A lot more for a lot less: Disruptive innovation in healthcare

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than four decades
ng a very wide range of
public services, including
care. Serco has derived
ard-won insights in the
ment of disruptive
in frontline
tions.

first is to understand,
you start, the existing
ves and barriers to the
reform in prospect.
the underlying cultural
ganisational realities, and
in a good position to
structures that
le obstacles and
age the right behaviours.
example is mutualisation,
may help to engage key
while innovative joint
arrangements can
the potential of vertical
tion.

Secondly, organisations often
to manage change
of their internal
s – so governance and
abilities need to be
ined, re-aligned,
es simplified, to reflect
priorities.

Finally, there is often a need
catalyst. Change requires
leaders who can step
from day-to-day delivery
make the driving of
tion their fulltime job.
tion carries risk. So an
partner can facilitate
by bearing the risk, while
bringing the bandwidth for
entation and acting as an
broker when change
tough choices.

It is in this role that Serco
forward to supporting
of change across the NHS
ging a depth of experience
capability to help innovation
ppen.

air Dick, Managing
or, Serco Health

Peter Ellis
Effective medicines management

Admissions and readmissions rates in the NHS have been exacerbated by medicine errors, non-adherence and other failures. Effective medicines management could save patients and save the NHS time and money.

PharmaTrust UK Ltd improves pharmacy services through its MedCentre and MedHome technology that has the potential to make pharmacists and medicines available wherever and whenever patients require them. By enhancing the availability and reach of pharmacists, they can truly be the most accessible frontline healthcare professional.

The MedCentre is a complete, pharmacist controlled, point-of-care medicines dispensing system. It can stock and dispense over 2,000 different medications. They are under the direct supervision of a pharmacist who can intervene at any point in the process. It ensures 24-hour access to medicines and pharmaceutical advice anywhere without the costs of traditional "bricks and mortar" pharmacies.

The PharmaTrust system has been operating in Ontario, Canada, since 2008. The Canadian example has shown that there are many potential benefits to UK patients and the NHS. Pharmacists would focus on patient counselling and clinical tasks instead of dispensing, while specialty or foreign language pharmaceutical advice would always be available. Patients would be guaranteed full counselling by a pharmacist, including as a routine follow-up. A reduction of errors such as through contraindications would reduce emergency hospital admissions. Finally, new models for reimbursement for dispensing could be developed, which would get away from facility and script-based reimbursement.

Peter Ellis, Managing Director, PharmaTrust UK

Ali Parsa
Transforming the value equation

The imperative for healthcare reform is inescapable. In any professional service, value is defined as quality relative to price. In healthcare, quality is defined as clinical outcome plus patient experience. This simple equation provides a tool to assess the value of UK healthcare. The conclusion is stark. In little over ten years, the denominator of the equation – the cost of healthcare – has tripled, whilst the numerator - patient experience and clinical outcomes - has undoubtedly improved, but by nowhere near the same three times. As such, the dispassionate economic truth is that we have seen a massive destruction of value in the largest sector of our economy. Few dispute that this trajectory is unsustainable.

Much academic effort has been spent researching the drivers behind innovation that re-engineers unsustainable industries. The conclusions are encouragingly simple. Study after study has shown that the vast majority of innovation comes from new entrants to a sector rather than incumbents, be they public or private. Think about the transformations that have taken place in the IT sector through a stream of new entrants. Yahoo did not do what Google did. Google did not do what Facebook did. Facebook could not achieve what Twitter achieved. Each new entrant has innovated to advance open source technology in a way that has revolutionised human interaction.

I will make a prediction: none of these established names will create the next big thing in IT. I'm confident making this prediction because history has shown one unfaltering truth about innovation: it does not happen because you ask incumbent organisations to become more innovative. Innovation happens because barriers to entry are removed. It happens when all sorts of people are encouraged to provide a whole variety of solutions, and where the best solutions can be adopted by unprejudiced recipients.

The Coalition is at a crossroads with the current "pause" in their NHS reform programme. They can choose to protect inefficient practices and providers, presuming that it is they and the investment already put into them that matter most. Or they can seize their moment, and empower many new entrants to deliver innovation that transforms the value equation in UK healthcare. Our hope is that they choose the latter. The country that pioneered the first blood transfusion, the first antibiotic and the first universal health service should still be a place where it is irresistible for the best talents to offer the boldest solutions.

