Jack: Good afternoon everybody, and welcome to our Made Tech Talks webinar as part of the Leeds Digital Festival, 2021. Very excited to be back. Today's topic is Agile, modular, collaborative: the future of NHS technology delivery. Our speaker today is the absolutely wonderful Hazel Jones, our Market Principle of Manchester here at Made Tech, and our Head of Health here. Now, before I hand over to Hazel, I'm just gonna run through how today's gonna work. So once we're done with a bit of housekeeping here, it's a 45 minute presentation from Hazel followed by a 15 minute Q and A at the end of the presentation. So, if you do have any questions for Hazel, please make sure to add them to the Q and A function bound at the bottom of your screen. And we'll endeavour to answer as many of your questions as possible in the allotted time at the end of the presentation.

Jack: Once the webinar has concluded, we'll be sending out feedback forms to all of our attendees. These take about a minute or so to fill it out. It's about four questions or so, and they go a really long way to helping us improve our webinars for the future. We'll also be sharing a little bit of information about what we've got coming out of Made Tech. So please do stick around at the end to find out a little bit more about that. Last few notes, this session does come with live captions, so if you wanna access those, please hit the CC icon found in your zoom toolbar to access them. We'll be sending out instructions on how you can get access to these throughout the presentation, just in case you missed it on the way in. Last note, this session will be being recorded. That's all from me, so I'm gonna hand over to Hazel. Hazel, do you wanna take it away?

Hazel: Thank you very much. Just to start by saying, sadly I have an engineer visiting today to service the boiler. So I apologize if you get random dog barking at the first part of this. But thank you so much for joining and thanks ever so much Leeds Digi Fest for inviting us. I'm just gonna give you a quick overview of the running order. So I'm here to talk about a new concept in terms of digital transformation and how delivery partners can support the NHS in the digital transformation. So I'm gonna start off by talking, looking at the new legislation for health and care and the impact of that, looking at prior digital transformation strategies in the NHS and what we can learn from those.

Hazel: I'm gonna quickly talk through some personal experiences I've gained from working in and for the NHS and there's gonna be a little bit of a rallying cry about this new kind of modular way of working and then we'll finish with questions, comments or feedback. Also this deck will be available to anybody who wants it, but I've also included links at the bottom of slides where I'm referring to external research, so that if you did want to take screengrabs you're more than welcome to, and I've also put a kind of further reading slide, right at the end of the deck, just if you wanted to get a bit more information

about some of the research findings that, that I mentioned. So off we go, and my co-host there is Mickey, so you might see him from time to time, but hopefully not, let's see how we go.

Hazel: So legislative change. So we've been through such a strange time over the last couple of years. I think frontline workers, key workers have been working relentlessly, the pace has been insane. But one of the really positive things that's come out of it is just seeing how, when we're all aligned against a common goal, just how much can be achieved. So that's within the NHS and from partners supporting the NHS. So I think that'll be a big, a big takeaway. But when we think about just the sheer volume of change that's impacted health and social care it creates this kind of pause to stop and really think about what's coming next for those workers within health and social care, especially as we see the most significant change in legislation since the Health and Care Act of 2012. We've got the Health and Care bill of 2021 that's been tabled that seeks to join together geographical health and care organizations in order for them to collaborate on delivering services that consider the kind of whole person really.

Hazel: So joining together, public health social care, community care and health to really start to build out pathways that consider the full patient journey in order to deliver better and safer patient care. And I think whilst this is seeking to remove some of those legal boundaries, what it doesn't provide for it is just the cultural change that's gonna be required from those different organizations in coming together. For those that don't know about the Kings Fund and those that are not familiar with the new integrated care systems that are proposed as part of this new legislation, I'd recommend the Kings Fund. They've got a brilliant explainer that really unpicks the different elements of the legislation and what it really means.

