHS Digital is not just what we do with the public . . . but being a bit of a kind of moral compass and challenge . . . so as NHS Digital develops its products and services – things like patient online, online bookings, those kind of things – challenging the organisation a bit to remember digital inclusion and the challenge of leaving people behind.

There remained an assumption across many (but not all) interviews and documents that people need to engage with the digitisation of health and social care, and there is little or no option for

doing otherwise in the future. As one interviewee neatly put it, ‘we are perhaps not getting as far as we could with this’.

Initiatives such as the government’s ‘digital strategy’ (Cabinet Office 2012)²²³ aim for digital services to be the default option for public sector services, including health and social care. Our analysis indicates that the focus of much work to date has been on redesigning digital services to make them accessible and straightforward to use, as well as offering ‘assisted digital support’ for those who have never accessed the internet (estimated at 10% of the UK population²²⁴). In line with the increasing consumerisation of technology and raised expectations about access to digital services, the approach to developing digital health services appears to be shifting. The above interviewee described less of an emphasis on digital skills and support and more on making digital health an attractive option for potential users:

What we learned through the programme is that there is a digital skills problem still but that’s probably not the biggest barrier because people are just becoming more adept in their everyday lives, technology’s becoming easier to use . . . What we found was that, actually, when people had a motivation and a perceived benefit they would make the minimal effort to develop the skills. What was more a problem [was] that we were not making a compelling digital offer that people wanted to do . . . that people are not viewing digital information offers, digital products, digital means of engaging with the health-care system with sufficient enthusiasm for them to make the effort . . .

Despite this shift, our analysis of policy documents and interviews with policy-makers, regulators and industry representatives indicated that the approach to developing telehealth tends to assume that digital is the de facto option that needs to be ‘engaged with’ (and which forms the starting point for a project or programme). This contrasted with those from patient organisations who advocated the language of ‘digital inclusion’ and emphasised digital health as one option among many.

The framing of digital literacy and digital connectivity as ‘deficits’ in disadvantaged populations that can be made good through training and support contrasts with approaches to health inequalities taken by some third-sector and patient organisations. The latter typically frame the challenge in social terms (e.g. poverty or loneliness) rather than technological ones. A technological framing tends to hone in on the provision of particular technologies, whereas a social (or sociotechnical) framing is more likely to produce a more broad-based solution that includes an assessment of the user experience, patient and carer needs and the use of co-design methodologies.

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