KSS Leadership Summit 2015

Kent, Surrey and Sussex Leadership Collaborative

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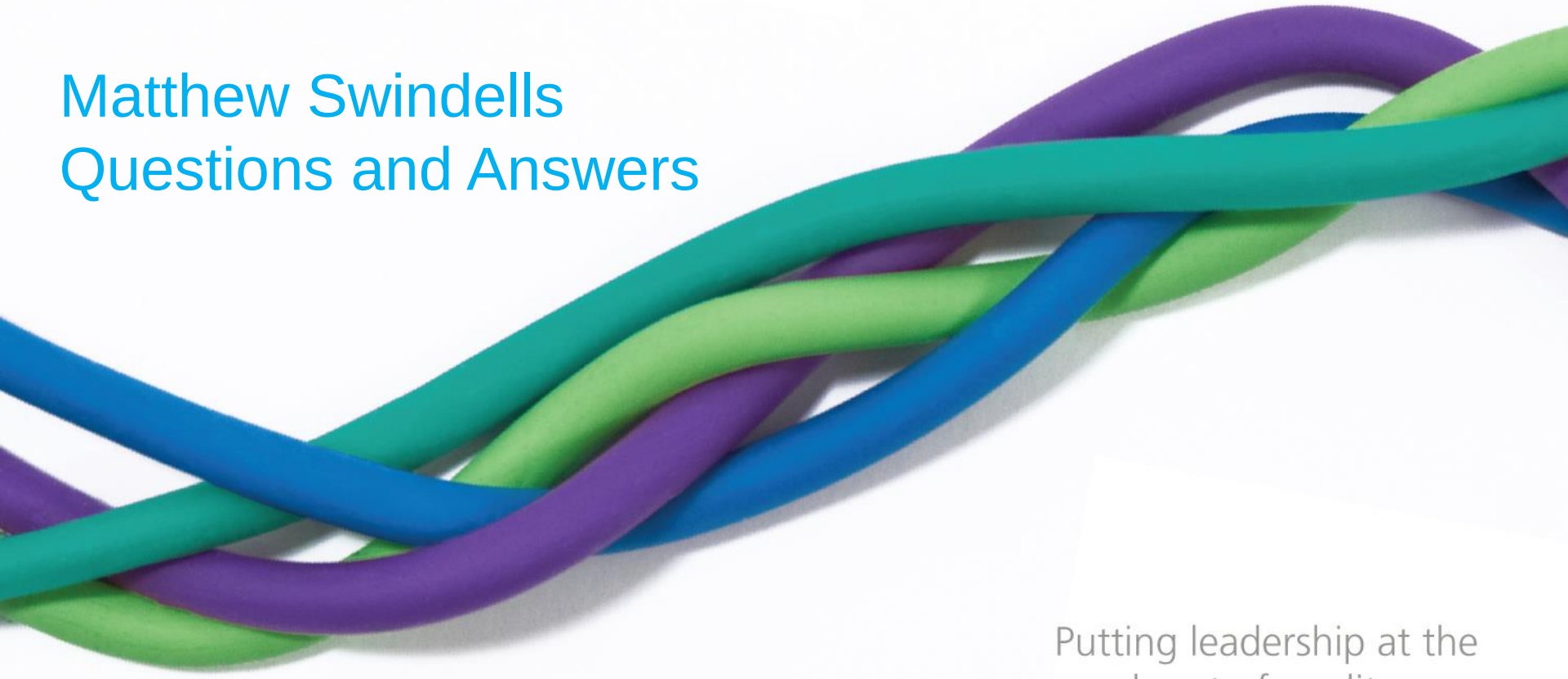
Questions and Answers



Putting leadership at the heart of quality care

What's moving faster: Patient owned health records or inter-organisation record sharing?

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- Both are moving more slowly than you would like. My sense is that in the UK a small number of patients are accessing their GP record and a small number of organisations, like Barts and their local GPs are sharing data.

- In the US, regional Health Informational Exchanges took off of their own accord with health systems recognising that even within a competitive environment, sharing data between providers improved outcomes and lowered costs.

- Patient access to records initially only took off because of President Obama's Meaningful Use investment in healthcare IT. Whilst most hospitals offer connectivity, only a small number, like Virginia Mason, have really impacted on clinical practice. However, in the past year as providers have started to think about population health there has been a much greater focus on patient ownership of their record and their care plan.

