

Podcast episode transcript: Mike Ristau and Ashwin Pinto

Michael Ristau: Hello, everybody, and welcome to another Inside Angle podcast. My name is Michael Ristau and I'm here today with Dr. Ashwin Pinto from University Hospital Southampton, NHS, where he serves as chief clinical informatics officer. And we're going to talk a little bit about some of the projects that we've implemented with University Hospital Southampton and how we got there. Doctor, would you like to introduce yourself and your current and your future role?

Ashwin Pinto: Yes, of course. My name's Ashwin Pinto. I'm a neurologist by background. I've been in practice in Southampton for 20 years, and in the last five to six years, taken on a senior leadership role in digital. And then quite excitingly and then at the last just month or two, I've been appointed to, as well as my current position, taking on a new role as a clinical digital lead for a group of hospitals and primary care physicians covering about two million people across the South Coast in a region called Hampshire and Isle of Wight. And that's an exciting new time for us as we look to really implement a mature digital strategy across a huge number of different healthcare providers in that region.

Michael Ristau: It's a big job. There's lots going on in the NHS, and obviously in your part of the world as well. Can you maybe give me a little bit of an overview of the NHS digital strategy and how it informs where Southampton has been going the last few years, and maybe a little bit about where you're headed?

Ashwin Pinto: It's worth perhaps going all the way back to the start of the digital strategy in the NHS, which was the attempt in 2005 or thereabouts to implement a strategy called NPfIT, National Programme for IT. And that was an ambitious strategy with funds behind it, with good funds behind it. But unfortunately, probably the NHS wasn't mature enough to accept that strategy. Frankly, they weren't the digital leaders, I think, more than anything else, I think the word the digital leaders who could help implement that strategy. So it was in trying to impose funding and without there being any run-up to it, lots of goodwill, lots of projects that people wants to get done, but without the senior leadership that would take a project through and implement. So some projects were successful. Frankly, most of it wasn't.

And about five years down the line and quite a lot of money spent, the government commissioned Professor Wagner from UCSF to come in and write a full report about why despite lots of goodwill and money, why we had failed to implement a national strategy. And out of it came quite a lot about some of the technicalities of procurement and so on, but actually a lot about leadership and the feeling was that the leadership wasn't there to implement a digital strategy.

So one of the reason I got into digital was because they implemented a national program of training in IT to identify and train up senior clinical leaders in digital. It's called the LHS Digital Academy. I was lucky enough to be in the first cohort which started in 2018. And about that time, again the impetus came for saying if we're training up our next future digital clinical leaders, then this is a time to re-look again at the strategy and aim for an integrated strategy to try and bring the NHS up to the levels of digital maturity that frankly quite a lot of other countries have been able to achieve.

I think it's this time around we're likely to be more successful because I think fundamentally we've got the right leadership in place. We've talked before about how important leadership is and the people who are involved, but also I think there's a better understanding of the problems that we're trying to fix. And also, the market's matured and there's better solutions out there to implement. So I think we're in a much better place in terms of digital strategy.

Tim Ferris came in from Boston and was our national clinical lead for transformation in digital. He recently left that role but set in place, I think, a really good strategy to say what we have to do really is work together closely as hospitals. It is a single National Health Service. And although we are individual independent providers, we clearly have to work together. Patients move between hospitals. In some ways we had as fragmented, if not more fragmented, a system than exists in other places where those are plurality of providers.

And so we have started to embark on a strategy where geographic regions will look to implement a single, we call it enterprise EMR, so that we can bring everybody up to the same level of digital maturity with all the advantages that will pertain in terms of documentation, quality of care, all those sorts of things that will naturally flow out of a more mature approach to working together. That's where we are on the strategy, a real desire for hospitals now to work together and bluntly to put in single EMRs across the whole system rather than piecemeal each provider going their own way with how they implement their strategy.

Michael Ristau: Thank you. And it's so much has happened, and just to encapsulate that journey in a few phrases is helpful. Now, as you look at Southampton, if you look your particular area, is there anything unique about that area that has informed your own strategy or some of the considerations that you've thought through the last few years?

