

Shipman

Common Worldwide Health
Service Issues

Tameside & Glossop PCT Plans

Hadfield View

Patients Views

Shipman's clinical governance errors and omissions

- Wrong diagnosis
- Wrong choice of therapy
- Wrong dose of therapy
- Administration of treatment without truly informed consent
- Lack of transparency
- Incorrect completion of the GP records
- Incorrect completion of death certificates
- Incorrect completion of cremation forms
- Incorrect communication of clinical details to GPs
- Inaccurate audit figures
- Absent clinical governance in all of the above areas

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IOM report: Crossing the Quality Chasm: A new Health System for the twenty first millennium.

The report finds that the current system is unable to provide safe, high quality care in a consistent manner. It consists of 10 rules to redesign the health system and a series of recommendations, including the allocation of \$1 billion by Congress to support reform efforts. Crossing the quality Chasm can be read or ordered on line at www.nap.edu.

Although it was thought by some that this report would not catch as much attention as the first, it has created quite a splash in the media. Headlines such as "US Health Care System said lacking" and "IT must BE used to reform US Health System" can be found in both the trade and popular press.

New rules to redesign and improve care

Private and public health purchasers, health care organisations, clinicians, and patients should work together to redesign health care processes in accordance with the following rules:

1. **"Care based on continuing healing relationships. Patients should receive care whenever they need it and in many forms, not just face-to-face visits.** This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the internet, by telephone, and by other means in addition to face-to-face visits.
2. **Customisation based on patient needs and values.** The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
3. **The patient as the source of control.** Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over the health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision-making.
4. **Shared knowledge and the free flow of information.** Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. **Evidence-based decision-making.** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

New rules to redesign and improve care.

- 6. Safety as a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
- 7. The need for transparency.** The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based-practice, and patient satisfaction.
- 8. Anticipation of needs.** The health system should anticipate patient needs, rather than simply responding to events.
- 9. Continuous decrease in waste.** The health system should not waste resources or patient time.
- 10. Co-operation among clinicians.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and co-ordination of care.

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What culture and legal changes Tameside and Glossop want in the UK

- Patient access to their contemporary record before during and after the consultation
- Patients can access research and data about local treatment outcomes
- The patient can correct their medical records for errors and omissions
- Patients are involved in the clinical governance cycle
- Patients are involved in clinical service development

Making patients part of the clinical governance cycle

- Patients and their carers are present at every intervention and now will see the records contemporaneously
- Patients will be motivated to have enough time to check through all their records.
- Patients will access and copy the real time record before death.
- Patients and their carers validate that what is recorded as happening in the record actually happened.

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1993 - Derbyshire FHSA

1995 - North Derbyshire FHSA

1998 - West Pennine HA

2000 - Tameside & Glossop PCT

- Patient access to records
- Lessons learnt
- Culture change at Hadfield

Patient access to records

- Hadfield Medical Centre
- Suburban practice in Derbyshire 13 miles from Manchester, 8 miles from Stockport
- Single handed
- 2990 patients
- Patient participation Group

Patient held records

- **1994** - patients requested access to their own records during discussions with the Patient Participation Group.
- **1995** – patients help design patient centred medical centre building.
- **1996** - staff and patients move in.

Patient held records

- **1998** – patient electronic health record group becomes active
- **2000** - first of five conferences.
- **2001** - practice chosen for MEP patient access on NHS Net with Bury Knowle, Oxford

The following Parliamentary answer was tabled yesterday

Electronic Health Records 23 Jan 2001 : Column: 508W

Mr. Levitt: To ask the Secretary of State for Health in what ways (a) patients and (b) patient groups are involved in pilot projects for the development of electronic health records. [144701]

Ms Stuart: A key component of the Electronic Record Development and Implementation Programme, which was launched in November 1999, was the inclusion of patient representatives in the selection of the sites. The National Health Service Information Authority (NHSIA) has encouraged the sites to involve their own patient communities through appropriate local mechanisms. In some instances this has involved condition-specific patient groups or patient representatives on project boards.

