FOR HEALTHCARE LEADERS
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‘THE WORLD AS IT WILL BE’

JEREMY HUNT ON EMPOWERED PATIENTS, INTELLIGENT TRANSPARENCY AND THE FUTURE OF TECHNOLOGY IN THE NHS

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AN IRREVERSIBLE POWER SHIFT

The rise of patient power, driven by technology, set the theme for the second *HSJ* annual lecture, delivered this year by Jeremy Hunt, with other key topics including transparency about NHS performance and Ofsted-style ratings for CCGs

Given what's happening in the Labour party I may not be the most interesting Jeremy in British politics right now – but I do want to talk about the most interesting issue in global healthcare. This is something we will all be talking about long after new models of care, accountable care organisations or any of the current "hot topics" have long become too normal to be interesting.

I am talking about the inescapable, irreversible shift to patient power that is about to change the face of modern medicine beyond recognition. And I want to talk about how this can ease pressure on frontline doctors and nurses, already working incredibly hard, by creating a stronger partnership between doctor and patient that leads to better outcomes.

Emma Hill of *The Lancet* said that every patient is an expert in their own chosen field, namely themselves and their own life. Doctors now regularly find patients who know more than they do about their rare disease in a way that fundamentally changes the dynamic between doctor and patient to a partnership, or even one where the patient is boss. Perhaps the most eloquent exponent of this change is Professor Eric Topol in his latest book, *The Patient Will See You Now*. He describes it as the death of medical paternalism and the democratisation of healthcare.

These changes are being driven by technology and by our ability to use data differently. And although healthcare has lagged the travel, retail and banking sectors in embracing what is possible, we are now on the cusp of changes in modern healthcare that will be as profound for humanity as the invention of the internet. Changes that will be as welcomed by doctors as by patients, given the evidence-based improvements in care that follow when patients take more responsibility for their health outcomes.

It won't surprise you to know I want our NHS to get there first. It may surprise you, however, to know that with the British people's and the government's strong commitment to NHS values, and the extra £10bn being invested this parliament, I believe we are well placed to do so. And it may surprise you even more that I strongly believe that by running faster towards that destination we are more likely – not less – to be able to cope with the huge pressures doctors and nurses face on the frontline now.

Patient power: the future

Last month I met Michael Milken, the Wall Street junk bond trader who went to prison, became a philanthropist and is now a major funder of cancer research. I asked him what advice he would give his grandchildren about how to lead their lives. He said: "Think of the world as it will be, not as it is now."

So how will the world of medicine look in a decade?

Take people with complex, long term conditions. Many of them are prescribed a confusing cocktail of medications, each with a different set of instructions which make it easy to forget or mistake doses.

So a British entrepreneur living in California has invented a microchip the size of a grain of sand to make these patients' lives much easier. This chip is attached to every pill you swallow, and is activated by the liquids in your stomach so your phone records exactly which medicines you have actually taken. Early evidence suggests that this could result in significant behaviour change by patients, notably much better adherence to drug regimes. In one study nearly 40 per cent more patients reached their target blood pressure when using the digital pill.

Or think about those suffering from mental illness. An app called Ginger has now been developed which advocates say can detect depression or suicidal tendencies with greater accuracy than a psychiatrist. Without even being opened, this app monitors whether you got out of bed, if you skip a meal and if you are texting or calling friends in line with normal social activity. By tracking what an average day looks like for that patient, this app detects deviations from the norm and alerts clinicians or relatives when they should check in to see how you're doing.

Or take a child with earache. At the moment his or her parent has to book an appointment with a GP, travel down to the surgery, and get their child's ear checked for infection with an otoscope. But now entrepreneurs have developed a simple attachment for an iPhone which

'We are now on the cusp of changes in modern healthcare that will be as profound as the invention of the internet'

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Hunt's vision: People from across the NHS gathered in London to listen to Jeremy Hunt

can take an incredibly powerful and accurate picture inside someone's ear. This means with two clicks the parent can send an image to their doctor, and with e-prescriptions and home delivery, the problem can be rectified without stepping outside your home. Time and money are saved, and that family's consumer experience is revolutionised.