Hazel: But one of the things that they do call out is the level of behaviour change that's gonna be required to really be successful in this endeavour. And for those of you that are from a change background, you might recognize this, but for those that might not be this is the psychology of change. So the kubler ross curve that indicates just for each individual that's involved in a significant change, just the emotions that they go through as part of that. And just thinking about this and what workers in health and care have already kind of endured in the last couple of years. Again, it made me think well, what do we need to do to change our models of engagement and ways of working so that we can be a better support to the health and social care system.

Hazel: So just looking at prior transformation strategies within within health and care and the different approaches and what we can learn from those. We first of all see a pattern of centralized digital transformation and then decentralized. So

starting off way back in 2002 and the NPfIT initiative that was aimed at making the patient record available to all who need it. For those that as old as me or even older, if that's possible, you might well remember just the media onslaught, the headlines around this and it was, widely seen as a failure a £10 billion program leaders within the NHS lost their job as a result of it, suppliers lost their contracts, the government lost face. But actually it did deliver some some key elements that are used to feed some of the innovations we see today.

Hazel: So Spine services that enables new innovators to hook in with those integrations and those services, so that they can find a patient's NHS number they can find where their registered GP practices and they can access the patient's records in order to present it to them. And things like the Summary Care Record, so that was a summary of a patient's GP record. So if a patient's opted in within their surgery, that means that any health and care worker can log into a portal and just see a summary of their historic encounters, what medications they're on and what kind of allergies they might have. So all aimed at providing better, safer patient care. And of course Choose and Book so that patients have a better ability to choose and book appointments that they're more able to, more likely to attend, so all that was delivered as part of NPfIT.

Hazel: But when we look at a report from the National Audit Office, in terms of access to those shared records across organizations. What we see is that around 50% feel that they can rely on digital records and that that information is coded in there once. But when you think about the Summary Care Record, that's seeded from the GP system, so it contains the information that's held at that GP practice and not necessarily across all other organizations. And that really comes through when you look at the other side of this this graph and just how many staff feel about being able to access information from other parts of the health and care system and how easy it is to update that information, with around 50% disagreeing saying that they're unable to do that. So there's still a long way to go.

Hazel: So then the government moved to a more decentralized approach. So with the hope that a thousand flowers would bloom, if they decentralize that transformation effort to regions. And a thousand flowers did bloom, but the constraints around that is that these systems were commercially built systems that for that reason are proprietary, so not open, and they were built to different standards because they were designed locally with different kind of data structures. And what that's meant is that they don't interoperate. So that's where we find ourselves today with a sea of systems that just don't interoperate making that journey to link up the patient pathway across multiple health and care organizations, all the more difficult.

Hazel: So then 2015, we see that we go back to a centralized approach to digital transformation, and the aim there was to enable citizens to access their record and digital apps so that they could take more of a role in managing their own health and care. So you'll be familiar with things like the NHS apps library that presents trusted apps, so that citizens can use those and healthcare practitioners can recommend them as suitable for using the NHS, and also the NHS app. So the NHS app I suppose it's up to each individual person as to whether they believe that's been a success but the facts are that the NHS app now has 16 million users across England providing citizens with access to their record. But yet again in most cases they've got access, but only to their GP record.

Hazel: So I just wanted to stop a little bit and just talk about the design of the NHS app, because it's built in a modular way that, for me, really opens it up to addressing some of the issues around interoperability in that it's built with a kind of a front door, a front web layer, that's the presentation of the app that each individual will see based on where they are, what services are available in their region. So it will only surface functionality that's available to them as an individual and within their locale. So you have the ability to view a GP record and that's a national level integration, and actually, as I'd said earlier about when I talk about Spine Services, the Spine Services really were an enabler for that level of integration. But it means that that each of the four key system providers across England have made an API available so that the patient record and the ability to book appointments can be made available.

