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HSJ EFFECTIVE TECHNOLOGY

O2 health

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DATA DESTINY

EXPERTS DEBATE WHERE TECHNOLOGY WILL MAKE ITS NEXT BIG IMPACT ON THE NHS

O2 health

THE TWITTER CHALLENGE

A wide-ranging discussion over the future of technology in healthcare took in everything from telecare to the digital divide to the NHS's failure to engage with social media. Daloni Carlisle reports on a lively debate

ROUNDTABLE PARTICIPANTS

Elisabeth Buggins, chair, Birmingham Women's Foundation Trust and member of O2 health advisory panel
Dr Felix Burden, clinical director of commissioning, long term conditions, Birmingham and Solihull NHS Cluster, and member of the O2 health advisory panel.
Rosemary Cook, director, The Queen's Nursing Institute
Jim Easton, national director for improvement and efficiency, DH
Mo Girach, special adviser, NHS Alliance
John Grumitt, vice chair, Diabetes UK
Dr Mark Newbold, chief executive, Heart of England Foundation Trust
Keith Nurcombe, managing director, O2 Health
Don Redding, director of policy, National Voices
Jennie Smith, head of strategy, O2 Health
Alastair McLellan, editor, *HSJ*, and roundtable chair

There is now near universal agreement that health services need to be better integrated and that this cannot happen without an IT-enabled shared care record that is accessible to everyone involved in the patient's care – starting with the patient – wherever they happen to be.

It's possible to trace a straight line from "no decision about me without me" in the July 2010 white paper *Liberating the NHS*, through the Future Forum's call for integrated care and then the government's response, which outlined a stronger duty for the NHS Commissioning Board, clinical commissioning groups, health and wellbeing boards and Monitor to encourage integrated working at all levels.

It's a line that takes in the King's Fund and Nuffield Trust joint report commissioned by the DH, *Integrated care for patients and populations: improving outcomes by working together*, which identified lack of information sharing as a barrier to integration. "Innovative approaches are needed to sharing data together with a commitment to developing shared clinical records," it said.

The forthcoming information strategy is expected to flesh out how this might take shape and to set out how information sharing can support not just integrated care but also new technologies, such as telehealth and mobile working; new approaches, such as measuring patient outcomes; and new incentives that reward integration.

This, then, was the background to the recent roundtable debate hosted by *HSJ* on behalf of O2 Health. Round the table were clinicians, managers, policy leads, and patient and professional representatives.

New ways of working

HSJ editor Alastair McLellan set the scene. Where, he asked, would technology make the most significant impact on the quality and efficiency of healthcare in the next three years.

Broadly speaking, there was general agreement. Use of technology to support new ways of working was a must-do, not an option, the group agreed. It will help support the challenges of meeting rising demand for healthcare from people with long term conditions and managing the impact of that on the acute sector.

The technology to do this exists – but it has to replace old ways of working, not add to them. Using it can no longer be an option for health professionals. Finally, the NHS must respond to new demands from patients who want to see technology solutions embedded in their healthcare so that they can manage their own conditions better.

Don Redding, director of policy for National Voices, a coalition of over 130 health and social care charities, kicked off this section of the debate with a focus on care for people with long term conditions.

"The technology is the patient," he said. "The big impact will come from telehealth and telecare supporting people to better manage their conditions while providing value to the system itself."

There would be two main areas where this technology would impact, he added: large populations identified as able to benefit from telehealth and smaller numbers of patients who are isolated because of their living circumstances.

"They might be living in a rural area or have no informal carers or be people with complex needs who require specialist care that is available only at a distance from their local health economy," he said.

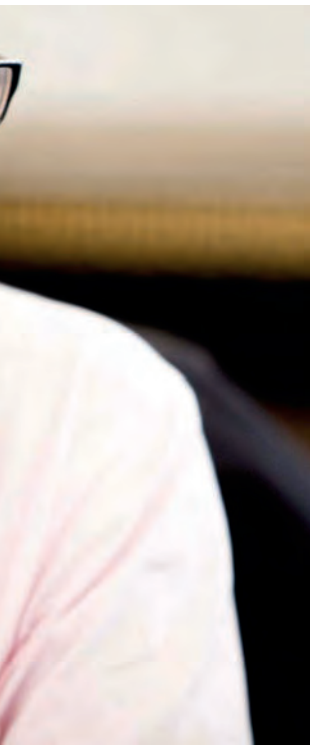
Dr Mark Newbold, chief executive of Heart of England Foundation Trust, came at it from a different perspective: managing the rise in acute activity.

