PATIENTS GET CONNECTED

ONLINE HELP IS AT HAND: 6-7
Junior doctors applying for their training posts this year have not experienced the chaos of online applications seen in 2007. Daloni Carlisle finds out why.

Cast your mind back to the summer of 2007 and the junior doctors’ recruitment round. The National Medical Training Application System was in disarray, with applicants and the consultants shortlisting them both struggling with an unworkable centralised computer system.

No such crisis is on the horizon for this summer, as by February 2009 over 18,000 applications had been completed using a new online recruitment system adopted by all but two deaneries. It was all going swimmingly.

Junior doctors applying for their specialist training posts in 11 deaneries were able to view the vacancies in each deanery, submit applications electronically and track their progress through the system. The deaneries were able to distribute CVs to shortlisting consultants electronically, for electronic scoring. Applicants received their interview offers online and were able to make appointments for interview through the system.

This was not just the matter of new software, though. What changed fundamentally was the whole approach to managing the project.

In 2007, the online recruitment system MTAS had been run as a national project led by the Department of Health’s Modernising Medical Careers programme board and introduced with a “big bang”, leading to the big flop. A Commons health select committee report branded the DH’s project management “indef”.

The British Medical Association is holding its judgment until the juniors start their specialist training in August – but adds that apart from a glitch with the Royal College of Paediatrics and Child Health’s own system, there have been no complaints.

The DH is clear about the success so far, saying feedback from applicants is that they have had a more streamlined and consistent application process. Moving from the paper-based processes used in previous years had simplified the process and offered them significant cost and time savings, added the spokesperson.
For those not familiar with MMC, it is worth spending a moment or two going over the scale of the task of recruiting junior doctors to their specialty training that will see them qualify as consultants and GPs. Every year, tens of thousands of junior doctors apply for a few thousand jobs in England – this year it was 36,417 applications from 13,226 junior doctors for 7,720 jobs. I:CAMS handled about half the applications.

Hicom had several challenges getting ready for January 2009, when the process kicked off. Security was high on everyone’s list of priorities. MTAS had suffered some breaches, with a few candidates’ applications becoming widely available. It was put down to human error in the end but was extremely embarrassing at the time and deaneries were anxious not to repeat it.

“This is confidential information,” says Mr Sanderson. “That’s the rationale behind us having a hosted environment and taking time, effort and investment in making it robust.” The hosting is not outsourced, which, he says, allowed Hicom to give a confidentiality guarantee that the deaneries were comfortable with.

The application form was another challenge, as it is a two-part form. The first part is national and is set out by the DH and MMC; the second part is defined by the deaneries and royal colleges. Each deanery has its own form for each specialty.

“Applying for a surgery post in Bristol requires different forms from applying for an anaesthetics post in Plymouth,” explains Mr Hinchliffe. “We had to produce 130 different application forms in implementing I:CAMS. We were able to build them within the system but adhering to all the rules. The system is flexible.”

Quick turnarounds
So was the project management. Each deanery wanted to build its forms at its own pace and to its own deadlines, for example. Each deanery had slightly different models for distributing applications to shortlisting consultants. Some wanted to send every application to every consultant; others wanted to distribute them in batches to different consultants. That required a high degree of flexibility in managing the projects.

“We have managed this at a local level with each individual deanery engaged at every level,” says Mr Hinchliffe. “We were quite fortunate to have the existing relationship through Intrepid, which meant that we knew people and knew the needs and so were able to deliver quick turnarounds.”
I was sitting down to write about the power shift from NHS Connecting for Health to the Department of Health when the news broke about the scandal at Mid Staffordshire foundation trust.

It wasn’t the Healthcare Commission’s report that immediately distracted me – even though it uncovered grim enough failures to wash, feed and care for patients during an investigation into high death rates. No, what I found really shocking was the immediate reaction of some of those working in the NHS.

Within hours of the report’s findings becoming known, people were calling the BBC and posting comments on the web suggesting the trust was being scapegoated; that any board focused on the trust was being scapegoated; and that any board focused on the trust was being scapegoated; and that any board focused on the trust was being scapegoated; and that any board focused on the trust was being scapegoated; and that any board focused on the trust was being scapegoated.

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Anxious about rising dust levels? Patients desperate for their drinks or drinking out of vases.