Hazel: My dog's gonna bark, I think, do apologize if he does. But the other interesting element to it is just the other level of integration. So Patients Know Best, that's a system that enables access to a personal health record. So that's also integrated with the NHS app. So if you live in a region where that system is being procured, then you will have access to records outside of your GP record. Similarly organ donation, so NHS blood transplant, organ donation, that's a national integration that means that now you can use the NHS app to register your organ preferences. And we've seen an increase of 150,000 registrations for organ donations since that was integrated, so a massive success. And then another one is eConsult. So eConsult some people may have already used it. It's an online triage-type service that enables you to book an appointment with your GP and give some information about the problem you're facing so that you can have an appointment booked with the right sort of professional. So that modular approach means that those services can be surfaced as they become available and a patient can see those services that are relevant to them. So really starting to address some of the constraints around interoperability.

Hazel: So then we find ourselves today with a new strategy. So we should all be probably aware that NHSX was set up in 2019 to drive the digital transformation agenda on, on behalf of the government and the Department of Health and Social Care. And we move back to a decentralized approach, but learning the lessons of the past, it's a decentralization, but with national oversight. So I mentioned before the National Audit Office did a really fantastic report on digital transformation and the lessons that could be learned from it. And one of those lessons and one of the big headlines really is around interoperability and just the real blocker that that is in terms of providing a joined-up patient experience and joined-up systems, so that health and social care workers have access to the data that they need to be able to perform their roles. And part of this new national oversight is to start to create to build out those standards. So that new systems that are built can be built in such a way that they can be linked up at a later stage.

Hazel: The other piece of information that I've pulled out, and this is from Health Education England, is looking at workforce transformation, and this is based on a survey that they carried out across different hospitals and trusts and organizations across the healthcare system. And one thing that stands out is just the sheer amount of time that’s spent by health and social care workers in maintaining their knowledge around compliance with standards and regulation, and when we look to the right and look at the time that's invested in IT and digital capabilities, that's 2%. So if we're embarking on a digital transformation and new ways of working, one of the big things that I took from this kind of study was just how healthcare workers felt that a better way to learn was through collaboration with their team members and colleagues. So I'll be coming back to that later on in the presentation, but all this is just to build out the context.

Hazel: So the three key takeaways, I think, from the National Audit Office findings were around digital maturity and capabilities within health and social care, so just how ready is the workforce to embrace digital technologies. They also focused on cultural barriers, so ingrained ways of working based on the kind of prior legislation that really separated out health and social care. And as I've talked about already, some of those technical barriers around legacy systems and interoperability and proprietary, kind of, vendor-locking approaches. So that gives you a bit of a context as to where we are today and what's coming up in terms of the change, the significant change for health and social care, and I wanted to touch on some kind of anecdotal experience that I've gained.

Hazel: So I've worked within the NHS. I was formerly Program Director for the apps, NHS apps library, so apps and wearables and that was a whole program that was aimed at looking at apps that already exist, that have already been built,

but just making them achieve the desired standards for them to be suitable for use in the NHS. I also worked with NHS Blood and Transplant, so that was during the second wave of Covid. And that was all based on digitizing a national blood testing program that was aimed at looking for potential donors from a pool of people that had had Covod and recovered from Covid. And within that set of people there would be around about 10% of those people that would have these high-grade antibodies that could be used to transfuse their plasma into vulnerable patients.

Hazel: So I worked there in a kind of a semi-SkunkWork-type project to digitize that program for them. And then I've also worked as an innovator, so, in the private sector for Push Doctor, so they were a private GP video consultation provider, and they wanted to pivot to be able to offer the system for use in the NHS. So that meant integrating, so a big interop program to integrate with the systems to be able to view a patient record, update a patient record, and then prescribe. And then now I've joined Made Tech and we support the NHS, so we provide digital teams into health and other parts of public sector and actually into private sector where they're helping public sector and specifically health. So I've joined now as a supporter of health and social care organizations.

