FOR HEALTHCARE LEADERS
HSJ
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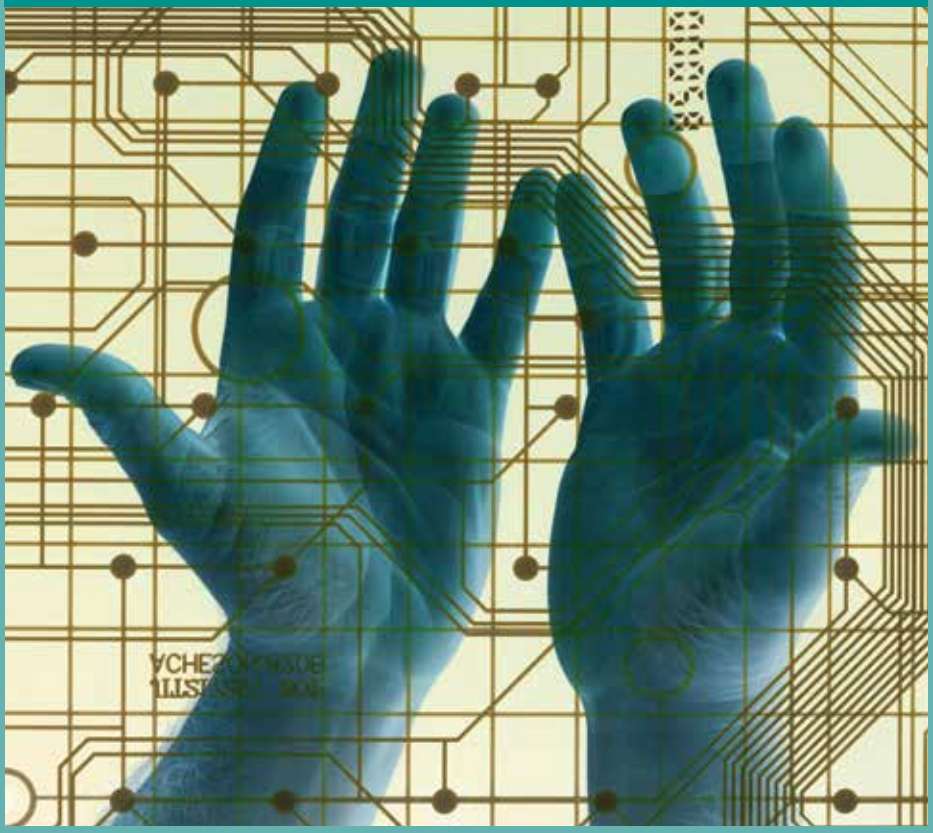
DRIVING CLINICAL ENGAGEMENT IN IT

A GUIDE FOR HEALTHCARE IT DIRECTORS



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FOREWORD
IAN DALTON

New world of possibilities

The NHS is at a key point in its history. A £30bn challenge, a focus on the quality of care and ever rising demand set the scene for the next five critical years. The success or failure of the NHS will depend on us being able to make fundamental change to the way that care is delivered. And to do so at pace and at industrial scale.

I'm passionate about improving healthcare. I want the NHS, and health and care systems like it around the world, to flourish. We need to change how we think about the delivery of care, to transform lives and put the patient at the centre of a new world of care.

IT needs to comes out of the shadows and play a major role in creating the new world of care

BT and *HSJ* technology guides aim to help NHS boards understand how IT can be used more effectively to drive the transformation of your organisation and of patients' lives. This guide, first in a series of three, is aimed at IT directors, to support you to deliver higher quality care at lower cost.

IT needs to comes out of the shadows and play a major role in creating the new world of care we need. Technology can positively disrupt the traditional journey of care, transforming people's lives. For example, it can enable people with long term conditions to monitor their own care at home rather than receiving unplanned responses to repeated crises. It can transform the working lives of staff, allowing them to spend ever more of their time caring for their patients rather than on paper-chasing.

At BT, we've found that lasting improvement comes not just from the smartness of technology but also from the ability to create genuine clinical transformation; from changing workflows and helping clinicians to work smarter. That's never an easy thing to achieve, as we know from our work supporting the NHS over the past 65 years.