Ali Parsa, Managing Partner, Circle

working with partners to actually reshape organisational boundaries which actually is quite achievable, and the second is thinking about how you incentivise staff and management in order to do it. And there are all sorts of new organisational structures which you can now introduce, whether it's things like social enterprise or mutuals which really do have a huge impact in terms of incentivising teams, or whether it's thinking about things like joint ventures which is much more about how you bring two organisations which don't have their incentives aligned and reorganise them so that they can really focus on a single set of objectives and therefore drive the changes that they need to.

Nick Seddon: Thank you, and Peter – Peter Carter first – one of the things that we've been reflecting on a lot this morning is innovation and carrying the workforce with you. And I mean you've said that you're kind of behind intelligent reconfiguration, so one set of reflections might be on that line. I'm just also interested by Dr Shetty's example of the sort of EBITDAR on your phone and wonder whether or not you think that nurses would like to have something similar.

Peter Carter: Well in some cases they do. I mean the problem with the NHS is although it's a national health service in many respects it's a federated health service. And you find in adjoining boroughs or counties huge differentials in how they operate things. I mean last year I was down visiting a service in Wiltshire where there was a team of six district nurses who maintained a huge number of people with long term conditions in the community, but they used tele-assessment and they used it very effectively. But they do have a small ward in the grounds of Swindon Hospital because occasionally people have to come in. And I visited the ward as well as seeing the service in operation, and I was quite interested because most of the patients with long term conditions were middle-aged to elderly, and I spoke to a woman in her 70s whose husband had been admitted.

And I first of all asked her how did she get on with the technology? And she said initially we were quite frightened by it, but the district nurse came out, talked us through it, and it's actually very, very simple. And I then said to her so how effective has it been? She said well I don't really know apart from the fact that until we had this bit of kit – which cost £2,000 by the way – on average my husband had – he's got COPD – about five admissions a year. And since we've had this bit of kit he has had one admission a year. And that's just a really good example.

The next day I visited another service in an adjoining county and I mentioned this and they said, "Oh, what's that?" And you think how can it be that people don't know about this stuff? I mean there is no transfer across. And it's incredibly frustrating to know that there are real solutions out there, but somehow because it's left to a local and often very narrow, parochial – and it is territorial – people aren't thinking, albeit unintentionally, what is right for the patient. People are tending to think about their organisational survival. And one of the great things which I hope comes out of these reforms is the way in which PCTs are no longer providing. That's now going to be predominantly back into acute hospitals to have the seamless care. And so hopefully people will get into this transforming community services agenda because it's not going out of their organisation although it is going out of hospital.

Nick Seddon: Thank you, Peter. And Peter Ellis, I suppose from the position of trying to bring an innovation into the NHS, perhaps say a bit more about the reaction of the service at different levels. And then also, I suppose, drawing from some of your own experience of hospital reconfiguration in London, I don't know whether or not I can tease a bit of that back story out.

Peter Ellis: Well I think it's been stated this morning that we're dealing with some of the high priests in the church in terms of the professions with an innovation like this. I mean we've taken the approach of collaboration and trying to bring the professions along. I have to say there is a point where you do think if they're not ready to jump on the bus you're going to slam the bus into reverse and run them over because there is a point at which your tolerance of that – and you've seen that. I found it interesting this morning that NHS Direct, you know, 12 years later it's still struggling with some of the basic tenants that it was set up to achieve because of the inability to move certain parties along.

> **ık that we have to try maintain a position re we're trying to think t is right for the patient. therefore we have to vith the consequences.**

> **"I mean the problem with the NHS is although it's a national health service in many respects it's a federated health service. And you find in adjoining boroughs or counties huge differentials in how they operate things."**

' Having left the NHS and worked in teaching hospitals many years ago, I come back to the UK to be somewhat distressed by the state of things. It was partly this issue that was motivating me because I felt, you know, how does innovation happen in the NHS? And one way was to try and join the academic and the clinical in a more close collaboration. I mean some references, I think complementary, were made about the NHS being a great centre of innovation in the past. My problem is using the word "NHS" as being this. I don't think the NHS drove the innovation. I think individuals did and they did it almost fighting the system. So they deserve an even bigger medal for

having achieved anything. And it's how does the system and the structures and the alignment of funding and reimbursement and incentives encourage the sort of behaviours you want to see in the system.