Hazel: And looking back, some observations from my time within the NHS. So when I was delivering the NHS apps library I inherited a team and really they had a varied kind of level of experience in using modern digital delivery practices, and the apps library was a ministerial commitment. It had already been promised the kind of, the deadline was fixed, there was no moving on that. And the approach back then was to look for delivery partners that could come in and help deliver. And I remember thinking at the time, well that doesn't feel very sustainable to me. If I go out and essentially outsource this to a delivery partner, then that means I've got a whole team of people that are not getting that hands-on experience, and how are they gonna be able to maintain the product once it's moved to a live environment?

Hazel: And so I'd gone out to speak to different delivery providers to really ask them about helping upskill the existing team. So not just pitching to do the delivery, but also, you know, agreeing to kind of coach, mentor and upskill my existing team. And I found that there wasn't much of an appetite for that, and I think there wasn't much of an appetite because it wasn't the norm. It wasn't something, you know, a, when a digital supplier is, is pitching to do a piece of work, they're signing up to deliver specific outcomes. And I'm sure it must have felt intimidating because, you know, they just couldn't measure what the impact of taking time to upskill the existing team, they couldn't build that into the kind of timelines, but that was pretty disappointing.

Hazel: And then the other observation was just around the duplication of efforts. So our team would receive requests from lots of different app providers to have their apps assessed so that they could be accepted and showcased in the NHS apps library. And we'd see these apps and there'd be lots of different apps, but offering very similar functionality, so we see these across mental health same for GP services. And it just struck me that, that we've got all these individual innovations being built in a proprietary way, and actually if we'd taken more of an open-standards approach and collaborated just how much more could we have achieved. But yes, that's one of the things, the other observations. But one of the apps that really stood out to me was a tool called Chat Health and Chat Health is a tool that enables young people to use text messaging, to be able to chat with their school nurse.

Hazel: So those that are as old as me, you might remember that if you wanted to see a school nurse, you'd need to go up to the nurse's office and sit outside and wait to be invited in. And that was pretty uncomfortable because your friends would see you sat there and want to know why you were sat there and, you know, what you're going to see the school nurse for, which could be quite uncomfortable. So Leicestershire NHS Partnership came up with this tool and they built it, they designed it and built it within one region, and then they deployed it and out to multiple regions. So they're in 60 healthcare organizations and serving 2.8 million young people at the moment. And I thought, what a brilliant idea to take something that's developed and then scaling that out to support other parts of the NHS. So it can be done, they're a big success story and, as you can see, award winning.

Hazel: So then the other thing, the other observation was really the cost of digital change in the NHS. So, you know, we see the headlines around the NHS Contact Tracing app you know, it is expensive to deliver within the NHS and also in terms of finding resources to assign to projects, to get stuff delivered, you know, that's a massive overhead for the volume of change that hospitals and trusts need to deal with. And I looked at the West Yorkshire and Harrogate Partnership, for example, and this is just a screengrab from their website, and I looked at just the themes of what their priorities are in terms of digital at the moment. And you'll see just by looking at those that there are some synergies, you know, this isn't just a local thing.

Hazel: These are applicable nationally as well, and just made me think again, where are the options for more broader collaborations and what more could be achieved by co-designing and co delivering some of these digital projects across multiple regions. And then the last one was even the new innovations were built using proprietary software. So even though the government has The Open Standards principles, and you'll see here, the NHS Service Standard

which, if you're not familiar with the NHS Service Standard, I really strongly recommend having a look at this. It's a really useful kind of checklist to make sure you're designing products and services in the right way and considering the users and patients and citizens in the right way. But really, why are we still developing new innovation in these old ways that have already led to vendor lock in? So that was another observation.

Hazel: So all of these things, so looking at the current context, looking at what's ahead for health and social care and, you know, the significant transformation ahead, and looking at my own kind of experiences of working within the NHS and integrating with the NHS. It made me stop and think, at Made Tech, what can we do in our little part of the world? What can we do to be a helping hand to those people that have been a helping hand to us over the last two years and have worked relentlessly to make sure that we are as safe as we can be. So I came up with this concept of the Made Well Collective and I just wanna talk about that because the Made Well Collective is a concept that's not only relevant to Made Tech. It could be relevant to other digital suppliers in terms of the way they choose to work.