"We know from our work in Birmingham that the rise in acute activity in the last eight years is based on a rise in admissions of frail elderly people due to lack of care available in the community and to readmission," he said.

"We need to use technology to underpin truly integrated care services. Everybody needs to work differently in a service that is designed around the needs of those patients. We need to understand who they are and offer proactive care. If we don't we will not make any inroads at scale into acute activity."

He wanted to see a shift from talking about bed numbers and cost savings to talking about patient outcomes, and to see more information going into the public domain.

"We need to get doctors and



Share dividend: (clockwise from top left) Mo Girach; Rosemary Cook; Keith Nurcombe; Elisabeth Buggins; Jennie Smith; Jim Easton; Felix Burden, who said he is already seeing real benefits from shared records in Birmingham; and John Grumitt

patients talking about clinical outcomes as it will help us understand where care is good and where it is not," he said. "We need to look at community clinical outcomes – are health services maintaining health and reducing the incidence of acute ill health? We need strong measures."

Slow adopter?

But John Grumitt, vice chair of Diabetes UK, suggested that the NHS was too slow to adopt technology, citing work by the Policy Exchange from November 2011 which noted: "The UK is one of the slowest adopters of new health technologies, falling dramatically behind countries like Canada, France, Sweden and Spain; and as a consequence our overall health outcomes are significantly behind that of comparable countries. Spending on health technologies is reflective of low adoption, with only 4.5 per cent of the NHS budget being spent on technological innovation, compared to the European average of 6.3 per cent."

Mr Grumitt recalled the story of Carphone Warehouse, which changed the way the mobile phone market operated by incentivising salesmen to sell customers the phone that was right for them. Usage went up and fewer people changed their handset.

He argued that the NHS needs to learn from this and take a new approach to incentives that can break down barriers to innovation.

More practically, he said the technology most likely to have an impact was the use of mobile communications to gather information about how people live and how this impacts their health.

'Only 4.5 per cent of the NHS budget is being spent on technological innovation, compared to the European average of 6.3 per cent'

Sitting next to him, Dr Felix Burden, clinical director of commissioning, long term conditions, at Birmingham and Solihull NHS Cluster and a diabetes specialist, rejected the idea of a technologically backward NHS. "In Heart of Birmingham we have an integrated clinical system with hospital, primary care and community data all available," he said.

"If a patient phones me up, then I can see exactly what is happening to them in primary care, and whether there has been a mistake in prescribing. I can see exactly what happened to them in one hospital."

Yes, he would like more hospitals to link into the system but even at this limited level the shared record access had real advantages. He had been able to assess every local GP's prescribing abilities both in terms of their errors and their omissions – such as failure to prescribe statins or aspirin when clinically appropriate.

He also revealed that he does a lot of this work in his own time, suggesting that there is little systemic appetite for this kind of transformative use of data.

His final plea was to integrate services around a group of patients who are often excluded

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Uncomfortable fax: (clockwise from top left) John Grumitt; Elisabeth Buggins; Jennie Smith; Keith Nurcombe; Don Redding; Mo Girach; Felix Burden; Mark Newbold; Rosemary Cook; and the DH's Jim Easton, who made a lighthearted plea for a ban on fax machines in the NHS

from the best care: the housebound. "I am obsessed with the housebound," he admitted.

"They are much more likely to be frail and elderly, and they are being actively excluded from a lot of healthcare provision... I know that there is lots of activity in terms of nurses popping in to see them – but it is not integrated."

Jim Easton, national director for improvement and efficiency at the Department of Health, predicted that there will be a significant change in the way the NHS uses technology in the next three years.

"We need to completely reshape the model for long term condition management and we will see a move from managerially led change to patient led change," he said. Technology had to stop being an add-on and start replacing outmoded service models, he argued.

He also predicted that social media will come to bear with people sharing experiences – and that the NHS will need to respond.

This fed into comments from Mo Girach, special adviser to the NHS Alliance and a King's Fund associate. He wanted to see technology empowering patients and supporting the self care agenda. He also agreed with Mr Easton. "The NHS is missing the whole agenda on social networking," he said.