Ashwin Pinto: We've been in an unusual position that, for example, when the National Programme for IT came in, as I said, in the mid-2000s, we did not choose to take the money and participate because we were more digitally mature than most others around us at the time. So we've been implementing digital solutions since about the late 1990s, early 2000s, largely building our own EMR. Not all facets of EMR. We don't necessarily need to go into technicalities, but some of the core components of an EMR we are building in-house. So that has informed our strategy.

We thought a lot more about our role as an integrator, so buying solutions and plugging them into what we already know we do well. And where we work really well is where we can work with a supplier, work with a vendor, and tightly integrate the technology and often the great expertise coming from the vendor to plug in into our existing systems to maximize the benefit, really. So we're not having to, as it were, reinvent the wheel. We've already got products in place on our side that we know will work if we can just find the right vendors and suppliers to work with us to implement solutions that work for everybody quickly without the pain of, as we call it, rip out and replace where you rip out a system and then you are restarting again to put in a new system and you've lost all your learning from your systems that you had in place before.

Michael Ristau: I think that's helpful. The national strategy, a little bit tailored, a little bit different in your region. Let's transition maybe and talk a little bit about the project where Solventum has engaged with you in your history there. So just maybe a few words on how did you identify this as a project or a need or the problem set that you were considering as you launched this project.

Ashwin Pinto: So just a little bit about the rather unique thing about UK documentation for ambulatory care. Unlike other healthcare regions, the UK has a system of transfer of care documents to the primary care physician, and that document is key to be timely, accurate, and with both the patient and the primary care physician as soon as possible. And our problem was frankly that we have something like a thousand providers, consultants, we call them providers, all writing letters every day with delays of two, three weeks. And with frankly, risk attached to that, if you are writing a letter with some important urgent change in medication and it's taking two weeks to get to the primary care physician is going to make the change.

So we identified firstly that we had a really, a difficult problem with getting letters out in a timely fashion. We have, like most healthcare regions, we have problems with recruitment. So the people who were having to do some of still correction of transcription, we did have an outsource transcription, but it was a hybrid model of some outsource transcription then we corrected in-house which all added to the turnaround time. And so we had a problem where we had lots of documentation, as I said, a thousand or so active people, providing, generating documents but in a pretty inefficient fashion.

And so the project was really to accept that things had moved on a lot from when we started that project and outsourced our transcription in 2008 or 2009, and we really needed to look at where the technology had moved to. And so as all hospitals do, we surveyed the market. We looked at and saw what there was out there. And what we really needed, and we discussed this a little bit about what makes Southampton unique, is that understanding we've got some real good understanding of our technology stack. We needed to work with a provider, with a supplier who could really work with us to deeply integrate a product because that would make it a much easier transition from the comfort that the clinicians had holding their old Dictaphone, digital Dictaphone, to move to a new solution that was going to meet their needs and the needs of the patients and primary care physicians.

So the project started in earnest in about 2022, I think 2022, with a series of workshops with clinicians to try and understand a little bit what they needed, and then really importantly a very small project working group to just get us through that technical aspects of the project to make sure that we had that deeply integrated solution, very unique. The thing I liked about working with the team from 3M as they were and as you are now, was that real understanding that we had some technology that they could use to plug in your solution to make it a really nice, integrated product.

So that took a bit of time, took the best part of six months, possibly a bit longer, and then we had a fairly fast implementation phase of over a year with, sorry, just a bat under a year actually, come to think about it, where we quite quickly roll through. We rather deliberately said that we weren't going to leave anybody behind. We weren't going to. We thought the solution was really well-designed, and that if clinicians used it, they'd soon see the benefits.

And so we took it in two stages. The first stage we did over that year was to put in the product that allowed so-called backend transcription. That again was partly to give the clinicians a little bit of comfort that that was the solution they knew from before. They didn't particularly want to see words on the screen to start with. They just wanted to be able to pick up a microphone and generate a document. And over the course of the year, as people got more comfortable using it and using obviously the suite of products directly into the EMR and then flex to generate documents for transfer of care to primary care physicians, they obviously got more comfortable, more confident in the product.