Hazel: And it's relevant to people within the health and social care organizations in terms of what they should expect from delivery partners such as us. So what is it? So we've got three missions, only three, so three missions that I'm gonna describe. So essentially the Made Well Collective Mission One is about creating a space so that different, so if we think about the way transformation is driven across health and social care, then that's attached to a strategy. So in this case, the long-term plan that sets out the key targets and the key themes and priorities. So there's already synergy at that point because those themes and priorities have been set at a national level.

Hazel: So if regions can look across other regions for like-minded innovators, so that they can pull their funds and pull their resources to deliver rather than delivering within their own regions, you know, join together across multiple regions to deliver, to collaborate on delivering a specific project. What that would mean is that instead of all these projects happening at a regional level, that all need a data protection officer or an information governance specialist, that all need a clinical safety officer or a clinical lead, that all need delivery managers. If those resources could be pulled together and working with just a single delivery partner, and that could be any delivery partner to deliver once, that means you are collaborating to work with one team paying once, but then deploying that across multiple regions. So you're getting the economies of scale in doing that. So that’s the first mission.

Hazel: The second mission is that when you've done that, start to adopt this Open Standards Principles in terms of the artifacts that you create, as well as the

products and the software that you've built. So if you are prepared to make that an open-source project, then that means that once you've launched it, then other regions that were not part of that original co-funding team are able to then save their money and save their resources by adopting something that's been built and is already in use in other parts of the NHS. So sharing artifacts, such as the user research, the patient citizen research sharing this, the safety case and hazard log. All of these things are repeatable processes that happen every time a project is initiated.

Hazel: So if those things, and the data protection impact assessment, and the training materials can be made available then that means you are saving those hospitals and trusts that are gonna adopt this tool, time and money in being able to reuse something and even adapt it. So if they want to add to the functionality, they're not starting from scratch, it becomes an incremental change. And thinking back to the original co-funders and actually in the user research that we carried out one CIO from a Trust did ask: “What's the benefit to me if I've invested time and money in building something? What's the incentive for me to freely give that away to other people?” And really the benefit is that once we start to build a repository of open solutions, then that means that those co-funders can benefit from adopting projects, digital products and services that have also been built under that kind of open-standards principle.

Hazel: So a massive kind of economies of scale there, that means that change is achieved quickly and in a much more efficient way. And then making that, so assigning an open-source license to that software and giving it a runbook. So a runbook is literally just a how-to guide in how to deploy software within your own environment. Then it means that there's no vendor-locking. All that stuff is freely available, you can work with any other vendor too, if you want to make incremental improvements, or you can use your own internal teams to make those incremental improvements. It just feels like a much more efficient way of working that I think would really help the NHS to deliver their digital transformation at pace and leveraging that knowledge and experience from within the NHS to co-design and co-deliver these products and services.

Hazel: And then mission three, which is one that's really close to my heart and I talked about it in terms of my experience at NHS Digital on the apps library is, please expect your delivery partners, and delivery partners, please adopt this approach of building in the upskilling element into your delivery plans. So delivering for clients, it's not sustainable, you know, the sustainable and the right thing to do is to upskill, to mentor, to pair with those organizations. So that they're really part of that journey and then are able to continue that journey, once your kind of engagement has come to an end. So that's mission three. Now you might be thinking, you could be thinking two things here,

right? You could be thinking “This person's absolutely bonkers, what's she on about?” Or you could be thinking, “Actually, this sounds really obvious”.

Hazel: I really hope it does sound really obvious cuz it is, but you might be thinking “It's impossible, it's never gonna work”. So I'm gonna introduce you to Virtual Visits. So this is an example of where we've used this approach already. So Virtual Visits. This was built as a result of a tweet from Sonia Patel when she was CCIO at North West London. And she sent out a tweet asking for delivery partners to step up and build a tool that would mean that loved ones were able to visit with inpatients virtually during the first wave of COVID. And Made Tech partnered up with Hillingdon, Kettering and London Northwest to co-fund and co co-design what's now known as Virtual Visits and it's been built in the open, so it's available on GitHub we’re in the processes, a process of rolling it out and making it freely available to other hospitals and Trusts.