'I am pretty sure there is one fax manufacturer out there who is being entirely supported by the NHS'

Keith Nurcombe, managing director of O2 Health, agreed. "I think the biggest change in the next three years will be the ability to share more information with patients to support them to manage themselves better, and to provide information about their lives back into the NHS," he said.

He warned that unless the NHS starts to give patients their own information, they will go elsewhere. "They will take technology that works on their smartphone and use it themselves," he said.

This was not science fiction, he added. "It is now possible to for a diabetic patient to take their own measurements and send them to clinicians," he said. "The question is: what do we do with that information?"

This shift is a big cultural change – and while people such as Mr Grumitt are ready and waiting, many others are not, warned Jennie Smith, head of strategy for O2 Health.

"I think we need to take into consideration what patients currently expect from their healthcare," she said. "They like to go and see their doctor. They like to see white coats and stethoscopes. We need cultural education from a patient perspective as well as a professional perspective to explain that using technology is not about replacing the face-to-face consultation but about enhancing it."

She also said the time was ripe to start looking not just at how community staff can use technology to stop unnecessary hospital referrals or admissions but also at how acute staff can use the capability to improve patient discharge processes.

Keep it simple

Elisabeth Buggins, chair of Birmingham Women's Foundation Trust, made a plea to keep things simple and make better use in the NHS of technology that is already at many people's fingertips.

"The most cost-effective intervention we have found used ordinary mobile phones and texting," she said. Patients use monitoring kit they can buy from the pharmacy, text their results and get advice back from professionals about how to manage their health.

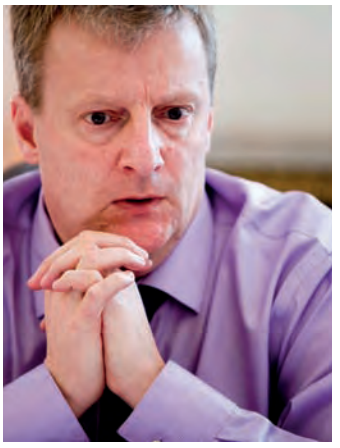
This had proved particularly helpful around the transition from children's services to adult services, a notoriously difficult care boundary to negotiate.

"It has great benefits," she said. "It stops the dependence that we tend to develop by giving patients clever kit, teaching them to use it and then taking it away."

She agreed with Ms Smith on the cultural issues. "We talk a lot about the what and the how but very little about the underlying culture and how people are too fearful to try new things. We need to develop a culture where we give people permission and time to have a go at doing things differently."

Rosemary Cook, director of the Queen's Nursing Institute, which recently produced a report exploring the cultural barriers to technology uptake by community nurses, also picked up this theme.

"The NHS needs to see technology as a clinical issue, not a technology issue," she said. "It does require new professional behaviours in the way you relate



to patients and how you organise care."

Without these changes, technology becomes an add-on and leads to even greater duplication, with professionals checking the monitoring signs in telehealth systems or keeping paper and electronic records.

"We end up with a lot of add-ons – add a website, add text messages – but we still have the old system," she said. "But using this technology should not be a choice. It has to be integrated into what we do. It is time we told people it is not OK to keep illegible handwritten notes just because we have always done it. This is the fundamental of new healthcare."

So much for the three-year view, then. What about the immediate year ahead? Mr McLellan asked the roundtable for the single most important change they want to see in the next 12 months to move this agenda forward. Many of the responses were extremely practical.

For Dr Newbold it was simple: education and training of staff in new ways of working delivered through e-learning. His trust had introduced such a package – VITAL, or virtual integrated teaching and learning, now completed by 5,000 nurses – saving tens of thousands of hours of staff time that would have been spent in classrooms.

"It has been hugely effective in delivering a broad range of competencies and assessments across the organisation and we are ready to share it," he said.

Mr Grumitt called on the new health and wellbeing boards to start to live up to their promise and include the patient voice while Mr Redding urged the NHS to "get ready for co-ordinated care and shared records".

The information strategy due out soon from the DH will set out what needs to be done, he suggested. "Many people in patient groups think that access by patients to their own records will be an enhancement of the relationship with the GP," he said.