And then in what I think was possibly a little bit of a tiny bit of a risk, but I decided it was the right thing to do, we switched everybody over on one day to front-end transcription, which really reduces the amount of time taken for letters to come out because we're no longer routing those letters through a med sec or a medical secretary or transcriptionist to correct anything. It's all mostly now done by the physicians themselves to correct the documents.

So I think it was the story of the journey we've been on. When I reflect back, it was all that hard work at the start and lots of hard work at the start that then meant really we were set in stone from mid-2022 to get us through till the first phase of the project ended in 1st of April 2023. And then we literally switched everybody over on the 1st of May 2024 to what is now the same sort of fluency suite that you would use in any of the hospitals in the US.

So quite proud of it, but it was a lot of work to get there. It wasn't a very fast implementation over two months. It was lots and lots of technical work then quite a good project team that took it through the hospital in about, as I said, 10 or 11 months ending in 2023, and then this final flick of the switch in 2024 to take us to what I would now call a mature speech recognition platform.

Michael Ristau: Thanks for the summary. I think the planful approach towards change management is important. At the end of the day, you're dealing with physicians who don't want to be interfered with, want to document, get an output on the other end. And it better work and it better meet their needs. So I can completely appreciate the thinking there. Were there any unexpected challenges as you went through that process? It was very planful. You talked about the technical work upfront, but was there any aspect of the technology or the organization or change, either good or bad, maybe that came up?

Ashwin Pinto: Well, I'll start with organization change because I think it's the thing that physicians feel most vulnerable about. So actually, physicians by now are using speech recognition, aren't they? They're picking up their iPhone, they're using Siri, they're using whatever Samsung's assistant is called. People have some understanding that speech recognition is mature and an excellent technology. So I think the technology bit wasn't what worried my physician colleagues. I think a lot of it was about if the hospital are implementing this new system, what am I going to lose as a result? And particularly am I going to lose my secretary, my medical secretary who I depend on if you take away this work?

And one of the first things I explain to people is that's the one thing we're not doing. We're not taking away medical secretary. And instead, rather than your medical secretary spending hours trying to correct your documents, she can focus on planning the surgeries correctly, getting the investigations sorted for the patient and so on. So it was freeing up people to care.

One of the things that I know, some we anthem we use all the time, is their strap line because it actually we should not be asking people to do tasks that add frankly very little quality to the care of the patient because actually it's a task that has been overtaken by technology which allows your medical secretary or your PA to just do the things that really make a difference to the patient. Ensuring that their MRIs, it's done before surgery the next day, all those things that are really important that they didn't have time to do before because instead they have this huge amount of documentation that they had to get through, and that was frankly inefficient as a way of getting documentation out to primary care physicians and patients.

Michael Ristau: Thank you for that. You'd mentioned before a little bit about the collaboration and teamwork between the Southampton project team and Solventum team. Can you just speak to that a little bit?

Ashwin Pinto: Yeah. We had a small team. It was very small. That was about, on the Solventum side, it was about four or five. And on our side, again three or four or five. It was weekly meetings, short meetings. We all enjoy short meetings that were just laser-like focused, just picking out point by point as we went through the technology just to make sure that both sides understood what the nature of the problem was and how to solve it.

And at every stage, it felt like it was a very symbiotic relationship of making sure that we could get the product to do what we needed it to do. And frankly at the start of it, as you often don't know because the technicalities of a product, I didn't know all the things that were capable of being done within the M*Modal product suite. But of course we were then delighted to find out that all the things that we built actually that happen for a completely different product for our previously outsourced transcription, we could very easily repurpose for M*Modal.

And that I think was why we were quicker than we might've been, because we had effectively got some of the technical background that M*Modal needed to plug in. So we're not Epic. We're not Cerner. We don't have... In some ways, the integration is always going to be a bit more difficult, but because we have done some of that work anyway, I think the project team from the Solventum side found it reasonably easy to work with us to get the product in.