Hazel: But when you think about it, this is really an applicable piece of software that could be used across any organization that has a visits as a concept. So whether that be hospitals, hospices, care homes, prisons, this is open source it's already been bought and paid for and should be made freely available to any other part of the public sector. So it does work, and this is an example of it. Please do visit the madetech.com website if you want to find out more about it. But yes, that's just to show that it can work and we're already operating in this way.

Hazel: So this new concept of integrated care systems to me, when I read it, this kind of collaborative open, modular way of working for me, is a no-brainer in terms of really starting to deliver those benefits and efficiencies that are so badly needed across the NHS and social care organizations. So in terms of what you can do to help, so there's a few things. So if you are in health and social care, you can, obviously, we'd love you to join us, be a part of this journey, help make this work, we're here to help you find like-minded co-funders for your projects. But also for you, look for those reuse opportunities you know, avoid the kind of not invented here syndrome and reinventing the wheel. If it's already out there and it can just be adapted in a cheaper and quicker way then you are gonna derive those benefits and the users of your service are gonna derive those benefits much quicker.

Hazel: And if you're a digital delivery partner, open source your software and your artifacts, please. Let's start collaborating at a national scale and really enabling this digital transformation within the health and social care system. And please factor in the upskilling element of your delivery plans to make sure that you are walking away and leaving teams in a better position than when you started. So that's the rallying cry that I mentioned at the beginning. And also if you are out there and you feel as passionately as I do about doing the right

thing for health and social care, then come and join us, come and work with us. We're always recruiting and we're always looking for socially conscious people to help us on our missions. So yeah, please do reach out. And that's it guys, thank you so much for listening. I think I'm four minutes early, and I think Mickey's been a very good boy, thank you. And lovely engineer has serviced the boiler, thank you so much. So I'd love to open it to any questions, comments, feedback, please, thank you. Jack, over to you. You're on mute my Love.

Jack: And we are back. That's brilliant, Hazel, thank you so much for taking the time. We're just gonna go straight into our Q and A, if that's all right with you. Our first question is, and these are quite long form questions, so bear with me a little bit. First question is: "When we talk about upscaling, you mentioned ensuring existing digital teams can support digital solutions. But is training and support for the NHS staff in scope, when they have supplying services and interacting with that data to help a patient?"

Hazel: So in terms of what we saw from different research, is that I think there's a big assumption made, that workers within health and social care are as digitally illiterate as everybody. And that's a huge assumption to make. So there was a piece of work actually done looking at midwives and, you know, they carry out home visits and not all of them were comfortable with using digital tools, you know, as part of that kind of visit. So a kind of a digital maternity app that records the output of that consultation. You know, you'd be surprised at just how many weren't comfortable with that. So when I'm talking about the Madewell Collective and this new kind of approach I'm talking, I guess, about the digital teams, so where at the moment hospitals, Trusts and other parts of health and social care will look to digital partners, much like Made Tech to come in and help deliver a project.

Hazel: And that's the bit that I suppose I'm focusing on, is I think there should be an assumed obligation as part of doing that, that you're gonna work with people that may not be familiar with new, with modern digital practices. And that it's, you know, was part of your obligations in delivering a project. One of those outcomes has to be taking on board responsibility for that training, that training element. So yeah, I hope that answers your question. But I think whether it's a service user as in a citizen or a patient, whether it's a health or care worker, I think all of those, we shouldn't make assumptions that people are comfortable using digital tools.

Jack: Excellent, and in the chat: "Wonderful answer, thank you." Next question: "Is there a list of where the Virtual Visits is being rolled out to? Thank you 😊"

Hazel: That's a really good question. There isn't a list at the moment, actually, but it's something we could publish, yeah.