By sharing the knowledge and expertise of professionals from the public and private sectors through these guides, BT is ready to help you transform for the future and will be with you on the journey to create that new world of care. ●

Ian Dalton is president of BT Global Health

JOHN WILLIAMS

Information needs to be a priority as we build hospitals for the future

TOP TIP

Record systems must focus on the individual patient

The Future Hospital Commission, which reported in September 2013, has set out how the care of acute medical patients must change to cope with rising demand, increasingly complex conditions, systemic failures of care, poor patient experience, and a medical workforce crisis.

The report, which was commissioned by the Royal College of Physicians, puts the patient experience at the heart of healthcare, sets out a radical restructuring of acute medical wards, and defines a new organisational and management structure which identifies responsibilities that stretch out from the hospital into the wider community.

Critical to all of the Future Hospital Commission's recommendations is the availability of accurate, real-time, high quality information. To achieve this, radical changes are needed in the strategy for information and communication systems in the NHS. In response to the need for these changes, the Future Hospital Commission has identified a number of priorities in information management.

As the cornerstone of integrated patient care, the patient record must be the main source of data to inform the service. The patient record is where the vast majority of clinical information about an individual patient is recorded and stored. It provides information to all practitioners who care for the patient, is a source of communication to others and is the major source of data extracted for secondary purposes. Regrettably, individual patient records are presently dispersed across organisations and across services. The data held is not integrated which severely limits the ability of the NHS to deliver safe, efficient, integrated care.

Records must be integrated across organisation boundaries

The NHS contains a plethora of incompatible patient record systems that have been developed to meet the needs of specific services or specialties. This approach needs to change, so that systems are designed around the patient. Patient record systems must be focused on the individual, not on the disease, intervention, service or the organisation in which the patient is seen.

Electronic patient records must be integrated across organisational boundaries so that appropriate information can be recorded both by practitioners and patients, and a comprehensive view of the record accessed by them in a wide variety of clinical and care contexts.

The safety of patients is dependent on many factors but especially the quality of the

INFORMATION GOALS

- Patient record systems to be focused on the individual and integrated across organisations
- Records to be standardised across the NHS
- Information about quality of care to be fed back to clinicians
- Staff to be trained in information management

data recorded about them and communicated between professionals; as a consequence, the quality of the data and the ease of data capture are of paramount importance. Much greater attention needs to be given to user-centred design and sensitive deployment of new technologies such as tablet computers and "bring your own device". This will lead to more accurate recording, validation and transmission of patient data in the busy clinical environment.

Uptake of record standards is needed across the NHS

However, this alone is not enough. Information systems must be able to "speak to" each other and so must conform to national standards. This means that the structure and content of records must be standardised across the NHS. We need information standards to ensure uniform terminology; drugs and medical devices; communication; patient identification; professional identification; and safety. Technical standards are needed for operating systems, networking and application programme interfaces. Professional standards for structure and content are needed to minimise inefficiency and errors arising from incompatible record structures in different organisations.

Evidence- and consensus-based clinical record standards have been developed and endorsed by the Academy of Medical Royal Colleges and now need to be widely implemented across the NHS. The medical, nursing and clinical professions are united in their view that this standardisation of the content of patient records is of paramount importance, and have established a Professional Record Standards Body to oversee the continuing development and sustainability of content standards.

Universal uptake of these standards is now needed across the NHS. Priority areas for further standards development and deployment are electronic medicines management and clinical incident reporting.

Patients need access to reliable information from both the individual record and the knowledge base of healthcare, and they should be given appropriate access to their records. Greater patient access to records is long overdue. However, research is

We need a learning culture, rather than one focused on blame

required to understand why there is low take-up of record access schemes and whether the structure, layout and functionality of records may need to be changed to make them more informative and useful to patients.

A standardised view of the record will help patients understand the content when it is derived from different sources. Access to reliable information from aggregate analysis of patient data, and to peer reviewed evidence, advice and national guidelines, must be universally available at the point of care.

As a learning organisation, the NHS must use the information it collects in the course of everyday care to enhance that learning. Information about quality of care should be fed back to clinicians on a regular basis. A learning culture, rather than one based on blame, would foster the standardised recording of clinical incidents and near misses within the record as part of the routine processes of care, so that feedback and learning is guaranteed. All staff responsible for the care of patients must be trained in the use of new technologies, the need for accurate, comprehensive record keeping, and the benefits and risks of data sharing. This would mean that training in responsible information management, and the use of new communication technologies, must be made available for all healthcare professionals.

