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Digital Transformation in the Health and Care Professions (BMHP6026)

Component 1: Written Report

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Introduction

Digital transformation has become a defining feature of health and social care delivery in the United Kingdom over the past decade, reshaping how professionals and service users interact and how care is organised, accessed and evaluated. Among the many innovations introduced across the National Health Service (NHS), video consultation technology – most widely known through platforms such as Attend Anywhere and NHS Near Me – represents one of the most significant shifts in day-to-day service delivery to have occurred within the last ten years. First piloted in Scottish rural and island communities, video consulting was scaled rapidly across primary, secondary and community care settings in England, Scotland and Wales, and its adoption accelerated dramatically during the COVID-19 pandemic, when remote consulting briefly became the default mode of contact across UK general practice (Greenhalgh and Rosen, 2021; Hughes et al., 2022).

This report critically evaluates the implementation of NHS video consultation technology as a digital transformation within UK health and social care, considering both positive and negative outcomes for the workforce, service delivery, patients and service users, and the wider community. Drawing on a range of academic, governmental and professional sources, it argues that while video consulting has delivered genuine efficiency, convenience and environmental benefits, its success has been uneven and conditional upon adequate workforce training, digital infrastructure and safeguards against widening health inequalities.

Impact on work force

The introduction of video consulting has altered clinical roles and required practitioners to develop new competencies, though the workforce impact has been more complex than initially anticipated. A persistent assumption in early policy discourse was that remote consultations would be quicker and less demanding than face-to-face care; however, evidence gathered through the multi-site Remote by Default study found this assumption to be largely unfounded, with remote consulting frequently proving no easier, and sometimes more time-consuming, for clinicians (Nuffield Trust, 2022; Greenhalgh and Rosen, 2021). Turner et al. (2022), in a qualitative study across eight general practices, similarly found that online and video consultation tools created additional administrative work, professional isolation and dissatisfaction for some staff, rather than the efficiency gains originally

promised. The discrepancy is telling: workforce planning relied on scheduling data showing shorter appointment slots, while qualitative accounts capture administrative and cognitive work that such data does not record – suggesting the "quicker" assumption reflected how remote consulting was modelled on paper, not how it was practised. This pattern is not unique to general practice; embedding new technology successfully into any care pathway appears to depend as much on structured training and supervision as on the technology itself (Hughes et al., 2022).

Role competency has also had to expand. Clinicians have needed to acquire a "webside manner" – the communication and technical skills required to build rapport, read visual cues and manage clinical uncertainty on screen – alongside confidence in deciding which patients are appropriate for remote review (Hughes et al., 2022). However, training provision has lagged behind implementation: a survey of GP registrars found that 85.9% had received no formal training in remote consultation skills, with only 36.2% satisfied with the quality of the remote musculoskeletal consultations they were able to deliver and most reporting greater confidence with face-to-face assessment (Sahni et al., 2021). This training deficit is compounded by wider workforce pressures, with BMA data indicating that a high proportion of GPs are at risk of burnout (British Medical Association, 2024). Administrative and reception staff have experienced role change too, taking on responsibility for scheduling video appointments and supporting less digitally confident patients and colleagues, which slowed uptake in some practices during early implementation (Health Foundation, 2021). At the same time, clinicians who were shielding, in quarantine or managing caring responsibilities benefited from the flexibility that remote consulting allowed, illustrating that workforce impacts have been genuinely mixed rather than uniformly positive or negative (Greenhalgh and Rosen, 2021).