In some ways this is just the onward march on modern technology finally taking off in healthcare. But these changes are doing something more: all of them are giving patients much greater control of their own healthcare and responsibility for their health outcomes.

Opportunity for doctors

Is this good or bad for doctors?

US health-tech entrepreneur Vinod Khosla says that soon we will never ask a doctor for a diagnosis. Somewhat provocatively he asks why would you trust a human brain to make a judgement when a single drop of blood contains 300,000 biomarkers that can be analysed by a computer before you even have any symptoms. More likely than his prediction is a partnership between a doctor's judgement and the information provided by data analysis: whilst the best computer chess programme can now beat the best human player, it has not yet defeated a human being working in partnership with a computer.

That partnership will seem blindingly obvious when it happens.

Like the transition in tennis from depending on linesmen at Wimbledon to using Hawkeye, the move to the "quantified self" in medicine presents a huge opportunity to improve the quality and accuracy of a diagnosis. Perhaps the most high profile example of this is Angelina Jolie choosing to have a double mastectomy after genetic sequencing. But it is also clear that in an era of chronic conditions, when patients take responsibility for managing their condition, the outcomes are better.

The Expert Patient Programme showed that, after training patients to self-manage conditions, 40 per cent felt reduced pain, tiredness or breathlessness within months; and some reported a reduced use in NHS services such as GP consultations and hospital visits. Likewise when it comes to lifestyle decisions like obesity or smoking, doctors cannot be held responsible. But working with patients who are prepared to take responsibility, they can transform life chances. No one disagrees with this – so now it is time to move away from the ivory towers of theory to the gritty job of implementation. Today I will therefore talk about this government's plan to make this happen and the four elephant traps we need to avoid in the process. But first let's look at our progress to date.

NHS progress to date

Over the last few years we have been pursuing an ambitious digital strategy in the NHS. Three years ago I – perhaps foolishly – said I wanted the NHS to go paperless by 2018. I am sure someone somewhere will be able to find a lone sheet of paper in use in three years' time, but the spirit of that ambition remains alive and well, not least thanks to the inspirational leadership of Tim Kelsey and his team and NHS England.

For example, last year the number of GP practices offering access to summary GP records rose from 3 per cent to 97 per cent. And in the last two years the number of practices offering e-booking and e-prescribing rose from 45 per cent to 99 per cent. Take up by the public is still lower than we want, but from April next year all patients will be able to access their full GP electronic record and not just a summary. By 2018 this record will include information from all their health interactions across the system and by 2020 it will include interactions with the social care system too.

By then patients will not just be able to read their medical record but add their own comments. They will also be able to link it to wearable devices like Fitbits or Jawbones.

As important as the improvements in clinical care that come from electronic health records is the cultural change that comes from true transparency. In January, the World Wide Web Foundation ranked the UK first in the world for open data, which includes a health category. Similarly, Professor Don Berwick of the world renowned Institute for Healthcare Improvement, has commended our "serious commitment to evolving the NHS as a learning organisation committed to the never-ending pursuit of safer care".

'Bureaucracy, blurred accountability and a blame culture are still too common'

We are now the most open and transparent healthcare system in the world.

From a standing start a year ago, the new MyNHS website has drawn together outcomes and performance data across the whole health and care spectrum, from individual consultants, GP surgeries and dentistry practices, to care homes, hospitals and mental health facilities.

The site now holds 700,000 individual pieces of performance data and has been visited over 300,000 times – with many of those via the BBC! We now have a new look MyNHS with much more user friendly functions, and we will continue improving it to help drive this consumer revolution in our NHS.

But we didn't stop with a new website. There's now monthly publication of 'never events'; some 10.5 million responses to the Friends and Family Test; the new duty of candour; the new "no-blame" patient safety investigatory service, IPSIS; CQC ratings by hospital department; GPs soon telling patients about local hospitals' CQC ratings to inform referral choices; Sir Bruce Keogh's review of the professional codes to ensure people report openly and learn from mistakes; and from next March the publishing of estimated avoidable deaths by hospital.