In summary, electronic records must be focused on the patient, and the data recorded must be capable of transfer between clinical applications, professionals, contexts and settings, safely and without any loss or change of meaning.

Standardisation of structure and content across the NHS is key to integration of records and to integrated, safe, efficient care. It will also enable the provision of rich and valid data for the many purposes that underpin service evaluation and research.

If we want to realise the hospital of the future, information must be a priority area for the NHS. ●

Professor John Williams is director of the Royal College of Physicians' health informatics unit

How to promote clinical engagement with IT: expert tips

Clinical engagement is frequently named as the make or break factor when it comes to the success of healthcare IT projects. Little wonder, then, that more and more NHS organisations are now employing clinical IT leads. They work across organisations, supporting clinical engagement and ensuring that systems fit clinicians' needs.

We asked eight doctors and nurses whose roles include clinical IT leadership to give their top tips for successful clinical engagement...

Reach out to all users of the system, not just medics

TOP TIP

Target clinicians who are less comfortable with technology

"Ensuring engagement with clinicians is a big challenge for two main reasons. First, we often engage with the keenest as this is easiest.

"To deal with this natural trait it is important to look at strategies to seek out those who are less comfortable using technology. Even if not directly involved in design or the implementation of a system, they need to be consulted on how the system will affect their normal practice.

Discussing the threat to their normal practice gets their attention

"I find discussing this 'threat to their normal practice' is a useful way in to capturing their attention and ensuring that they do get involved. Indeed starting a discussion on how things might change in their working lives usually brings people forward – but it is important to get this across at an early stage. I liken this to the threat of the building of a telephone mast next to their home – it brings people into the discussion.

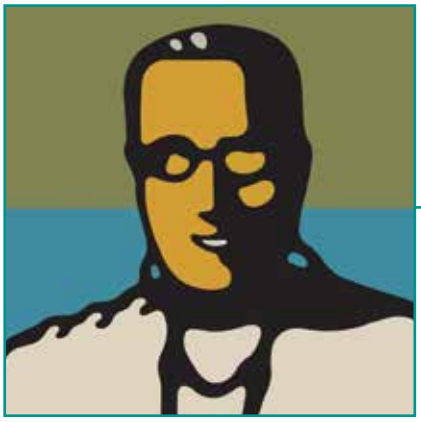
"Sometimes the consultation can be achieved in open house, roadshow-type meetings but personally I find that identifying these key individuals and spending time with them is an important part of my role as CCIO.

"Second, sometimes in hospitals we fail to recognise the full extent of the word 'clinician'. The danger is that organisations just think about the medical staff. Even when we get beyond this and start looking at nursing staff and professions allied to medicine we still often don't have the full picture.

"So for me the engagement is for all users of the system from administrators, ward clerks through to the nursing and medical staff.

"Any weak link can roll on to affect others using the system."

Dr Ian Jackson is chief clinical information officer (CCIO) at York Teaching Hospital Foundation Trust



Time to use the power of patient stories

ENGAGEMENT TACTICS

- Update clinicans on IT developments that are 'hidden' to them
- Articulate tangible advantages such as fewer prescribing errors
- Have a system to collect qualitative outcomes
- Be visible
- Listen when people say the system does not solve their problems

"I tell colleagues that the proposed system will help them deliver better care, increase safety and improve communications. Clinicians often view access to records from other care settings as important.

"I talk about the ability to have reliable data on their activity and/or quality of care in near real time based on the data they have entered. When clinicians understand this it encourages improvement in data quality.

"I also find that patient stories can be powerful, whether of disconnected care that could have been improved or of care supported by clinicians sharing relevant information with the patient's consent.

"IT directors need to work with key interested clinicians and CCIOs (or similar) and disseminate via existing communications channels. They need to be seen to be listening and update the clinicians on developments. Often development is hidden and from the clinician's perspective not much happened with the network upgrade, but they can access data quicker... It is important they understand how and why this was brought about."