Jack: Wonderful. The next question, I think you covered it a bit, but; “Who is the Madewell Collective aimed at?”

Hazel: So the Madewell, so I should say actually today is the launch of the Madewell Collective as well. This is the first time we've spoken publicly about that, about it, so it's literally only going live today. So the initial focus will be around working with health and social care organizations to just help facilitate that alignment across potential co-funders and getting that up and running. But what we're also really interested in doing and have also had interest in terms of like-minded digital delivery partners that we work with is extending that out so that if there are other digital delivery partners that will kind of join us in terms of our ambition for using open standards, that we will start to surface their open-standard projects as well. So that we're building out a, you know, a broader range of open-standard solutions that are available for reuse.

Jack: Excellent, next question is, next question is; “How do I go”, sorry, “How do I begin to go about finding co-funding partners?”

Hazel: Ah, so that would be, so there's two things. So one is the, so in the user research, there were kind of two things that came out. One is that organizations may already know other peers in other, in other health and social care organizations that they already have worked with on other things. So they can come with, come to us and say: “We'd like to, co-fund a piece of work, and these are the different parties that, that want to be involved”. Or the other option is you can reach out to us. So there's gonna be a link to the Madewell Collective in this slide deck, or you can visit us by www.madetech.com/made-well, and you can let us know and say, look I don't know any, but I would like to find co-funders and we can advertise your opportunity to other relevant parties and try and secure those for you.

Jack: Wonderful. Next question is: “I have a product already in development. Is it too late to get involved?”

Hazel: No, I don't think it is too late. So you can apply open standards. I'm sorry. Mickey's, just joining us. Thanks Mickey, if you'd like to sit down. You can apply open standards at any time. So the thing that you would need to do is just check with the parties involved, that they are comfortable in sharing the artifacts and publishing those in the open. That's the only thing, but yes you can start that now.

Jack: Terrific. Let me just scrolling through: “As a potential earlier adopter, would I be getting the raw end of a deal than someone joining later, when there's more technology already on the tape?”

Hazel: Ah, that's a bit now. So this, this did come out in user research. I kind of alluded to it earlier. So the questions were raised in terms of, well, if we're the co-fund and we're investing all this money and time and effort what's in it for us? But really the principle to this is, if we can get more people involved and if we can share information about projects that are under way already, so that people can see that there's ready work that's being carried out, rather than commissioning a new piece of work. We can keep you in the loop on what's happening with those and when they'd be ready for adoption, and also at the other side of it. If you have, co-funded keeping you available as part of that collective, keeping you up to date, sorry, on other work that's been commissioned. So that if you've got a strategy for your region, that as we saw on the West Yorkshire and Harrogate partnership where they've got all these key themes we'll be able to show you all the key themes of projects that are underway so that we can, you can adopt those at a later stage.

Jack: Brilliant, next question. We have question: "How free is free?"

Hazel: Well, to me, free should mean absolutely free, right? So, so the bottom line here, my view is that once it's been paid for it's been paid for. So if even one trust has built something and they want to open source it, and there's been no co-funders, it's public money and it should be made freely available to any other public sector organization. So from our perspective,e what we have found in deploying Virtual Visits for example, is that some health sorry, some NHS hospitals and trusts that their incumbent teams might not have the skills or they may feel that they don't have the skills all the time to do that initial deployment. So Made Tech can spend time helping those hospitals and trusts to do that, or they could speak to any other of their delivery partners to, you know, to deploy that code. So, for me, the principle is, it should be totally freely available, and there should be no lock-in to any individual delivery partner, digital vendor or delivery partner.

Jack: Wonderful. Next question, but my window's doing a bit of a funny thing , whatever, sorry: "What if a trust or another provider has a product already developed that they want to share. Can they add it to the collective?"

Hazel: Yeah, if they want to surface it as an open project that's available, then yeah, absolutely.

Jack: Wonderful, sorry, one moment: "As another provider, can I use your code in my product?"