To support this process the NHSIA has appointed Marlene Winfield as Head of Stakeholder Relationships: Patients and Citizens, to consult national patient groups in order to ensure an appropriate level of patient involvement in the programme at both national and local levels.

Some sites have specific objectives in relation to involving patients, and have conducted patient surveys of attitudes to sharing information, confidentiality, the electronic health record, patient access and patient-held records and these results will be shared.

In addition, a project involving two general practices is also being supported by the NHSIA in the development and implementation of the electronic health record. The general practitioner's practices involved in the project are Hadfield Health Centre in Derbyshire and Bury Knowles Health Centre in Oxford, and are exemplars in their involvement of patients within the practice. The practices are exploring issues around patient self-monitoring and access to the electronic record at the time of consultation; use of electronic records and their migration to electronic and hand-held patient information integrated into the record.

Tom Levitt

Patient held records

- **2002** - HRI project with Merton and Sutton patients e-mail own glucose and blood pressure results to records.
- **2002** - West Pennine HA project to give 109 patients own E.H.R (Now 220 patients have medical records on floppy discs for use at home/on holiday Records have been translated into other languages)

Patient held record

- **2003** – Tameside and Glossop PCT fund patient access and correcting records at HMC and Market St. Hyde (H. Shipman's old practice)

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Lessons learned

What patients wanted 1

- Access from own PC via internet.
- Patients felt the pilot should have been given a minimum of 6 months to run.
- Easier access. Fingerprint reader rather than pass code.
- Add their own data e.g. blood pressure, cholesterol and weight
- Medical glossary linked to the E.H.R.
- Print out, floppy disk or CD to have when away from home.

Lessons learned

What patients wanted 2

- Audit trail.
- Blood group.
- Hospital letters.
- X-ray results
- Blood test results
- Control of who has access to the record.
- G.P's to break bad news before it appears in the record.

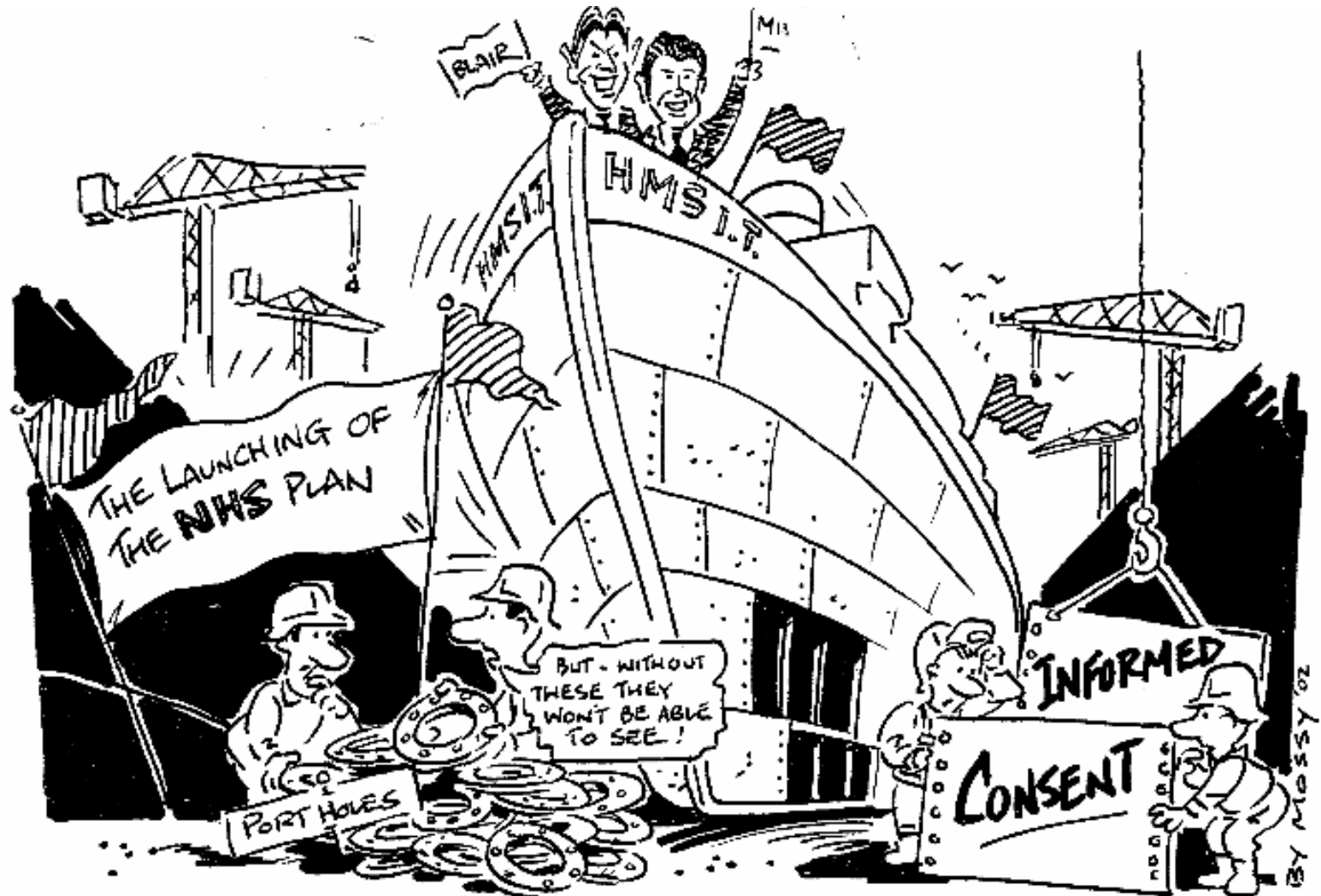
Lessons learned:

- Patient centred
- Records transparent. Nothing hidden
- Records easy to understand
- Patients become partners in ownership of their health
- Patients become involved in decision making and have time to think about these decisions as records accessible at all time
- Patients see hospital and other agency correspondence

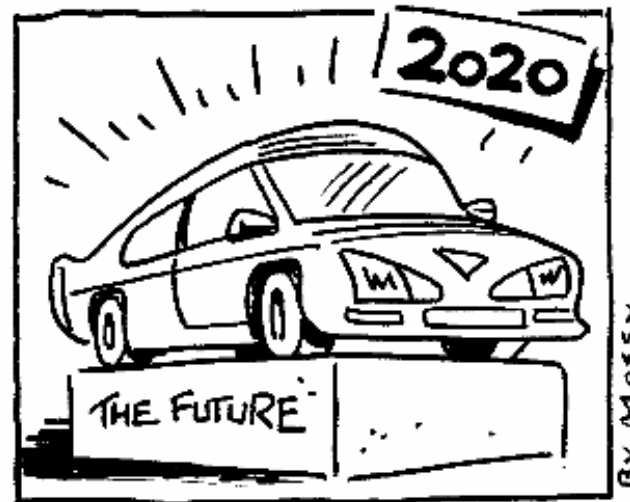
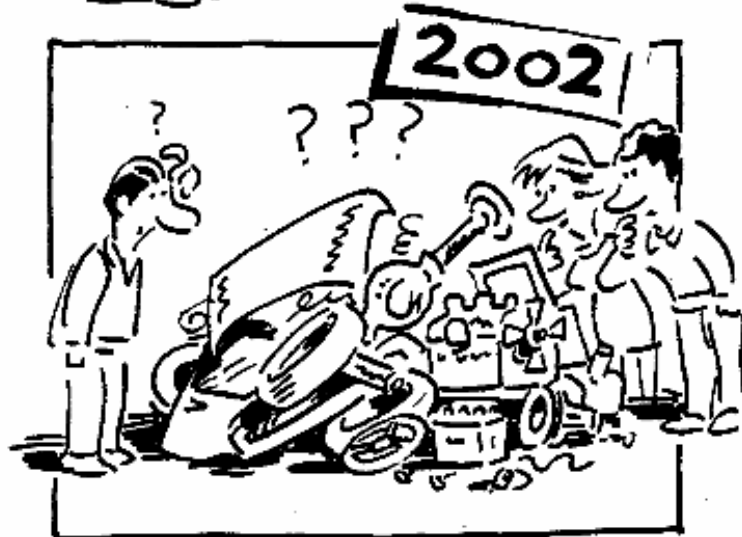
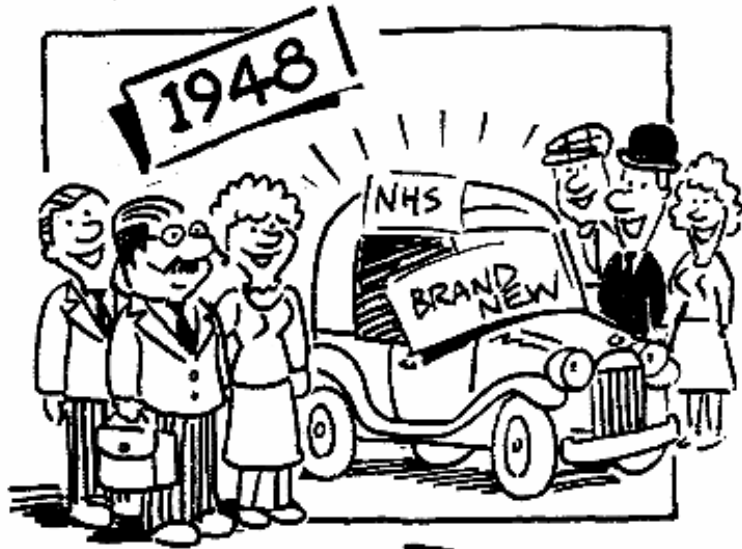