Dr Phil Koczan is a GP and CCIO of UCLPartners Academic Health Science Partnership

The clinical lead for IT needs to be respected by his or her peers

"The way to engage clinicians in IT projects is for the clinical lead for IT to be respected by his or her peers and be in or have recently been in a position of authority and influence within the organisation.

"He or she should be knowledgeable about the system(s) and demonstrate both genuine enthusiasm for its adoption or deployment with a real belief in the benefits that the new systems will afford.

"In tandem with this, the CCIO should be able to articulate tangible advantages for the clinical users. These should be around areas such as improvement in the accuracy, quality and accessibility of information, enhancement in clinical quality and outcomes, and a reduction in clinical and prescribing errors through, for example, evidence-based and decision support systems. Having a track record of delivering what was promised is also of paramount importance."

Dr Les Boobis is CCIO and clinical safety officer at City Hospitals Sunderland

We need to sell the positives but do it honestly

TOP TIP

Show clinicians what they will no longer have to do

"Engagement from all clinical professions is essential – without this, new technologies are destined to fail.

"The way to engage is to show clinicians what they will no longer have to do: populate patient details, collect audit data, fill in the Safety Thermometer, write letters and referrals – it is all done for them automatically. Reducing bureaucracy lights everyone's candle.

I have a roll out plan but also expect to see extensions to these plans

"A good system will also enable qualitative outcomes to be easily collected and benchmarked, not just numbers – always a turn-on for clinicians.

"We need to sell the positives but to do so honestly. IT solutions do not always work first or even second time. That's why I think it is essential to identify champions in services – even better if they were sceptics initially – and to engage in a planned and timely way, with clinical involvement and response when problems arise, as they inevitably do.

"In Medway Community Healthcare we provide a wide variety of services to patients, many multidisciplinary, and it helps to find clinicians' stories that are relevant in different settings.

"One district nurse, for example, talked about how she shared with patients what she was inputting onto the tablet, describing her care as 'no longer face to face care, more side to side'. That's powerful.

"As a CCIO, I work hard to be visible, approachable and vitally to listen and hear. I have a roll out plan but also expect to see extensions to these plans – this really does show you're listening."

Fiona Stephens is clinical quality director and CCIO at Medway Community Healthcare

"Listen to your colleagues – when they tell you that a proposed IT solution would cause problems (or not solve their problems) they are not always being resistant to change, not infrequently they are right.

"Listen to your colleagues – find out what their problems are and make sure that any proposed systems will actually solve them. If you have a choice, implement those bits of the system that will solve at least some of their problems earlier rather than later.

"Listen to your colleagues – but you have to be prepared to say no to short term expedient solutions that will derail the overall strategy and cause long term bigger problems."

Dr Mike Fisher is CCIO at The Royal Liverpool and Broadgreen University Hospitals Trust

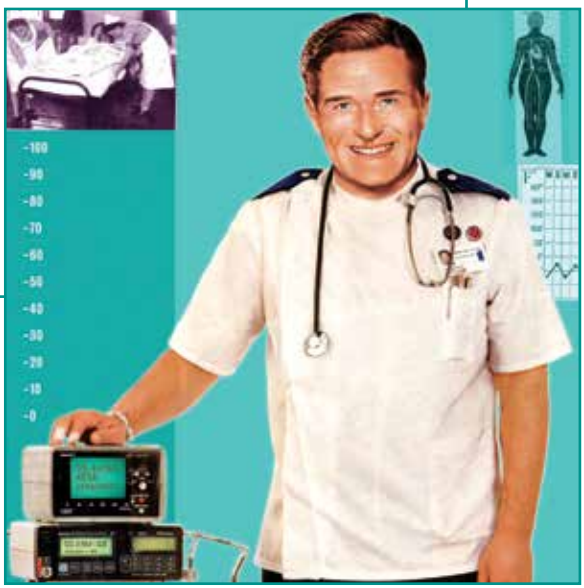
If staff feel change is forced on them, they will resist

"Clinical engagement requires clinical leadership. If staff feel that change is being forced on them by IT departments, they're likely to resist. It needs to be visibly led by people who understand their job and speak their language. That credibility is essential to persuading staff to change how they work. Benefits also need to be visible.