Impact on service delivery

Video consulting has been promoted primarily as a means of making day-to-day service delivery more efficient, and there is measurable evidence of this in some contexts. NHS trusts that combined broader digital communication and scheduling reforms — of which video consulting formed one part — reported substantial reductions in non-attendance: Guy's and St Thomas' NHS Foundation Trust reduced its Did Not Attend (DNA) rate by 17.2%, generating an estimated £2.6 million saving in its first year (Bartlett et al., 2018),

while United Lincolnshire Hospitals NHS Trust reduced its DNA rate from 5.8% to 4.1% following a similar digital launch (NHS England, 2023). NHS England (2023) has since estimated that shifting 30% of outpatient appointments to virtual delivery could save almost five million clinician hours and £266 million annually through reduced non-attendance alone. In Scotland, the Near Me platform has been scaled to a level where an estimated 15 million patient miles are saved per year, freeing service capacity and reducing pressure on transport and estate infrastructure (Reform Scotland, 2020). These efficiencies align with the NHS Long Term Plan's ambition to save £1.1 billion annually and cut outpatient attendances by 30 million visits through digital-first approaches (NHS England, 2023).

However, these efficiency gains have not been straightforward or universal. Detailed comparative research found that the apparent efficiency of shorter, remote consultations was often achieved at the expense of consultation quality, including reduced information richness, weaker shared decision-making and less robust safety-netting (Hammersley et al., 2019). Earlier randomised evidence on telephone triage similarly found that remote-first models could reduce overall efficiency due to "double-handling", where problems needed to be revisited in a subsequent contact (Campbell et al., 2014). Technical reliability was also repeatedly identified by patients and clinicians as undermining otherwise positive experiences of video consulting (Donaghy et al., 2019). Much of this evidence is also observational rather than experimental: DNA-rate reductions often coincide with wider scheduling reforms introduced alongside video consulting, making it hard to isolate the technology's independent contribution (Bartlett et al., 2018). Furthermore, embedding video consulting into mainstream service delivery has proved slower than policy ambitions suggested: NHS Digital data shows that even by July 2024, video and online consultations still accounted for only around 5.2% of all GP appointments, behind telephone (26.1%) and face-to-face (64.8%) contact, indicating that successful scale-up depends on organisational digital maturity, leadership and sustained investment rather than technology alone (NHS Digital, 2024).

Impact on patients

For many patients, video consultation has improved the experience of accessing care. Patients have reported that video consultations offer clearer communication, visual

reassurance and better rapport-building than telephone contact, while removing the need for travel, time off work and, in some cases, significant cost (Donaghy et al., 2019). The benefit has been particularly pronounced for patients living in remote or rural areas: an evaluation of Near Me use for colorectal referrals found that fifty patients collectively saved 6,685 miles of travel, 148 hours of travelling time and £1,767 in costs, while patients requiring specialist obstetric review avoided over 1,000 journeys of up to 200 miles round trip (Reform Scotland, 2020). For patients with stable, predictable long-term conditions in particular, video consulting has generally proved an acceptable and convenient substitute for face-to-face care (Greenhalgh and Rosen, 2021).

These benefits, however, have not been experienced equally, and there is growing evidence of both access barriers and clinical risk for some patient groups. Turner et al. (2022) found that online and video consultation tools could restrict access to care by making it harder for some patients to communicate effectively with their GP, putting those who were already digitally excluded at a disadvantage. Husain and Greenhalgh (2025), in a narrative interview study, found that older patients from disadvantaged backgrounds with limited English proficiency experienced compounding, intersecting barriers to video consulting, concluding that digital health technologies can act as "mirrors and magnifiers" of existing social inequality rather than neutral tools of access. This pattern echoes wider evidence on telemedicine equity, which identifies age, income, geography, language and disability as the recurring fault lines determining who benefits from virtual care and who risks being left behind (Paton, 2026). This tension is less a contradiction than a difference in who is studied: rapport and convenience findings are drawn from patients who engaged successfully, while access-barrier evidence samples those who struggled or were excluded – different ends of the same population, not conflicting realities. Clinically, a UK-wide study of remote consulting found that remote GP consultations carry greater risk than face-to-face care for patients presenting with certain urgent conditions, including new chest or abdominal pain, physical injury, diabetes and palliative care needs, with identified risks including missed or inaccurate diagnosis, underestimation of severity, delayed referral and inadequate follow-up (Nuffield Trust, 2023). Qualitative evidence from dementia care also suggests that some remote check-ins can feel transactional and poorly matched to patients' actual needs, particularly for those with complex or fluctuating conditions (Tuijt et al., 2021).