Lessons learned:

- Benefits the Clinician
- Inexpensive – no new equipment. Some new software
- Patient aware of previous consultations – no need to go through these
- Presentation of data is simple through using NHS coding
- Less time spent explaining to patient for fully informed consent

Lessons learned:



Lessons learned:

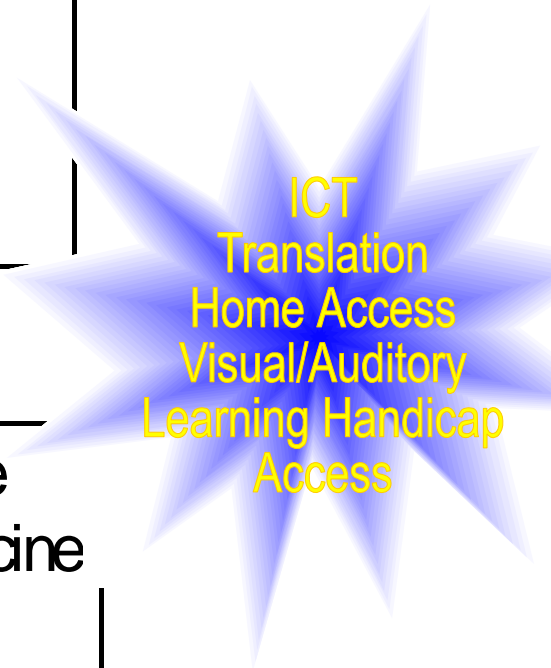
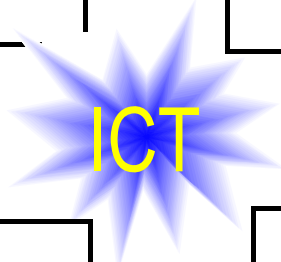