I said in July this kind of intelligent transparency would not just empower patients, but could also help make the NHS the world's largest learning organisation.

But whilst we can be proud of our progress in building a patient-focused culture, for anyone who believes in the NHS as passionately as this government does there is much work to do. We still put too many obstacles in the way of doctors and nurses wanting to do the right thing for patients; bureaucracy, blurred accountability and a blame culture are still too common.

So here are four "elephant traps" we need to avoid followed by some areas where we need to go further and faster to harness the opportunities offered through empowering patients.

The four elephant traps

Firstly the bureaucracy trap. Surely technology helps to reduce bureaucracy by eliminating repetitive form filling? Not in parts of the US. Whilst thanks to President Obama's Health Information Technology for Economic and Clinical Health Act, the US has gone further and faster than most countries in digitising hospital records, this change has met huge resistance from doctors because of the extra burden that can reduce contact time with patients.

Put simply for many doctors it feels like screen contact has replaced eye contact. One recent US study videoed 100 patient visits and found doctors were spending around one third of the time looking at their screens. Another found that emergency room doctors spend 40 per cent of their time filling out online forms and just 28 per cent with patients. An emergency department in Arizona tried to attract applicants by stating they had no electronic medical records in the advertisement. In the UK, some think the new IT system at Addenbrooke's helped tip it into special measures.

The lesson here must be to ensure that new IT systems improve rather than reduce clinician productivity – so that it helps rather than hinders them in their jobs. Professor Robert Wachter of the University of California, San Francisco, says this means understanding that the digitisation of health care is about "adaptive" change rather than just "technical" change – a change in behaviour rather than just a new process. And I will discuss later the need to get this right in general practice as well as hospitals.

The second elephant trap is the accountability trap.

One of the best reasons for investing in digital records is to allow communication between multidisciplinary teams in different organisations for patients with complex needs. But by making cross-team and cross-agency working easier, there is also a risk that accountability to the patient is blurred. Let me read you a line from a recent report about a tragedy in our NHS: "Assurance had become circular. The CQC was taking reassurance from the fact that the PHSO was not investigating; the PHSO was taking assurance that the CQC would investigate; the SHA was continuing to give assurances based in part on the CQC position. Monitor asked for assurance and received the perceived wisdom."

Now let me read you a line from a completely different report about a different tragedy: "There was a systemic culture

'The digitisation of healthcare is about adaptive change rather than just technical – a change in behaviour'

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where organisations took inappropriate comfort from assurances given by other organisations. As a result, organisations often failed to carry out sufficient scrutiny of information, instead treating these assurances as fulfilling their own, independent obligations."

That was Morecambe Bay and Mid Staffs respectively, perhaps the two greatest healthcare scandals in our recent history, with more in common than we've cared to admit. One of the biggest lessons that I have learnt in my time as health secretary is that if the buck stops with six people, it stops with no one. Technology should allow easy communication with the person responsible for your care. But what if no such person exists? We must never let shared records become an excuse for diluted accountability or the lack of a personal touch, which is why the work done by the Academy of Medical Royal Colleges about clinical accountability outside hospitals is so important. I am delighted that guidance has been published today.

The next elephant trap is the cost trap.

Computer systems are expensive. They can also be a total waste of money. Just look at the Connecting for Health catastrophe. £9bn over 10 years came to virtually nothing in our biggest ever IT disaster. Whilst all such investments have the right intentions, many in practice diverted resources away from frontline care. And often the investment was targeted at improving organisational convenience rather than patient experience. The lesson here is surely that incremental improvements closely tied to clinician productivity and patient experience are as valuable as big bang changes which carry much greater risk.