Patients desperate for their bells to be answered? Yes. Gagging for a cup of tea, a decent meal and help to eat it? Probably. Anxious about rising dust levels? Almost certainly.

Patients covered in sores and so desperate for a drink that their filthy flower water looks appealing? Probably not.

Still, my list is bad enough. And what was so depressing about the reactions to Mid Staffs was the mindset they betrayed; that poor care is so much the order of things that it cannot be prevented and nobody should complain.

There is plenty of evidence of this kind of thinking. Year after year, whichever body is stuck with the national IT programme and the place of public services on open codes, complaints systems unclear.

It was very much a case of getting customers to speak to each other as well as to us.”

Another benefit for deaneries and the NHS has been the link with the Intrepid software. Once doctors are appointed, the deaneries can feed their details through to the education and training management system, which is linked to the electronic staff record.

‘Once doctors are appointed, deaneries feed their details through and their career is managed with only one record’

“From the point of registration right through to the ESR [electronic staff record], their career is managed with only one record,” says Mr Sanderson.

The system could be used with other groups, too. Deaneries are taking on recruitment of other staff groups, such as allied health professions, pharmacy and some nursing recruitment.

Privately, MMC has said it will not be looking for another provider. Publicly, it is not endorsing I:CAMS and says that some of the success of this year’s recruitment was the move to national processes for small specialties or those larger ones for which shortlisting, scoring and interviewing systems have been standardised.

“More specialities using national processes has resulted in 45,000 fewer applications needing to be processed in the first round of recruitment in 2009,” said the spokesperson.

National processes administered by deaneries were used to manage 70 per cent of recruitment to specialty training and more will go this way in 2010.

Does this experience really have lessons for wider IT procurement? Mr Sanderson thinks so.

This was a project delivered by a small company that knew its NHS customers well.

“This project was 70 per cent management, 20 per cent development and only 10 per cent design,” he says. “Without doubt it required software innovation, but given our experience in the market, which simplified the design process and rapid development technologies, it was the strong management skills that proved key to delivering a project of this nature and scale.”

A NHS chief executive David Nicholson continues to consider the future direction of the national IT programme and the place for large companies with a track record outside the NHS versus niche companies with a track record inside the NHS, he could do well to look at what Hicom achieved.
COMMUNITY INVOLVEMENT

Giving people a voice

Local knowledge gave Warrington PCT an edge in cracking its service redesign

Giving the community an active voice in service design is often discussed, but is not easy to do. When Warrington primary care trust set out to design its strategic health plan, no one knew how detailed and incisive the community’s views would be.

Warrington PCT developed the A Healthier Warrington programme to provide more effective forums for the community to give feedback on local development and health strategy.

The PCT knew an effective 10-year health strategy depended on the community’s input and support. Faced with an ageing population and diverse mix of social deprivation, Warrington PCT needed to research and understand:

● service usage and satisfaction, particularly in relation to GP services and access;
● community views on the trust’s proposed pledges to improve the health service;
● the importance the community put on preventive healthcare.

The trust worked with information provider Dr Foster Intelligence to deliver nearly 10,000 community opinions to the strategic planning team. A questionnaire asking residents about their personal experiences of NHS services and their opinion of the PCT’s proposed priorities was posted to more than 75,000 people. The PCT, GPs, community centres and library helped distribute the questionnaire, and it was made available online.

Discussion sessions brought together a small number of people with similar backgrounds and included a wide range of ages and backgrounds, including people with disabilities, ethnic minorities, people with mental health problems, people with long-term conditions, and prisoners. There was also one group discussion with local decision makers and opinion formers.

Greater ambivalence

Jan Holding, head of partnerships at Warrington PCT, explained: “We have striven to ensure that seldom heard communities have been given the opportunity to have their say on what is important to them.”

Participants were asked to prioritise proposed plans and were given the opportunity to question senior decision-makers.

The independent regulator for the NHS called the Healthcare Commission which publishes an annual assessment of the quality of service at every hospital on a scale from “weak” to “excellent”. Mary, who has a sharp mind, interrupted me disdainfully.

“Is this the same Healthcare Commission that said recently Mid Staffordshire foundation trust was the worst hospital it had ever looked at when six months before it said the service was good?”

I fired up the laptop and showed Mary the HCC report for one of the local trusts.