Impact on community

At a community level, the environmental and public health case for video consulting is one of its clearest benefits. In Scotland, avoiding patient travel through Near Me has been estimated to save the equivalent of 242 tonnes of carbon dioxide per year in gastroenterology services alone, with national scale-up estimated to prevent around 15 million miles of patient travel annually (Reform Scotland, 2020). Beyond direct environmental impact, this reduction in travel also lessens the burden on family members who would otherwise take time off work, arrange childcare or provide transport, particularly in rural and island communities where video consulting was among the earliest and most sustained applications of the technology (Reform Scotland, 2020). Reduced footfall in hospital and clinic settings also carries public health value, a benefit that was particularly evident during the COVID-19 pandemic when minimising in-person contact reduced infection transmission risk across communities. Family members and carers have also taken on a more visible role within the consultation itself, particularly where a patient's successful use of the technology depends on their support, reflecting a shift towards more explicitly co-produced encounters between clinicians, patients and their wider support networks (Greenhalgh and Rosen, 2021).

Set against these gains, however, is clear evidence that video consulting risks deepening existing community-level health inequalities if implemented without care. Health Innovation South West (2022) reported that around 29% of the UK population still has "very low digital engagement", meaning a substantial minority of communities are structurally disadvantaged by any shift towards digital-first care, particularly older people, those on low incomes and those with limited English proficiency (Husain and Greenhalgh, 2025). Communities with poor broadband infrastructure or limited access to private space for a video call at home face practical barriers quite separate from digital literacy alone, and successful implementation depends on family members or carers being available to provide technical support (Hughes et al., 2022). Health Innovation South West (2022) concluded that co-design with digitally excluded groups, rather than assumptions about universal digital readiness, should sit at the heart of any digitally enabled NHS service, a recommendation with direct relevance for co-production and public health strategy at community level. This infrastructure gap extends into social care settings: a scoping review and interview study of English health and social care professionals found that care homes' use of video consultation during the pandemic

was undermined by a fragile technical infrastructure — unreliable equipment, software and internet access — even where staff were motivated to use it (Warmoth et al., 2022).

Conclusion

Video consultation technology illustrates both the promise and the limits of digital transformation in UK health and social care. Implemented at scale over the last decade and accelerated dramatically by the COVID-19 pandemic, it has delivered measurable benefits: reduced non-attendance and associated cost savings for services, greater convenience and reduced travel burden for many patients, and meaningful environmental and community gains through avoided travel, particularly in rural and island settings. At the same time, the evidence reviewed in this report shows that these benefits have not been distributed evenly. Workforce readiness has lagged behind implementation, with persistent training gaps and a mistaken assumption that remote consulting reduces workload. Service delivery gains have often come at the cost of consultation quality and remain modest in scale a decade on. Most significantly, patients and communities who are older, digitally excluded, or facing language or income-related disadvantage risk being left behind or placed at greater clinical risk by a shift towards remote-by-default care. For video consulting to fulfil its potential as a genuinely transformative digital innovation, future implementation should prioritise blended rather than remote-only service models, sustained investment in staff training and digital infrastructure, and active co-design with digitally excluded groups to ensure that efficiency gains do not come at the expense of equity or safety. It should be acknowledged, however, that the evidence base underpinning these conclusions is still maturing: much of it is qualitative or observational, and the longer-term effects of remote-by-default care on delayed presentations remain unknown. This report's judgement is that video consulting is a qualified success rather than a settled one, and that its future value depends on whether implementation continues to be shaped by evidence, or by convenience.

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