Finally the data security trap. We need to be honest. None of this – none at all – will be possible if the public do not trust us to look after their personal data securely. Remember Vinod Khosla's 300,000 biomarkers in a drop of blood? But who will send their sample to a laboratory if they are worried about the security of highly personal information? The plain truth is that the NHS has not yet won the public's trust that it is competent in protecting basic personal information. Hospitals, GP surgeries and social care organisations do not yet all have proper data security protocols in place. So the new guidelines being developed by Dame Fiona Caldicott, our national data guardian, as well as the CQC's review will be vital.

Let's be ambitious when it comes to technology – but let's be humble as well. We haven't always got this right, especially when it has interfered rather than enhanced the relationship between doctor and patient.

So I am delighted to announce today that Professor Robert Wachter, not only UCSF Professor but also author of *The Digital Doctor* and a world expert on the promise and pitfalls of new IT systems, will conduct a review for the NHS on the critical lessons we need to get right as we move to a digital future. He will guide and inspire us as Professor Don Berwick did on safety and we look forward to receiving his report next summer.

Five point patient power plan

Four elephant traps to avoid – and five suggestions where we need to go further to make a reality of patient power.

Because we have already started this journey, this plan is more about plugging some gaps in the architecture and making sure we square the opportunities ahead with the significant financial and operational pressures we face. But if we plug those gaps and stick to the plan I am confident – as promised in July – we really can make NHS patients some of the most powerful in the world.

First we need to plug the transparency gap. We have more information than anywhere else, but we need to go further, and ensure that we have truly intelligent transparency. That's why the King's Fund report on CCG accountability is so important. I can announce today that we are pressing ahead with these changes in accordance with their advice.

They advised that aggregated ratings were only possible if human judgement was used to interpret the data we have, so NHS England will provide ratings of all CCGs, similar to the ratings that Ofsted and CQC provide in the following categories: outstanding, good, requires improvement, inadequate. This will help people have a good sense of the quality of healthcare provision in their area and how it compares to other localities. By June next year we will publish these– both as an overall rating, and for cancer, dementia, diabetes, mental health, maternity and learning difficulties. In line with the King's Fund recommendations, the ultimate judgements for these ratings will be made not by algorithm but by expert committees. I am delighted to announce the names of the people chairing two of these committees today: Harpal Kumar for cancer and Paul Farmer for mental health. The overall CCG rating published next June will use 2015-16 data and be informed by the current NHS England CCG scoring methodology. However, under Ian Dodge's leadership NHS England will be developing a new methodology based on the wider responsibilities CCGs now have for their local health economies. Ian will consult with CCGs on this so that the new methodology is in place from the start of the next financial year, to inform the ratings published in June 2017. We will also do more to ensure the public get clear information about the quality of

'The lesson is that incremental improvements are as valuable as big bang changes which carry much greater risk'

their local GP surgery, informed by the Health Foundation's work.

Secondly, we need to tackle the accountability gap that I touched on earlier. How can patients be truly in control if they don't know where the buck stops for their care? We've made good progress on this front with the introduction of named GPs, names above the bed in hospitals, and the Academy report into named responsible hospital consultants. We're now going further, and hard-wiring the principle of a named, responsible clinician into planning guidance next year.

Today's report from the Academy of Medical Royal Colleges on clinical accountability in community settings is another big step forward, and I can announce that their principles will also be incorporated in planning guidance.

Thirdly, we need to tackle the time gap. Patients will never be powerful if we do not give their doctors enough time to listen to them. Managers will never make the right decisions if they do not have time to listen to their own frontline staff. We need to think about this across the system, but today I am announcing a four point NHS England plan to help one group in particular: GPs.

Firstly, by cutting down on the ludicrous amounts of time they have to spend chasing different organisations for payment by allowing everyone access to GPs' own payments system. Secondly, to stop the pointless referrals from hospitals back to GPs when they miss an appointment – a total waste of professional time that accounts for around 3 per cent of all GP appointments. Thirdly, we must make general practice truly paperless by 2018 – and end the embarrassment of fax machine communication between hospitals and surgeries.

Unbelievably someone told me recently that the NHS is the world's largest purchaser of fax machines– not a world first to be proud of and we must put it right. Just two hours a week returned to each GP through rooting out bureaucracy and smarter use of technology is equivalent to a 5 per cent increase in GP capacity alone.