“Mary wanted to see was proof that they have no infections, whereas the annual assessment only confirms compliance with an improvement and prevention process. It took a fair amount of surfing between the HCC site, the trust site and the Health Protection Agency site before I found the service was good.”

She needs cataract surgery and is reluctant to go into hospital again because she has been alarmed by coverage of official reports damning the standards of cleanliness in hospitals. The scandal at Mid Staffordshire foundation trust was the last straw for Mary, who is on the verge of deciding to put up with deteriorating eyesight rather than risk an early demise in hospital.

Mary asked me how she can be sure she will be safe in hospital.

I explained that she doesn’t have to go into the local hospital if she thinks she will get better service elsewhere.

“How will I know which are the safest hospitals?” she asked. “You hear all the time now about old people dying in hospital because they get a horrible infection.”

I set out to reassure Mary by explaining that there is an independent regulator for the NHS called the Healthcare Commission which publishes an annual assessment of the quality of service at every hospital on a scale from “weak” to “excellent”.

One of the surprising findings from the research was the community awareness of, and involvement in, mental healthcare. Many participants were not happy with the level of support provided and believed that many people were going for extended periods of time without diagnosis or treatment. They also expressed concern about the lack of time GPs had with each patient, leading to a potentially damaging under-diagnosis of problems. The main suggestions for improvement were to:

● better promote mental health issues to help reduce stigma;
● make people more aware of available services;
● encourage people to be more confident in using services.

The research showed that the PCT’s pledges aroused strong feelings of responsibility in the community. The initial pledge of “delivering better health and wellbeing for everyone” was seen as by far the most important, and due to its all-encompassing nature was suggested as the title for all the trust’s priorities.

Providing support and intervention, particularly in the areas of bowel, cervical and breast cancer, was identified as the most important recommendation in the programme.

As well as forming a “people’s panel”, to be consulted regularly on health development issues, further deliberative events and focus groups are being planned to ensure that all in Warrington continue to “have their say”.

FRANK BURNS

ON CONSUMER INFORMATION

I soldiered on and explained how trusts report patient safety incidents centrally and that comparative information on these incidents is also available on the web. Again, we looked at the data for a local trust. After she had recovered from her initial shock at the sheer number of incidents I tried to explain that high numbers of reported incidents could indicate a safer trust and that trusts with low numbers might not be open about things going wrong.

In the end I had to admit that because of under-reporting and the lack of robust national standard definitions this data cannot be relied on to differentiate between trusts.

I tried to talk about the importance of recording accidents but she was so overwhelmed by the type and scale of errors that she covered her ears.

We briefly discussed the value of hospital standardised mortality rates. After I explained that the experts disagree on whether they offer a reliable comparison, Mary was relieved to hear that these aren’t yet available to the public.

My offer to make her a cup of tea brought an end to the discussion and provided a merciful release for both of us.

“Do you want to know what I think, Frank?” she said when I returned with the tea. “These hospitals are public services. Why don’t the people in charge just do their job properly and make sure they’re all as safe as each other? Then I could go and get my eyes seen to at the local hospital without all this nonsense with the computer. Why can’t they do that?”

Frank Burns is a former NHS chief executive and was the author of the 1998 strategy Information for Health. He is an independent healthcare consultant and a senior associate with MECHealth IT consulting, fgburns@yahoo.co.uk
Like the term “Web 2.0” or “social media”, Health 2.0 is not about a specific technology or social network. It encapsulates how the internet can go beyond broadcasting information and is now being used to build health-related communities and relationships. Ultimately they promote the power of the individual to share, learn and engage with people with similar conditions and with healthcare professionals.

Patient-focused social networks, blogs and other Health 2.0 sites are empowering patients with a range of short and long term conditions from cancer to diabetes to build communities so patients and carers can offer support to each other.

These sites are also enabling the medical profession to gain insights into the impact of the drugs and care on patients’ lives beyond the consultation room or testing suite.

The benefit for patients does not stop at community support. The rise of Web 2.0, from blogs to review sites, has seen customers forcing organisations to become more transparent and ensuring they fulfil the promises they make.

This, coupled with an increasingly consumer-orientated society, means people are turning their opinions to the quality of the healthcare they receive. The now well-known patientopinion.org.uk website allows patients to rate their healthcare and add comments, good or bad.