BY MOSSY

Current Information Strongholds

Patients

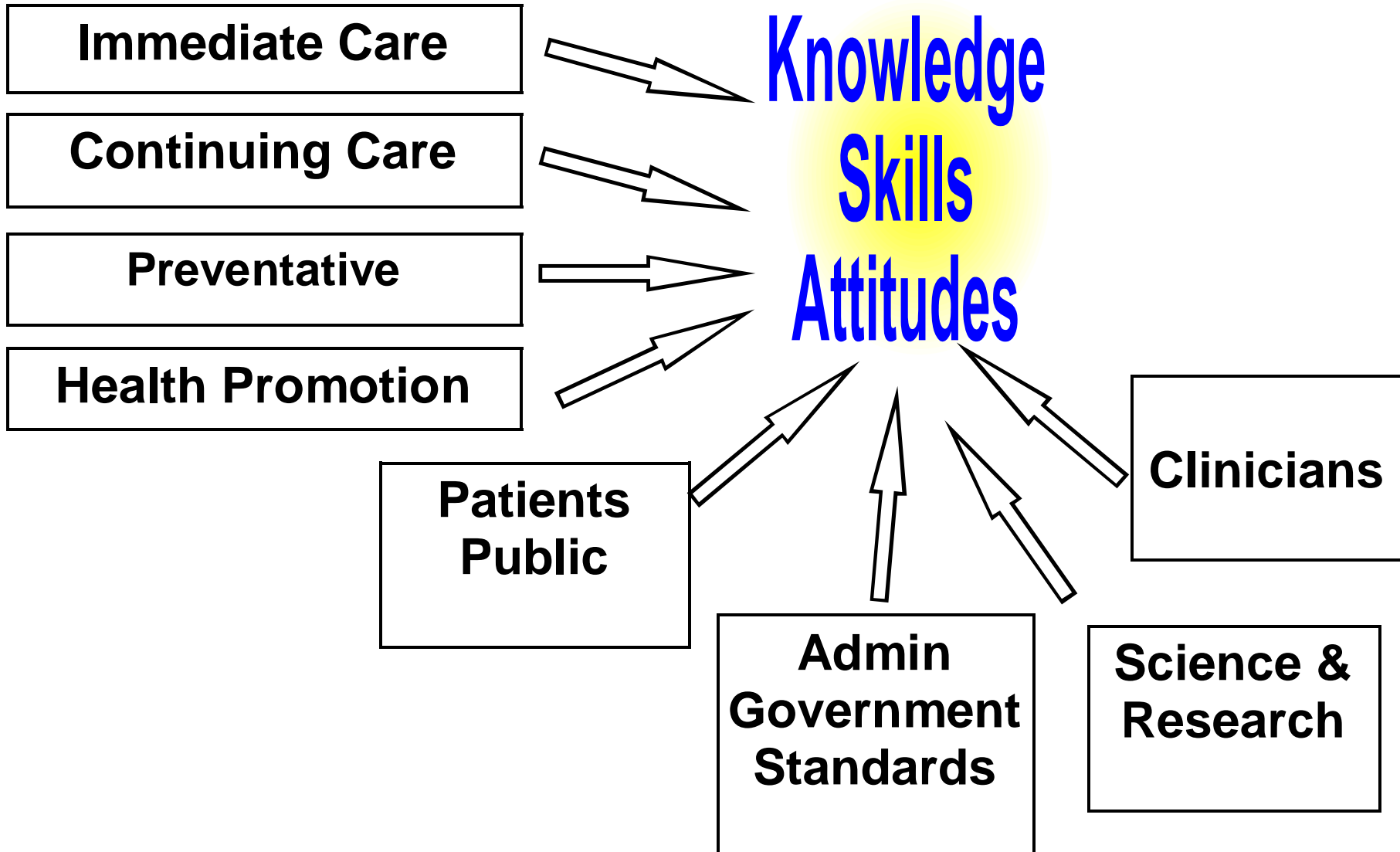
Clinicians



PCOs
NICEs
NSFs
Trust'

Evidence
Based Medicine
Science
Research
Development

Culture change (shock?)



Patients and information are the most under utilised resources in health service provision