Finally, we need to support GPs to innovate locally across organisational boundaries. Today an independent review on the PM Challenge Fund has shown a statistically significant 15 per cent reduction in minor self-presenting A&E attendances by patients at those practices. This is family doctoring at its best: keeping people happy and healthy outside hospital.

Next, a patient-centred system needs to ask whether it is really giving patients choice and control over their care at every available opportunity.

So we will continue to explore ways to increase choice in maternity, end of life care and the roll out of personal budgets, where NHS England have promised plans before the end of the year.

Finally, and most difficult of all, we must continue to tackle the culture gap which still acts as a barrier to putting patients first.

Professor Sir Mike Richards frequently expresses astonishment at the variations in care he has found in NHS hospitals – much greater than he anticipated, with world class hospitals like Frimley and Salford Royal alongside 24 hospitals which have had to be put into special measures. The CQC says this variation is not principally about money, challenging though the financial situation is right now, but about leadership and culture.

People become doctors and nurses because they want to do the right thing for patients. But too often a defensive culture makes them pay too high a price for speaking out if they think they have made a mistake or seen a colleague making one. There will always be mistakes, sometimes with tragic consequences. But the overwhelming patient interest is in an open and transparent culture that learns from those mistakes and stops them being repeated. And that patient interest is served not just by eliminating variation between hospitals – but within them as well.

A patient-centred system cannot justify mortality rates 15 per cent higher for those admitted on a Sunday compared to those admitted on a Wednesday. Hospitals must be allowed to roster according to patient need – and to those who point to low morale as a reason not to change this, I simply say the highest morale is almost always found at the hospitals that are best at looking after patients.

There is no conflict between a motivated workforce and a patient-centred culture – on the contrary the overwhelming evidence is that they go together. So we must challenge those who resist improvements that put the patient interest first with the utmost vigour.

Conclusion

Technology in healthcare should never be an end in itself. It must be about improving the safety of your baby's delivery, accurately identifying if you're having a heart attack, or diagnosing your cancer more quickly. But most of all it must be about control – about moving away from a culture when you "get what you're given" to a democratic culture where for the first time in centuries of medical history the patient is the boss. Both the tech optimists and the tech sceptics have plenty of evidence to use.

But I am unashamedly one of the optimists. When it comes to the coming changes in healthcare, it's not man versus machine, it's what man and machine can accomplish together. And to that there are no limits. ●

'A patient-centred system needs to ask whether it is giving patients choice and control over care at every opportunity'

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The panel (left to right): Mike Bewick (top) and David Loughton; Alastair McLellan and Sir John Oldham; Anne Rainsberry and Miles Scott; Professor Cathy Warwick; Lucy Moore and Sarah McBride; and Conor Burke

TIME TO HAND OVER POWER

CCG ratings dominated the headlines after Jeremy Hunt's annual lecture – but experts convened to debate its implications were far more interested in his vision of powerful patients, reports Claire Read

Opening a roundtable convened to reflect on this year's *HSJ* Annual Lecture, *HSJ* editor Alastair McLellan admitted it would be somewhat different from other such events. "Normally when I chair these roundtables, I say everybody keep your feet firmly on the ground because otherwise what we talk about won't reflect the reality of healthcare in the here and now," he explained. "But this roundtable is to reflect on the lecture, and that is deliberately something which asks a policy maker to look into the future. It is a platform for a bit of blue sky thinking, rooted in reality we hope."

He urged the panellists at the roundtable – run, like the lecture itself, in association with FTI Consulting – to aim for a similar balance. Yes they should think broadly, just as Jeremy Hunt did when delivering his speech, but they should also remain firmly focused on the real world.

Ratings, and Mr Hunt's specific pledge to introduce Ofsted-style assessments for clinical commissioning groups, attracted most of the headlines after the lecture. It was therefore a natural place to begin the roundtable discussion.