"Simulation wards are particularly effective. They help staff to understand the change that is coming, calming nerves that can quickly harden into resistance if left unaddressed. Persuading always takes more time than compelling, but it is crucial to building the support large-scale change needs."

Fergus Keegan is deputy director of nursing at Kingston Hospital Foundation Trust

Simulation wards help staff to understand the coming change



ENGAGEMENT TACTICS

- Ensure change is led by people who understand clinicians' jobs and speak their language
- Remind clinicians regularly that IT is improving outcomes for their patients and they need to lead change
- Make sure they understand not just what is changing, but why. If they understand the benefits to patients, they're more likely to embrace change

ALLISON BURRELL AND GERRY BOLGER

Celebrate success and promote understanding

TOP TIP

Clinical staff must feel their priorities are driving the technology, not vice versa

"Any development and implementation of a clinical change strategy requires the full support of the organisation's clinical community. There is a strong correlation between the extent to which staff feel engaged and mortality rates.

"How do we engage and infuse passion and belief into clinicians? My passion and ability to relate with everyone helps but I also constantly remind them we are improving outcomes for their patients and I need them to lead the change. I articulate honestly about the project. As a nurse, I am out there working with them clinically; I facilitate celebrating their success. The engagement lead needs to be a senior clinician who can communicate with all levels of clinical staff."
Allison Burrell is clinical engagement lead at Barts Health Trust

You have to put the patient at the centre of what you're saying

"Clinical staff only have one priority: their patients. If you want to engage them, you have to put the patient at the centre of what you're saying.

"That means explaining how the changes will help staff to make more informed decisions, improve safety or release time to care. Clinical teams should feel their priorities are driving the technology, not vice versa. They have to understand not just what is changing, but why. If they can understand the benefits to patients, they're far more likely to embrace change." ●
Gerry Bolger is Imperial College Healthcare Trust nurse lead for clinical systems implementation

Capture once and use often

TOP TIP

Consider a phased approach to taking away paper records

When Royal United Hospital Bath Trust created electronic nursing risk assessments two years ago, something astonishing happened.

Where typically nurses filled in paper-based assessments about 45 per cent of the time, the electronic versions quickly hit – and have maintained – over 95 per cent completion.

These nursing risk assessments cover details such as whether patients are at risk of falling or developing a pressure ulcer.

Having the risk assessments initially completed – and the ability to electronically trigger a reassessment – is fundamental not only to a trust's ability to improve patient care and meet patient safety targets but also to achieving CQUIN payments and demonstrating to regulators the quality of care it provides.

Anne Plaskitt, senior nurse quality improvement and one of the trust's chief clinical information officers, says: "At first using an electronic system was an alien concept to the nurses.

"But now we have reached a genuine tipping point, where the automation and systems we have built into the system over the last two years have proved themselves and nurses are now actively asking for more parts of the paper record to be transferred to the Electronic Patient Record."

Nurses are asking for more of the paper record to be put on the EPR

The ultimate aim is for all nursing (and eventually all clinical) records to be electronic.

The electronic nursing assessment significantly differs in many ways from the paper-based version, says Ms Plaskitt. For a start, they can automatically schedule when reassessments should happen and to automate tasks.

Take, for example, the patient who develops a pressure ulcer in hospital. This is recorded as a harm event, the nurse is then prompted by the system to reassess. The system also automatically sends an electronic referral to the tissue viability nurse.

"There is no need to do anything more," says Ms Plaskitt. "The referral and care record can be viewed remotely by the tissue viability nurse who can then prioritise clinically. It's been very, very useful."

Electronic nursing assessments are also an incredibly powerful management tool, enabling rapid audit and validation of data, for example for scorecards and Safety Thermometer.

Any ward manager can now review all patients on the ward at a glance to check whether assessments have been carried out – and what they are showing.

"I can look at compliance of the whole

TIME FOR A RETHINK

Using IT to transform services requires a change of thinking. Here are five things to rethink...