Dr Burden added a practical spin to this, saying he was ready to take the shared record further by creating new ways for patients with long term conditions to view their own test results. This could be a web-based view or perhaps by text message. "I do not think it will cost very much," he suggested. "At any rate, the most expensive way of doing this is by producing letters."

Mr Easton admitted to verging on the facetious when he suggested outlawing fax machines in the NHS. "I am pretty sure there is one fax manufacturer out there who is being entirely supported by the NHS," he said. "We are relying on nonsense."

More seriously, he wanted to see a move away from episodic based tariffs to tariffs that support improved outcomes and indicated that these will start to appear over the next year.

Mr Girach called for clinical commissioning groups to grasp not just the commissioning agenda but also the decommissioning agenda while Ms Smith called for more collaboration to join up the dots between small-scale trials and move to widespread adoption of technology.

Mr Nurcombe pushed this further. "One of the biggest issues with the NHS is the need to pilot everything," he said. "We work with lots of different people and I understand that every business sees itself as slightly different to the next one but do we really need to do everything in triplicate? It takes forever to do anything.

"It makes it very expensive for the NHS. For suppliers like O2, we become cost-effective by doing things at scale."

Ms Buggins agreed. The NHS abounded with simple, proven solutions that remained in silos. She cited electronic medication dispensers used in her trust to helped people at home take their medication correctly. "For every £1 we invested, we saved £19.50," she said. "I cannot see why we do not make that available everywhere."

She also picked up on the theme of enforcement to drive through change, relating the experience of Belgian public services that had made it illegal to gather the same information more than once, enforcing sharing.

This would make a huge difference to people's lives. "Particularly prisoners who every time they move have to go

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Social networking: (clockwise from top left) Mark Newbold, who suggested social media could be used to tackle public mistrust of NHS leaders; Don Redding; Jim Easton; Elisabeth Buggins; Alastair McLellan; Rosemary Cook; Keith Nurcombe; John Grumitt; Mo Girach; Jennie Smith; and Felix Burden

back over their traumatic history," she said.

Rosemary Cook made a radical suggestion. "I want to see a consortium of suppliers provide every community nurse with a handheld computer and the encouragement to use them, for example by making it clear they cannot keep driving back to base to pick up the paper notes," she said. "I want to see everybody pitch in and put their money in."

Digital divide

Mindful of the need to address the real world, Mr McLellan then asked the roundtable to discuss the barriers. These ideas were all well and good, he said, but in the NHS there were some real debates about whether a move to technology-based solutions would further disadvantage groups already marginalised and struggling to access the NHS.

Access to broadband required money and some IT competence. "Does technology open up a divide between those with access and those without," he asked. "Should we accept that or does it give us pause for thought?"

Not all patients want to engage in their own health management, he added. "There is a desire out there for people to use technology to engage with their own health – but also a desire not to. You can lead people to water but you cannot make them drink."

'There is a desire for people to use technology to engage with their health – but also a desire not to'

The debate around the evidence produced so far by the Whole System Demonstrator sites on telehealth indicated that many health professionals are yet to be convinced by it, he suggested.

The debate around the nature of nursing may prove even more fundamental, especially with the forthcoming publication of the final report of the Francis inquiry into Mid Staffordshire Hospital. "The debate is very polarised," said Mr McLellan. "Is nursing a highly technical skill or is it about bedside nursing and compassion? Will the whole agenda around Francis push us away from new ways of doing things?"

Ms Cook agreed. "The perception is that being technologically competent is an alternative to being caring," she said. "We have simply failed to persuade the public that making a nurse or any other professional highly technical and skilled does not remove the fact that they are also compassionate and caring. That is a huge issue and going to get worse."

Dr Burden explored what sort of technologies the NHS requires in the next year and called for a dose of realism. He said: "There is a real need to press on with the absolutely mundane issue of that which is already available and not [go] rushing off with more bizarre solutions."

Even in his very deprived area of Birmingham – where he both lives and works – most people have a mobile phone even if they do not have a landline and will respond well to personalised texts reminding them of appointments, for example.

Ms Buggins agreed. "I work with a small charity for asylum seekers and refugees and what strikes me when I visit their homes is that they may not have a chair to sit on but they have a big TV," she said. "We assume that people are technology deprived when that is not always the case."

And as Mr Easton pointed out: "People who are disadvantaged around technology are also disadvantaged in the current system by lack of access to transport to existing services or poor language skills."