Mr McLellan asked panellists if an Ofsted-style model could and should be applied to the NHS. This would be a system, he said, "in which regulation produced ratings which are acted on by the public as well as by the service". A Department of Health press release had said that giving patients access to CCG ratings, would make "healthcare services in local towns and cities... much more accountable to their local population than previously".

It was a point somewhat rowed back from during the lecture itself, Mr McLellan noted. During a concluding question and answer session, Mr Hunt had essentially suggested a good rating would be reassurance to the public and a bad rating a recognition improvements were needed. The refinement of this message was perhaps sensible considering the number of roundtable participants who saw limits to the parallels between school choice and healthcare choice.

"One of the things I think is interesting about the parallel to Ofsted is that we don't have a national schools service," pointed out Anne Rainsberry, regional director for London at NHS England. "So baked into that is the fact that already people expect differentiation in schools. We do have a national health service, and the concept is that you have a similar offer wherever you go. Now we all know that isn't true, and it's highly variable for all sorts of reasons, but I think there's an interesting psychological difference in terms of how people see schools versus how people see health."

Different too, she argued, was the scope of choice available in healthcare in comparison to education. "A lot of people aren't able to exercise choice or look at ratings when they start to access healthcare because they're in the back of an ambulance, and at that point you're unlikely to say: 'I was reading the ratings the other day, and could you turn left here?' Figures vary, but it's going to be 50 to 60 percent [of people] who are accessing healthcare who are in the urgent and emergency care pathway."

Sarah McBride, director of delivery at North East

ROUNDTABLE PARTICIPANTS

Dr Mike Bewick senior clinical adviser, Performance Improvement and Transformation Team, FTI Consulting
Conor Burke chief officer, Barking and Dagenham, Havering, and Redbridge CCGs
David Loughton chief executive, The Royal Wolverhampton Trust
Sarah McBride director of delivery, North East Hampshire and Farnham CCG
Alastair McLellan editor, *HSJ* (roundtable chair)
Dr Lucy Moore former interim chief executive, Colchester Hospital University Foundation Trust
Sir John Oldham adjunct professor in global health innovation at Imperial College London and chair of 2013-14 Independent Commission on Whole Person Care
Anne Rainsberry regional director for London, NHS England
Miles Scott chief executive, St George's University Hospitals Foundation Trust
Professor Cathy Warwick chief executive, Royal College of Midwives

Hampshire and Farnham CCG argued: "Anything that puts more information and control into the public domain is the right thing to do. The challenge is an Ofsted rating about a school in comparison to a vastly complex [healthcare] system that's got huge influences and interactions within it. Being able to consolidate that into one system-wide rating, I think, is going to be tricky."

Mike Bewick – until recently deputy medical director at NHS England, now senior clinical adviser at FTI Consulting – also emphasised the challenge of creating a rigorous system-wide ranking for healthcare.

"My view is that [such ratings] are inevitable, it will happen, and we have to do something that makes it translatable to the public so they understand what they're dealing with," said Dr Bewick. "But please let's get the metrics right and get the assessment right, because if we're using aggregate data that looks across a whole wide range of things that's affecting that system, I think we're in danger of polarising the view of an organisation based on untrustworthy evidence."

The impact a negative rating can have on an organisation and its staff has been well rehearsed, and one roundtable member had personal experience of what he called the "unintended consequences" of ratings. David Loughton is chief executive of The Royal Wolverhampton Trust which has, since last year, run Cannock Chase Hospital – formerly part of Mid Staffordshire Foundation Trust.

"It will be many, many years and definitely not within my time before we actually make some significant progress, because that organisation was so damaged, and people just don't want to work there still to this day because they don't want it on their CV," he said. "So I think you've got to take a great deal of care when an organisation goes into special measures – what is going to be the impact on that organisation's recovery. Mid Staffs is an extreme example, but you can go back many, many years – events at Bristol Children's Hospital, for instance; they struggled with recruitment there for many years."