Hazel: Yeah, absolutely. So our work is published under the MIT Open Source License. So that means that anybody can use it. It's totally open, totally freely available.

Jack: Wonderful, just I think….

Hazel: And just on that as well, I was gonna say that that goes back to the modular piece is that to me, that's, in my head, there's no reason why things that have been built, so things like Virtual Visits couldn't be added as modules within existing software and technology. It's just about providing that functionality freely and, and giving access to that code means you can achieve that quicker then that's a positive thing.

Jack: Excellent. I think we've got time for one more question: “Do I need to involve Made Tech if I'm picking a “piece of technology” off the shelf?”

Hazel: Do you need to, so I suppose from a Made Tech perspective, we are kind of digital partners into different clients. So we don't need to be told we like to be part of a conversation so that we can, you know, we can point out things so we can give it advice on things. But we don't need to be told things. It's more a case of: “Let's think about the sustainability of some of the decisions that we're making when procuring off-the-shelf so that we can just make sure that all those, all those considerations are being surfaced”, but yeah.

Jack: Wonderful. I think that's time for us, wonderful stuff. In which case I'm just gonna share my screen very quickly to go over a few points on the way out. Yes, as I mentioned before we would love to get your feedback. All of our attendees will be receiving feedback forms, again about a minute to fill out and goes a really long way to help us improve our events for the future. Coming up next, our next upcoming talk is: “Accelerating Delivery - 10 questions to ask yourself and your teams”, which will be taking place at the Lean Agile Exchange with Anikh Suban, one of our Delivery Principles here at Made Tech. You can catch that on Thursday 21st of October at 2:00pm. You can also catch our podcast, which is up and live at the moment, Making Tech Better, which comes out every two weeks.

Jack: One of our Lead Engineers, Claire Sudbery is our wonderful host of that. We have over six in episodes up and running on all major podcast platforms. So if you do get the chance, have a listen, they're all up there ready to binge. And if you feel like it, leave us a review. And last of all, I'd just like to say another massive thank you to Hazel for taking the time to speak to us today, and again, to our wonderful audience for taking the time to listen. If you wanna reach out to Hazel, if you didn't get your question answered during the Q and A please feel free to reach out on Twitter. We're always looking for a chat likewise here at Made Tech, if you want to keep up to date with all things, Made Tech, our website is up on the screen as is our Twitter handle. And that is absolutely everything from us.

Hazel: Well, could I just answer just one more question from Andrew Halliday.

Jack: Of course, of course.

Hazel: I'm so sorry. So Andrew, thanks so much for your question and thank you for confirming that this should be totally obvious. Right, and it's that age-old question around how do we get buy-in. So Andrew's question, sorry for those, that haven't read it is: “How do we get people on board with it? If this new collaborative way of working means that, that we're not gonna need so many resources on all these individual products, cuz we're gonna come together at a collaborative level and how do we sell it in because is there an implicit, is there an implied risk of redundancy if we don't need so many people?”, And my answer, to be honest, Andrew to that would be that, I think my experience of digital transformation over the last 20 years has brought opportunities with it.

Hazel: So if ever there's a role that's redundant, you can bet your bottom dollar there's a new role that becomes available. Perfect examples of that are Service Designers and User Researchers. So did you hear about those 10 years ago? I certainly didn't, never heard of them. And now they’re such an invaluable resource to any piece of work because they make sure that the voice of the users and citizens and patients are considered. So, to me, it's not so much about you know, “people are gonna be losing jobs”. It's about diversifying into new roles where they can still get the benefit of achieving their personal values of doing good and, you know, being a socially conscious individual, trying to deliver the right thing, but it might just be with a different job title in a slightly different role. Although I don't, I honestly don't think there'll, I think there will always be a shortage of, of data protection, especially in health and social care. But anyway, I hope that answers your question.

Jack: Wonderful. And that really is all the time we have. So again, to our audience, thank you for stopping by and have a wonderful afternoon. Take care.

Hazel: Thank you so much.