Could text messaging or using TV channels to disseminate information be enforced by CCGs, asked Mr McLellan. Probably not, was the answer, as the GP contract is too vague to allow something so specific. "At the moment all we can do is try to convince people of the logic," answered Dr Burden.

Mr Eastman, who is at the heart of DH attempts to wean NHS management off the idea of central directive, pitched in. "The job of the new system is to figure out what is done at what level," he said.

"We need national standards and contracts to move in this direction, but we need local action and I am more optimistic about CCGs and their leaders who are very motivated to drive out unwarranted variation."

But shifting to new care models – and giving people the freedom to innovate – did require managerial skill. "It's not about top down or bottom up but about how you create skills in the system," he said. He hoped some of the approaches developing from the chief executive's report, *Innovation, health and wealth*, such as academic health science networks will support this.

Different areas and different health communities would take this challenge at different rates, he added. "I do not have a problem with working with young people in the forefront of this. That's where this information revolution started."

On the question of whether using technology would help reduce inequalities or "massively increase" them, Mr Easton was unclear. "I think we need the mindset of the former," he said. This might mean looking to the internet for translation solutions as a more efficient and cheaper alternative to employing translators, for example.

Unused laptops

Mr Nurcombe highlighted another set of barriers – ironically ones that are designed to help: procurement frameworks. Often they are out of date, he said, not fit for purpose and ultimately they stifle innovation.

The other was the mindset around technology – a point that echoed earlier comments around the cultural shift needed.

"Technology must be viewed as the enabler, not the driver. Services are very poor at understanding what their problems are and how technology can best deliver against them. In practice, this breeds a lack of credibility and failure [in technology projects]."

As an example, he talked about giving community nurses

secure laptop computers. "The NHS has spent millions on this but nurses do not use them because they are too cumbersome, the connection speeds are too slow and no one was clear about what they wanted to achieve."

Returning to Ms Cook's challenge to give every community nurse a handheld computer, he said: "I would consider that challenge, but I would want to know what they were going to do with them."

Another theme to emerge was the extent to which GPs use different clinical systems and whether this prevents sharing of data. Mr Girach was in favour of making everyone use the same system; Ms Smith supported an interoperability approach.

But Mr Nurcombe pointed out: "The biggest issue is not that GPs have different systems or that they do not interoperate. We have lots of geeky people who can make it happen. The real problem is that the systems are closed." This is a statement likely to raise the hackles of the system providers, many of whom have worked to support interoperability and information sharing, as well as those of some GPs who argue that sharing information willy-nilly is neither acceptable nor desirable and will breach patient confidentiality.

Nor is it universally true, said Dr Burden. "The culture in Heart of Birmingham is very much to share information, with only three out of 75 practices not doing this routinely," he said.

Mr Easton moved the debate on. "The vision you are all describing requires us to negotiate a new deal around information. We have to do that as a society and we have not yet had that argument."

Mr McLellan agreed. "It is too difficult a conversation to have," he said. "But when I encounter those who use the patient confidentiality argument, I ask them to name me someone who has been harmed, let alone killed, by a lack of patient confidentiality. Yet people die everyday and are harmed everyday because we do not share information."

Another barrier raised was that of professional resistance. "There is no doubt health professionals do obstruct this and it is because of lack of confidence and competence," said Ms Cook. "That is a very practical thing and it needs to be dealt with."

It needed to be tackled at post-registration level, she suggested. "Most of our pre-registration nurses are confident with technology, it is the older generation that needs support."

It was not just professionals who may lack skills, added Mr Redding. "Health literacy levels among the public are not high," he said. "Nor are technical skills. So, yes, there are some technologies that can support people to look after their own health but there needs always to be support."

The final barrier highlighted in this debate was one dear to the heart of many an NHS manager: service redesign.

Dr Newbold said: "I think many of the solutions to the QIPP challenge lie in technology but we cannot implement them and that is because of the struggle around redesign. We know we will see better outcomes, but we are struggling to do it. Why? Because NHS leaders are, by and large, not trusted by the public we serve and often not by our staff either."

The solution to this might in fact lie in better use of technology to share information about decisions, about service levels, about outcomes. "We need to be more transparent and more accessible," said Dr Newbold. "And social media is an excellent way to do that." ●

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