Outside of such prominent and serious stories, Lucy Moore said she was not entirely convinced patients pay all that much attention to healthcare

'People in the back of an ambulance can't look at ratings'

rankings in any case. "I've just come from an organisation which has been at the sharp end of ratings" – Dr Moore was, until recently, interim chief executive at Colchester Hospital University Foundation Trust – "and my initial response is it's interesting how the public try quite hard not to pay too much notice of ratings. It's also easy to argue that in many parts of country actually people don't have too much choice."

"I think your ability as an individual to use ratings is dependent upon the choice available to act upon them," agreed Sir John Oldham, adjunct professor in global health innovation at Imperial College London and chair of the 2013-14 Independent Commission on Whole Person Care. "In some areas, like conurbations, it may be more possible than it would be in Cornwall. In those areas, maybe the ratings are a pressure on the system to improve – though the evidence isn't great that would come about."

Conor Burke, chief officer at Barking and Dagenham, Havering, and Redbridge CCGs, was also keen to understand what was trying to be achieved through the CCG ratings, suggesting the lecture had not made this clear. In principle, however, he declared himself a fan of such information. "I think ratings are a fantastic thing, because I use them all the time in things like TripAdvisor – I choose where I want to go [based on] other people's experience of those services. So I think implicitly, it's something that is attractive to us as people and humans because we want the best," he argued.

Purpose of CCG ratings

"The challenge here is what's the purpose behind the rating. TripAdvisor creates a market, so is that the purpose through this – the poor providers actually go and the prime providers or commissioners succeed?

"Or is it about regulating an individual commissioner? Or is it about system improvement, could that be the opportunity, could it be about trying to drive

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forward something?"

Whatever the purpose – Mr McLellan suggested it was to reduce the number of CCGs without being accused of unhelpful structural tinkering – some panel members felt there could be benefits. Miles Scott, chief executive at St George's University Hospitals Foundation Trust, took "a very positive and enthusiastic view" of ratings.

"It seems to me they have enormous potential for engagement: engagement of patients and the public but actually also – perhaps almost more importantly – engagement of staff," he said. "My experience of working in hospitals is that staff can get very engaged by rating systems, and it's a really good way of talking to people and pulling together programmes for improvement within an institution."

There were caveats. Like others, he argued any rating needs to be easily comprehensible. "I think you have to rate things, often institutions, that both staff and patients understand," Mr Scott said.

Professor Cathy Warwick suggested it would also be a case of taking care to rate those things which actually matter to patients. "Very often in maternity, what women and families care about is not always what different professional groups care about," said Professor Warwick, chief executive of the Royal College of Midwives. "So I think the issue of what a CCG is being rated on and who will produce the data for the ratings is incredibly important. Women often rate respectful, considerate, transparent care over and above things like mortality data, because it means more to them."

It was a comment which explicitly moved the debate onto the idea of patient power. The focus of post-lecture headlines may have been CCG ratings, but it very explicitly was not the focus of the speech itself. Mr Hunt's key theme was patient empowerment, particularly through technology, and so he may be pleased to know this was the area of the lecture which most engaged our roundtable panellists. As Sir John Oldham put it: "I actually found [ratings] the least interesting bit of the speech in some respects."

Sir John's interest was instead piqued by the secretary of state's "strong advocacy for the

'You have to rate things, often institutions, that both staff and patients understand'

healthcare system to embrace the digital revolution, in a way that changes the service delivery, not just adds on to the existing model of service delivery. And in doing so, actually empowers the users of the service to get involved but also to manage things for themselves."

He continued: "[The digital revolution] lowers the power gradient between the user of the service and the professional providing the service in a way nothing else does. We shouldn't forget that most people with long term conditions actually spend 8,000 hours in a year having to manage their own condition, and yet interface with the health service for, on average, three or four hours. But we spend 99 per cent of our management time on the three or four hours, not the 8,000."

Mr Burke also found the most compelling part of the lecture to be "the potential for the empowerment and liberation of patients, or people". However, "the downside I felt was actually not everybody wants to be liberated. So one of our areas, Barking and Dagenham, is a very, very deprived area, it's very industrial – we have the highest cardiac mortality in the country, we have the highest obesity rates in the country, people aren't choosing to actively manage their healthcare.