What does Spain do well that keeps their cost per capita lower for over 70s?

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- I'm sure it's a combination of dietary, societal and health care factors. There is never one silver bullet.

- However, if you look at the Valencia region you can see a health system that has created a clinically integrated network with financial alignment around improved outcomes and lower cost across the whole continuum which has delivered the best outcomes and lowest costs in Spain. So there is something to learn there from the original "Accountable Care Organisations".

How confident are you that the NHS will change information governance/sharing protocols, enabling digital transformation to impact the way we care for people?

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- Not very.
- I worry that media campaign against data sharing will prevent us from doing what's best for patients until there is a proven case of harm to a patient due to failure to share, then the media campaign will be reversed.

How do we become less risk averse but remain safe, innovative and transform at the pace required?

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- I think we do this by creating a culture of quality using technology to eliminate unwarranted variation and create a feedback loop.

- If we can learn from Clay Christiansen's work on innovation we would find that if we could standardise the 80% of pathways that are the same we would create more space for clinical innovation around the other 20%. We would also find that the process of standardising best practice would create the environment for changing the standard and deploy new innovations more quickly.

How do we help the shift from seeing HCP as the 'holder' of the care to seeing the individual as the 'holder of their own care'?

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- The NHS has a whole journey to go on to become less paternalistic and more collaborative.
- South Central Foundation, which provides healthcare for the Alaskan Native people around Anchorage refers to their patients as Customer-Owners. They are trying to capture the idea that health professionals work **for** you to manage your own health.
- I have always been fascinated by the work at the Dartmouth Institute on shared decision making which showed that well informed and engaged patients tend to choose less interventional therapy than a doctor would choose for them.
- They're great national and international examples of patients being a full member of the care team, we just need to make it the norm rather than the exception.

The introduction of technology is another structural intervention into a social system. How might it be used to really engage us in a shift in org. mind-set?

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- It is important that technology is viewed as a tool to support improvement, not the answer in its own right . It is my experience that big technology projects that fail are the ones that are viewed as technology projects and owned by the IT department. The ones that succeed are part of wider change program and are owned by the executive.

What assurance about data protection, I may not want sensitive information in the wider digital world.

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- We need to ensure transparency about what data is held on an individual and who is accessing it. People need the right to determine when their data can and can't be used

- It is also important that relevant data is available to clinicians at the point that they are treating a patient and isn't locked away by systems that won't talk to each other or bureaucracies that can't keep up with C21st medicine.

How do you obtain consent to share information from clients, especially the elderly?

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- Consent should be obtained in the same way as consent to treat – by a professional discussing the pros and cons with an individual.

- Most patients assume that the doctor who is treating them has access to prior information about them and are shocked when they find out how bad the NHS is at ensuring that this happens.

Being 50, I now worry that I'll be 67 before there's a 50:50 chance that the NHS will have adopted tech as an aid! How do we shift the innovation curve itself?

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- Me too.

- The innovation curve will be shifted by leaders who are prepared to challenge the status quo and take on tough challenges to deliver a better NHS in the future. It won't happen by magic.

What threat do you think computer systems have from cyber attacks?

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- There is a constant threat from bad people trying to break computer systems and access information that they have no right to do.
- It is important that the information industry is constantly vigilant and investing to combat these criminals.
- Equally, we can't lock the NHS in the dark ages because we are afraid of the technology.
- The undocumented number of patients who are harmed by clinical decisions made without access to all the relevant information, drug errors that could have been avoided by closed loop medicines management, patients whose condition deteriorates when this could be avoided by intelligent surveillance and clinicians who can only practice the medicine they know because of the absence of clinical decision support is the counter to the risk of information breech. We should not be complacent about the status quo.

What is the biggest barrier to the adoption of data analytics and digital technology in the NHS?

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- It's hard to put a finger on **the** biggest barrier – the cost of the investment needed, the absence of a compelling plan to take advantage of the potential that information and technology offer, fear of the scale of the change, comfort with current working practice; all these are important.

Can you explain exactly what you mean by ‘vertical & horizontal’ integration?

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- By vertical integration I mean tighter integration between tertiary centres, secondary care hospitals, primary care, community care, social care, and nursing homes – top to bottom integration around the patient’s health needs.