And that's what we're talking about from PharmaTrust. If we can move to a more risk-shared, capitated way of paying for medicines management, which our technology allows you to do because you don't need to separate the dispensing piece from the prescribing piece, you can start then to create behaviours in prescribing and dispensing and support of patients that achieves everybody's goal which is a reduction of unplanned and untoward admissions. If we've got – whatever the number is – eight or 15 per cent of our unplanned admissions are due to medicine failures or errors, we've got to tackle it and tackle it in a different way. And just playing at the fringes isn't going to do it. You're going to have to redesign the way medicines are managed, and we're hoping our technology becomes an enabler of some of the rethinking of that process.

Nick Seddon: Thank you. I don't know if there are any questions from the floor or you're all going to have to have a think. But Jane, have people from other hospitals around the country visited and said we want to steal your Formula One idea? Do you I mean is there creative stealing going on?

Jane Collins: Yes there is. Clearly Formula One aren't going to go to every NHS hospital because they're there to run races, aren't they, or whatever they do. Certainly people are interested in that. But I do think – and that's what's very frustrating – that it needs to be framed in a way which is meaningful within that organisation. And there will be a different culture and it needs to be framed in that way. I mean I share Peter's frustration because I agree there are indivuals' innovations and the NHS isn't good at innovation. And that's because of the cultural problem. The stories are a way of getting over some of that. I think the way that we've been able to help more organisations is we've been able to collect data in a very consistent way over a period of time, and we have run charts for everything. And when people see that – and that's something being rolled out in the academic health science centre we're part of – UCL Partners – then they very much want to steal that.

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Nick Seddon: Thank you. And Peter Carter, this morning we were talking about glasnost and perestroika. So we're talking about the spread of best practice, the spread of good ways of doing things. What about the spread of transparency and how people do things in different hospitals? Arc for that?

Peter Carter: Yes, look Nick, I mean first of – I'll try and keep it succinct. We know that need registered nurses to do all of the things patients might need in hospitals. So I partly sympathy with Dr Shetty although I agreed of what he said. But what I thought he misse in terms of his example of do you need a nur BSc to assist in theatres. Well no you don't, you need are people that are well trained to whatever they're going to do. And in lots of there are ODAs (Operating Department Ass that do this extremely well. I think that peo defensive and very protective. So one of the certainly very pleased to say to this audienc know that there are people from the press h we have no problem with reviewing skill mi there will be times when you will need healt assistants because they are affordable – t that perhaps in a different era was almost e done by registered nurses. I mean that's rea

The trick is are they properly trained they properly supervised? And I'm saddene many of our hospitals people – registered n replaced by healthcare assistants and they' given as much as an hour's training. They g wards and they're asked to pick it up as the

Now I know you asked me about pere and glasnost but I think people need to kno Because when you see some of these appar in nursing care, well it's failures in care. I n mentioned John Lewis. I mean John Lewis exemplar. Do you think on a Monday morn member of staff turns up and they put a Jo tunic on them and send them on to the sho say, "Well, you kind of pick it up as you go course they wouldn't do that. They train pe make sure that they can do it.

In so many of our hospital boards I'r say it's exactly what happens. People are p predominantly elderly care wards, and all things that seem easy like wound care, fe elderly people in bed, manoeuvring them, – all these things seem so simple, people a picking it up as they go along. And you enc some of the shocking scandals that we've s health service. Now one of the things that we've got to be better at doing is opening t getting a clear understanding of it. First of you need from the workforce? And I've air declared that you don't need registered nu many of these things, but you do need the right and the supervision. But you do neec workforce to be properly trained and prop regulated. I don't know if that helps, Nick

Nick Seddon: No, no. That's fantastic. An you were talking about innovative comme structures and innovative governance and accountability. And I sort of nodded along