"So for me it could create a two tier system – so there could be people that are capable of taking that approach, but there are other people who choose not to for whatever reason. And so that does worry me about the most vulnerable and disadvantaged, and how do we take an approach when people don't want the power, they actually they want to be told."

Mr Loughton echoed this. "For me, the most interesting part of the lecture was this issue about empowering and engaging patients, but it's also about the difficulty of actually doing that with certain groups. Because if I go outside my maternity unit this afternoon, I'll

have someone with a big bump puffing away on a cigarette. So I think the thing we really have got to try to do is engage with these people that we have failed to engage with, to actually take some responsibility for their own ill health."

Mr Scott deepened the point, saying: "It's not just the question of maybe there are some people who don't want all this choice. It's more a question of how do you ensure those people who are articulate get to express their choice, and you react, but you don't necessarily distort priorities for everybody else based on those people's choices.

"You can't design the system around the minority. We need to facilitate the minority choices, but we mustn't design the whole system around them."

Embracing partnership

Professor Warwick felt there was a long way to go before healthcare professionals become entirely comfortable with this sort of partnership approach. "Over the last couple of years, I've been starting to really challenge midwives on this, because we think we're very women-centred, we consider ourselves to be at the vanguard in fact of being patient-centred. And I think it's a lie, actually.

"I think we pay a huge amount of lip service, not just in maternity but across the health service, of being user-centred, and I don't think we've even begun to think what that really looks like. I think it's actually a really big challenge, and I just see people's care driven by the needs of the institution on a daily basis."

Professions "are profoundly nervous of handing over care", she added. "In my own area, people still can't bear the idea that a woman who in our minds isn't suitable for a home birth will choose one, or indeed a woman who we think shouldn't have an elective [caesarean] section actually wants one. We really struggle I think with [the idea] people might make the wrong choices, and I think we've got a lot of education to do to help people start to feel comfortable with this. So we use the words, but we're scared I think."

Some panellists did feel progress had been made in changing the patient/professional balance of power. Mr Loughton remarked on how the nature of complaints and complainants had changed in the time in which he has been a chief executive. "Years ago if I saw a complainant, they'd be complaining about the catering, the car parking. If I see a complainant now, it's usually with a consultant, a member of staff, and the complainant walks in with a lever arch file of information they've got off the internet. And that has really changed now – people complain mostly about clinical care now, not support services. And they are informed, a lot more informed."

Sir John agreed. "When I started out as a doctor, the definition of professional was a possessor of knowledge," he reported. "Now I am an interpreter of knowledge, because that knowledge is available in a much more widespread way."

The key, he suggested, was for the NHS to properly engage with that reality. "The NHS can act as the accreditor if you like, the mechanism, the route by which people can access information, be the facilitator. I don't know anybody, including my own relatives, who if they have been given a new diagnosis don't Google immediately to find out what's gone on where. So let's embrace and formalise that."

If Jeremy Hunt can preside over such a feat, Dr Bewick suggested the current secretary of state's legacy would be secure. "I thought it was incredibly well crafted, the speech," he said. "Because he did say at the beginning, once we are past the hot topics of the time – and then he listed, to be honest, quite a lot of the *Five Year Forward View*.

"I think he was knitting a legacy together there that it's about patient empowerment, it's about the growth of tech, it's about the changing attitude towards measurement in the system and how we use that. And I think that will be his legacy and he should be proud, because I think he's stuck to it when a lot of other secretaries of state have been deflected.

"[And I'm not saying that] in a sycophantic way. Because the money has been a big issue, and he's not really made it a big issue – I think others have done. The money will have been forgotten because there'll be a solution; there will have to have been a solution. If what he does [on patient empowerment] comes to fruition, that will be remembered in 25 years' time." ●

WILDE FRY

FOR HEALTHCARE LEADERS

HSJ ANNUAL LECTURE

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