The NHS is aware of the benefits of garnering feedback online (and the perils of ignoring it), so NHS Choices includes similar features and shares feedback with patientopinion.org.uk. The forthcoming option to rate GPs is another step towards greater transparency and the empowerment of the individual to make a difference.

The most exciting forthcoming development is NHS Healthspace, which is a personal health record, and allows patients to store and keep track of health information such as blood pressure, blood sugar levels, weight, peak flow readings and much more, which can be securely shared with their GP or agreed healthcare provider.

The scheme, which is part of Connecting for Health, is being piloted across the UK and is allowing patients to take an active role in their own healthcare in collaboration with their clinicians.

High satisfaction

Patients will be able to use the internet to track their conditions in a secure online environment. Future facilities will also enable transactions online, including booking appointments and ordering repeat prescriptions, providing the patient with far greater control.

Professionals are seeing the benefits, too, which increases its chance of adoption, with The National Clinical Advisory Group voting Healthspace the “most exciting part” of the national programme for IT, saying it “was the most exciting product for the next few years”. These tools are essential in the current battle against avoidable conditions such as obesity and heart disease.

The US has been leading the way in this area for the past few years, and “Health 2.0” was coined there. There are full online health assessments, access to lab test results, and direct electronic communication between patient and doctor.

Even though the latter of these might send chills down the spine of many GPs, a US study showed 67 per cent patients wanted secure, online communication with their doctor. One US hospital reported high patient and clinician satisfaction with its trials with email.

Although there are fewer “face to face” contacts with patients, time wasted trying to catch up with patients on the phone is vastly reduced. Patients, too, are finding that quick questions they may have that required a visit to the doctor, and time off work, are now answered with a quick secure email. The system also allows an easier paper trail to be made, which is particularly important in the litigation culture of the US.

Even with all the above activities, the traditional challenge for patients has been the inconvenience of having to be tied to a PC to gain access to tools online. And for some, access to a computer is simply not possible. This is why the next development in healthcare may well be where the revolution will happen – mHealth.

mHealth, a phrase coined to describe the use of mobile devices to manage personal health, has not always been convenient or possible, often due to cost of devices and poor take-up. However, all this is now
‘The Nintendo Wii Fit was the first games device to provide health-related measurements such as BMI’

changing – and at the centre in the current rise of popularity of mHealth is the iPhone, which (as with several other current mobile devices) has facilities to run additional software applications on its operating system, in a similar way to a computer.

These applications range from games to productivity tools and, increasingly, health-related applications. Of the 24,000 applications for the iPhone, many of which are free to download, more than 1,000 are dedicated to medicine, health and wellness.

So perhaps it isn’t surprising that the launch of the latest iPhone 3.0 operating system demonstrated the importance mHealth has acquired within the healthcare sector. Johnson & Johnson’s LifeScan division was one of the select few picked to demonstrate their new iPhone application at the launch event. The application designed for diabetes patients uses a mix of features on the iPhone, allowing patients to do a range of tasks from measuring glucose readings via bluetooth, track ‘n’ trend readings via charts and even a “meal builder” to create meals that are reflective of the users’ current insulin values and intake needs.

Personal health devices

The reason why mHealth will make such an impact is not just the gadgetry – it is because of its simplicity and usefulness. At the least, patients used to mHealth are becoming freed from computers and paper and can manage their health because the tools they need are in their pocket.

It could be argued that the popularity of mHealth and the related interest of non-medical organisations to help build wellness tools was inspired by the Nintendo Wii Fit.

For the first time, a games device was able to provide health-related measurements such as BMI and provide advice and tools to help improve an individual’s fitness level through a range of exercises from yoga to skiing. A study published in the British Medical Journal stated that Wii players use more energy than playing sedentary computer games; however, the study also indicated it should not be seen as a total replacement for regular exercise.

The fact it was the third bestselling game of 2008 in the US, selling in excess of 4.5 million, clearly showed there is a market for personal health devices. More recently, this has extended further with other devices such as the handheld Nintendo DS including a pedometer. Other games manufacturers are also moving into this space.

The challenge for the health service will be knowing how to engage with these new technologies and cope with the changes in attitudes and expectations from patients who are using them.

The future is already here, and the more opportunities patients get to embrace Health 2.0 and mMobile, the more likely they will be expecting clinicians to share the learning from these as part of their health management in the same way they currently prescribe pills. So the challenge will not be one of technology, but of a changing mindset with people being seen as partners and not just patients.