I was really pleased about that because bluntly, some suppliers and vendors will think we are a single hospital EMR, what should we put in the work to work with you? Because actually it's so much easier for us to plug into Epic or plug into Cerner. Whereas in fact, I think we've implemented something that's just as good as those enterprise EMRs but different because we didn't start with an enterprise EMR in our UMC, in our University Hospital.

Michael Ristau: Thank you. We're proud of that, and I think that we view it as a core capability to be able to integrate with a variety of different EMRs, whether it's a big few or a long tail of others. So I'm glad that worked in your case. You mentioned the delay in letters. What other KPIs did you have in mind?

Ashwin Pinto: Bluntly, I want that down to less than five working days and actually less than two working days if I have my way. We've seen a small reduction, but we knew that with the first phase, the phase that took us to every physician in the hospital using M*Modal, we knew that we wouldn't see a big reduction. People had to get used to the technology. We hadn't fundamentally changed the interaction with their medical secretary to correct the letter because we hadn't given the clinicians an easy way to correct their own letter themselves. So it's, "Watch this space. Come back and ask me in a few-months' time when we get the data working with them so then to see what our reporting looks like," because I would think what we'll be able to show that our turnaround times for letter are falling.

But one key metric I'm looking for is what percentage of physicians are going to, I call it self-service. They're going to self-edit that. That is finish their document, sign it, and then it's out. So we'll see. I'm predicting that we knew we were at 25% at the start of the project, at the start of the switchover on the 1st of May. I might be wrong, but I would thought that we're approaching 50% now. But we will see. I'll get the figures and I'll let you know.

Michael Ristau: Excellent progress. Now, we're happy to help you along that journey. Maybe the last question, unless you have some other remarks to make, what's next for Southampton? Where do you see you going?

Ashwin Pinto: We've been talking a while about the move towards structured data and ambulatory care. That's one project. And the second is our journey, our project to digitize inpatient noting, that's what we call it. So because we write our own EMR, we have nursing notes that are digital. But the moment, the medical progress notes are handwritten, which is something we are very keen to get to move on from. And we know actually, I was just talking to one of your technologists here at CES, that we've got a vision that we could use some of your technology, in this case on a tablet, to be able to document on the wards. I think that's going to be a huge thing for us in the next year. So that's a big project.

We've built our side of the application in a product called Apex, effectively part of Oracle's database technology. And we are confident, I'm completely confident we can integrate that. So clinicians can go around with their tablet and dictate their progress note for each patient that they see. So that's one big project, and that's probably the most important now because we recognize it's a sign of digital maturity we're a bit behind and we need. That's an important project for, for example, coding when we are discharging the patient. If we had a fully digital record, it would make our coders' life an awful lot easier when they're working to code those encounters and those admissions.

So the second project which I talked about is the ambulatory care. We are keen, I think, to become more structured on data in the way that you get from an enterprise EMR. At the moment, the documents are essentially free text, but I've seen the sorts of documentation systems that you get out of the enterprise EMRs and recognize that we need to move towards that. And we then will need to work very closely with Solventum to use the technology to feed our what will then be structured ambulatory care data.

So that, to take that group of physicians with us having got this for will be challenging, just as challenging the first phase. But I'm confident actually that the technologies that you've highlighted that have been showcased at the CES, I think we're on this cusp where ambulatory care is about to really change. And in the way that your ambient product will allow clinicians to feel confident that they can have a conversation with the patient, have a consultation with the patient, and some of that really quite tedious work of typing, whatever it might be into the EMR, will actually be a whole lot easier because the AI will do the heavy lifting for you and give you a structured report that you can put into the EMR. And that truly allows you to just talk to your patient and not be spending too long pressing hotspots on your computer or having to talk into the EMR.

Michael Ristau: Sounds exciting. I think I can speak for Solventum and say we look forward to helping you down that path. And I just want to say one more time, thank you so much for making the journey to our Client Experience Summit, participating with us, having this conversation, and I wish you the best.

Ashwin Pinto: Thank you very much, Mike.

Michael Ristau: Thank you.