- By horizontal integration I mean closer working between similar organisations – mental health and acute hospitals, acute hospital managers, social care and NHS community services to deliver more efficient care at particular points in the care pathway.

How does the NHS overcome interoperability and financial investment challenges to embrace transformational technology?

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- I think these are two separate questions.

- In terms of interoperability, we need to start viewing the patient or the person as being at the centre of care with information and expertise clustered around them, and get away from the venue of care (hospital, GP surgery) being the information and expertise entity. It strikes me as crazy that a hospital or GP can decide not to share their electronic medical record with another hospital or GP. This should be automatic. The only person who should be able to stop it should be the patient or person themselves.

- In terms of investment, the NHS need to recognise that continuing to do what we've always done is leading to a bad place. In the current financial environment one of the key levers to drive quality up and cost down is the use of information and technology to change the health and care delivered. There is no question this is hard – when you are fighting off alligators it's hard to remember you set off to drain the swamp!

Although it seems like a positive long term investment, how could the government and other organisations be persuaded to invest given the short term political focus?

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- See previous answer

How do we encourage people to look after their health using tech when so many rural areas in my patch don't have broadband connectivity?

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- You don't need broadband connectivity. Good technology should be able to run over a phone network. I demonstrated our Clinical Registries system in Melbourne Australia from a server in Kansas City, Missouri over a 2G mobile phone hotspot.

How to work with public and patients in approach to the digital transformation such that a cultural shift happens in the UK towards individuals owning their health

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- We need to be open about the changes that need to happen, what they will mean for individuals and the benefits. The NHS is not currently designed to enable people it is designed to care for people. We need to offer more of the former, so that people need less of the latter. I think it is wrong to assume that people only want to be passive.

How do we help people who don't want to own their health record and would rather a clinician took care of it at all?

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- It is important that we recognise that people are different. There is no point in investing in technology to keep the iWatch generation healthy. They aren't the people filling up our A&E departments.

- The core of population health management is population segmentation. We need to understand people's conditions, their aspirations, and the best way to impact on their health. If the best way is to automate a text message to their phone, we should do that. If the best way is a care manager calling them by phone once a week to review how they are taking their medicine and managing their diet, we should do that. And if the right answer is a face to face conversation with their GP, we should do that.

- At the moment we have too few ways to support people which means that we generally default o the GP and the A&E.

How can we collaborate better with 3rd sector to share information – such as Grassroots fabulous suicide prevention Stay Alive app?

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https://appsto.re/gb/xUmK2.i

- A transformed NHS with data that is clustered around the individual and shared under their control should be a massive boost for the third sector.

- The barriers to being part of an individual's care plan are really high at the moment, partly due to lack of imagination in payment models and partly due to information being locked away. This has to change so that examples like this can proliferate.

Who's paying for your work in the US?

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- I currently work for Cerner Corporation, a US based, global healthcare IT company

Is there a danger that time pressed clinicians will just do whatever the computer advises rather than using that data to make informed individualised decisions?

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- There is a risk of this. There is also a risk that time pressed clinicians will give patients the pain medication they ask for rather than explore the underlying cause or provided out of date treatment because they don't have the time to keep up with the current guidelines or check for the latest available trials.

- Intermountain Healthcare in Utah probably lead the world in the standardisation around evidence base care with their Clinical Process Models (CPMs). When they hand the CPMs over to their doctors that say, "It's now your responsibility to challenge this protocol against every patient you see to ensure that it is the right thing to do." It is as bad practice to blindly follow a protocol as it is to blindly deliver the medicine you learned at college 20 years ago.

How are you linking with NHS Vanguard schemes & how do we prevent duplication of effort?

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- We are trying to join Cerner clients in the UK with exemplars in the USA to help them accelerate their learning.
- We are working with the Wirral Hospital, which is an Accountable Care Organisation vanguard, to link them with Advocate Healthcare in Chicago, the largest ACO in the USA, and the Nuka Institute, described by Don Berwick as the best health system in the world.
- We are working with Royal Free Hospital, a Hospital Chains vanguard, to connect them with Intermountain Health.
- We are working with Surrey and Sussex Hospital, one of the Virginia Mason Institute partners, to show them how VM used our systems to manage quality.
- I'm always open to suggestions.