Dean Russell is head of digital marketing at Precedent Communications.
Ever since its publication on the 60th anniversary of the NHS in 2008, High Quality Care For All has been much discussed but poorly analysed. The focus on “quality” has been welcomed and the reform bandwagon has quickened. But there must be concerns about the fragmented nature of these reforms and the ambiguities in the Darzi report.

Lord Darzi's focus on “quality” rests on effectiveness, patient safety and the patient’s experience. These concepts are all clinically orientated and ignore cost. How much of each of these desirable “quality” improvements can Darzi afford and how does he propose that competing investments in each of them should be prioritised?

Over a decade ago the Cochrane Collaboration pressed all healthcare systems to move towards “evidence-based medicine” – interventions proven to improve patients’ health – and was criticised for failing to take cost into account. As a result of the consequent “economic imperialism”, the National Institute for Health and Clinical Excellence has taken an economic approach, recognising that what is effective may not be cost effective, but what is cost effective is always effective. This message has not been integrated fully into the Darzi report.

On patient safety, we should strive to do our patients no harm, while acknowledging that errors affect 10 per cent of patients admitted to hospitals and an unknown number in primary care. But how should investments be prioritised? “Bare below the elbows” appears to have no evidence base. Screening all patients for MRSA may not be cost effective. Where are the links between this policy, effectiveness, and cost effectiveness?

The third element of Darzi’s “quality” approach is patient experience. Again, the policy issue is the identification of investments that are cost effective. Clinicians confronted by a patient with urinary regularity in the night may offer surgery. Insight into the costs and benefits, which include incontinence and loss of sexual function, may deter the patient. Information about outcomes can cut activity rates to the benefit of patients. Darzi should have exploited better the limited evidence base to improve the patient experience.

The pursuit of improvements in “quality” involves investment in processes and outcomes. For many years the Royal College of Physicians has carried out audits of processes in stroke and chronic obstructive pulmonary disease. The Healthcare Commission has used this data modestly and failed to eradicate the large variations in processes that deliver care to patients.

Whitehall has now prioritised stroke and wants hospitals to adhere to national standards of care which will save lives and reduce morbidity. These standards are derived from the evidence base and have been recognised for years. They will be built into commissioning for quality and improvement (CQUIN) from April and failure to adhere to them will put the payment by results tariff at risk.

At the Commons select committee in March, the secretary of state made it clear that CQUIN will include patient-reported outcome measures. Using these measures for hips and knees, hernias and varicose veins, before the procedure and three months after intervention, will show whether healthcare makes patients’ physical and psychological functioning better.

The results are likely to be positive for hips and knees, but many hernia patients will be worse off, since it takes longer than three months to recover from surgery. CQUIN also excludes cataracts when there is evidence that a significant proportion of surgery does not help visual acuity.

The Darzi report has no implementation element and appears to rely on the goodwill of the medical profession. Each year payment by results tariffs have a 3 per cent “efficiency” element built into them. As independent sector treatment centre contracts come up for renewal, this makes NHS work less attractive to the private sector. Conspiracy or cock-up?

The payment by results efficiency element and the advent of “normative pricing” in 2010-11 will further depress costs. Normative pricing involves setting the payment by results tariff in relation to the average cost of low-cost producers rather than all producers. With the depression and parsimonious funding of the NHS, these policies will have to be deployed with care and evaluation. They are likely to produce mergers and the creation of “hospital chains”.

How can these effects be translated into changed clinical practice that results in conservative, safe, evidence-based and cost-effective practice? When the GP quality and outcomes framework was introduced, its effects were reinforced by money and the behavioural responses were quick and comprehensive.

CQUIN and patient-reported measures are in effect a hospital quality and outcomes framework greatly in need of an incentive structure. An obvious candidate for this role is the system of clinical excellence awards. These are in effect a system of performance-related pay where transparency is absent and performance is poorly measured.

Linking these awards to CQUIN and PROMS is essential, as is making these payments temporary and related to the performance of the team as well as to clinical success. Darzi may have roused elements of the medical profession to address better the quality agenda. Some of his thinking is confused and the reform elements are fragmented. But he has done well for a surgeon and the challenge for us all is how to support him in moving this urgent agenda forward swiftly.

Alan Maynard is director of health policy at York University.