Research Aims To use innovation theory to understand the barriers and facilitators which influence AI adoption in the National Health Service (NHS). To explore solutions to overcome these barriers, and examine these factors particularly within radiology, pathology and general practice.

Methodology 12 semi-structured, one-to-one interviews were conducted with key informants. Interview data was analysed using thematic analysis.

Findings A range of barriers and facilitators to the adoption of AI within the NHS were identified, including information technology (IT) infrastructure and language clarity. The factors influencing the adoption of AI were categorised into three themes: the NHS as a System, the People who will be adopting AI and the Technology itself. Several solutions to overcome the barriers were proposed by participants, including education and innovation champions.

Conclusion Education and champions should be explored as facilitators to the adoption of AI in the NHS. Clarity on information governance could support data sharing to develop AI products. Future research should explore the importance of IT infrastructure in supporting adoption, examine the terminology around AI and explore specialty-specific barriers to adoption in greater depth.

Leading innovation and improvement

143

SEPARATING WOOD FROM THE TREES. ANALYSING REGIONAL VARIATION BY SYSTEMATIC COLLECTION AND ASSESSMENT OF PAPER FORMS USED IN NORTHERN IRELAND HEALTHCARE

Matthew Costley, Martin Doyle, *Encompass, Belfast, UK*

10.1136/leader-2020-FMLM.143

Encompass is a regional transformation introducing an electronic healthcare record across Health and Social Care in Northern Ireland (HSCNI).

This technological advance requires thorough understanding of all aspects of HSCNI. The build of encompass will be guided by clinical staff in the role of subject matter experts aligning diverse processes across trusts to one way of accessing care for all citizens.

Our project collected all paper forms used across HSCNI, this forms foundation for standardisation of future healthcare and resulted in collection of over 10,000 paper forms.

These forms were collected centrally, catalogued and documented onto a database. This database was populated using a 5 stage protocol for the purpose of collating, assessing, documenting, removing duplication and analysis. Forms collected exhibited evidence of significant duplication and variation. Dissemination of this learning will promote significant quality and efficiency improvement.

Initial stakeholder engagement took place prior to collection of forms in partnership with clinical staff, analysis by the encompass team took place including protocol design with regional clinical experts and staff training.

Final results from the form collection showed almost 4,000 unique forms, after de-duplication. This triggered a further project currently underway, cataloguing data elements from every form to allow a strategic method of standardisation.

The benefits of standardisation envisaged are increased efficiency, patient care and patient safety. Collating all paper forms was no small task and the mammoth effort undertaken by all cannot be understated.

Our experience shows that there is significant variation in many areas, different forms generated in different trusts by different clinicians generate significant variation across a small region. We encourage healthcare professionals to standardise as much as possible through personalised efforts like this to continually drive improvement.

Leading across systems and organisations

144

CENTRALISING THE RENAL CANCER MULTI-DISCIPLINARY TEAM FOR EQUITABLE ACCESS TO SPECIALIST SERVICES

¹E Day, ²B Venugopal, ³G Lamb, ⁴G Oades, ⁴on behalf of the West of Scotland Regional Renal MDT Members. ¹Urology Trainee, West of UK; ²Consultant Oncologist Greater Glasgow and Clyde; ³Consultant Urologist Forth Valley Royal Hospital; ⁴Consultant Urologist Greater Glasgow and Clyde

10.1136/leader-2020-FMLM.144

Problem The multidisciplinary team meeting (MDT) provides a consensus and expert opinion. Traditionally each hospital has its own cancer MDT and refers on specialist centralised services. The following issues with this were raised:

1. Equal access to specialist opinions
2. A single renal surgeon providing the consensus opinion
3. Delays in the patient journey incurred by the referral process

Intervention A weekly regional MDT was established comprising of renal teams from each hospital in the West of Scotland as well as the specialists providing centralised services. Every renal cancer patient in the West of Scotland is discussed by a panel of specialists as well as local teams. A patient can be added directly to a waiting list for a centralised service.

Comparison The regional MDT was assessed in two ways.

A survey of MDT members highlighted the key advantages are: equality of access, a standardised approach across the region and real time liaison to specialists. The key disadvantage was the length of meeting as the number of cases discussed increased for all involved.

An analysis of the patient's journey before and after the intervention demonstrated a significant reduction in time from MDT to partial nephrectomy (a key centralised service) and no change in the time to communication of a decision.

Outcome The regional MDT ensures that each week every patient has the benefit of an expert consensus opinion and streamlines access to specialist services, including clinical trials. In addition, by its nature, the regional MDT has reduced variation in practice. It has increased the time commitment of individuals and we are looking at mechanisms to improve efficiency to offset this.

Learning Points in Leadership: In developing a regular team meeting across several NHS boards, buy in from local clinical representatives was vital to drive negotiation with local management.