1. **Frame IT projects as clinical transformation projects supported by IT**
2. **Ensure the right clinical leadership is in place to secure clinical engagement**
3. **Information governance is not going away – put the work in early to get this right and do not allow it to become an insurmountable barrier**
4. **Service integration cannot be achieved without information sharing**
5. **Moving to electronic systems can drive up quality and deliver improved clinical outcomes. Take time to quantify these and communicate them to clinicians**

trust – all 600 plus patients – in under 30 minutes," says Ms Plaskitt. "This afternoon, I will report for our scorecard how many patients with dementia have had a nutrition assessment and it will take five minutes." Previously, that would have required a physical inspection of every single paper record.

The big question though is whether patient care has improved. "I would love to sit here and say we have had X reduction in falls but it is not that simple," says Ms Plaskitt.

"We have seen more reporting of incidents and that's a good thing. We are now getting to the point where we feel we have reliable data. We are getting accurate information such as how many pressure ulcers really developed in hospital as opposed to how many were present on admission.

We are seeing more reporting of incidents and that's a good thing

"We have been able to get rid of paper-based pressure ulcer incidence collection as the data is now automated from the inputting of the harm event."

Moving to an entirely electronic system will take time, resources and training and at Bath they are going one step at a time.

Next on the agenda is adding the social history assessment, which will bring on board another core group of staff (therapy colleagues). Information collected in the social history will populate other sections of the record such as the postcode, health rehab and transfer of care records, echoing the overarching aim of "capture once and use often".

"For us we felt the risk of taking all the paper records away in one go was too great," says Ms Plaskitt. "I think we have got the balance right in our phased approach, driven now completely by the nursing workforce." ●

CARE INTEGRATION
CASE STUDY

Leading the way in sharing data with social care

The NHS and county council in Kent have a long history of joint working. Now the two are set to work even more closely and start sharing data not just with each other but also with patients.

Their joint submission for the Integration Pioneer Programme (IPP) sets out an ambitious programme to deliver integrated health and social care commissioning and provision across the county by 2018. Underpinning it is a need for sophisticated data sharing to support risk stratification, new tariffs, personal health records and multi-disciplinary care.

The system would support research and sharing of best practice

As Dr Robert Stewart, GP and clinical design director for Kent County Council (KCC) says: "Integration is the key word. We recognise that sharing information and the way that's done is key if there is to be any meaningful impact."

It is very early days yet but essentially the idea is that KCC and CCGs, under the leadership of the Health and Wellbeing Board, will set up an information sharing platform for health and social care data.

Dr Stewart's vision is a portal that puts patients at the centre – enabling a move away from health-dominated models of care for long term conditions – and that puts the patient in charge.

It would, for example, allow single assessments of patients regardless of who did it – or where. It would be used to support direct patient care as well as research and public health and sharing of best practice and ultimately could link with the local Academic Health Science Network.

GPs in North Kent are already trialling two information sharing platforms, the commercial Patients Know Best and the home-grown Health Informatics Service

TOP TIP

Information governance will be central to the success of data sharing

Business Intelligence system.

Dr Patricia Davies, chief officer for Swale CCG and acting chief officer for Dartford, Gravesham and Swanley CCG, says: "We already have integrated community, social care and acute teams in North Kent. We want to utilise information sharing not just with each other but with patients and put them in control of their notes.

"What we are really discovering is that technology needs to be adapted to different situations – there is no one size fits all."

Such pilots will help as the health and social care partners build the wider information-sharing portal, she adds. "We have got the joint teams together first, rather than waiting for the technology, so we will be looking to see how the technology can support them."

Dr Stewart recognises that information governance will be central to success. "It could a key barrier," he says. "Everyone is nervous about this issue. We are comfortable to share data but people are worried about the potential information governance risks they face on an individual level."

Another key issue will be interoperability. "While we recognise that there are lots of pockets of innovation locally – and we are keen on localism – we must end up with a common information system," he says.

Over 80% of council clients use the NHS number as an identifier

Kent is already part way there. All organisations are using the NHS number, including KCC who have already succeeded in getting over 80 per cent of their clients using the NHS number as their unique identifier.

Ultimately, he sees this venture not as a technology challenge but as a cultural one, not least of helping people to understand that they can share data but need to follow rules.

IPP programme status would of course have benefits but, as Dr Stewart says: "Kent has decided that regardless of whether we are successful we will be continuing this process anyway. Unless we get integration of health and social care, we will not be able to make the radical changes to make health and social care sustainable." ●

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