Editorial

Shaping sands, shifting services

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The unusually-titled Health Computing 2005 (HC2005) conference turned out to be apposite in the event: those who have been working in the health informatics environment over the last year or so will have many times felt as though they were trying to build sandcastles in a howling gale, while the shape of services (both healthcare and informatics) changed with what is coming to be the expected regularity.

In primary care over the last few years, those changes have included service reconfiguration to encompass the impact of walk-in centres, out-of-hours services, NHS Direct and NHS Direct Online, Shifting the Balance of Power, the New GMS Contract, Agenda for Change, practice-based commissioning, and the National Programme for IT (now known as NHS Connecting for Health).

The opening keynote speaker for the conference was then most appropriately chosen: Professor Nancy Lorenzi is internationally renowned for her expertise and publications on the management of change in the healthcare environment. Her address on transformational change reinforced the point known to many but heeded by few that success is 80% dependent on the social and political environment, and only 20% on the hardware and software – some might even argue that it should be 90% and 10%, respectively! She also pointed out that motivation can make even a poor system work effectively, but a perfect system will fail if the users are disempowered or unmotivated. And the introduction of IT cannot solve organisational problems alone.

She proceeded to give some very practical advice on strategies for effecting successful change – none of which is new, but without which failure is inevitable: clear objectives must be set and communicated, and a strategic plan formulated; people at all levels must feel ownership of the plan; attention must be paid to the organisational culture (‘culture eats strategy for breakfast’) and how it supports (or not) the changes being implemented; develop leaders and champions for the change (not just those in traditional positions of power); be patient and resist false urgency; stay involved, keep communicating; evaluate; seek feedback (and act on it); plan ahead for the next phase of change.1

Dr Peter Homa, Chief Executive, St George’s Healthcare NHS Trust, followed with an inspiring and amusing talk on dealing with change; his most striking points for me were the need to have a shared purpose and broad objectives focused on improving patient care, the risks of automating inefficient and ineffective processes, and the necessity to empower skilled change agents. Further wisdom pointed out that a broad vision, not a detailed blueprint, would produce more flexible and effective change, as would the encouragement of strong lateral relations and networking across boundaries, together with commitment to individuals’ development, with a focus on skill not status. Again, the emphasis was on leadership styles, communication, and the importance of organisational culture and power. He used a number of notable quotations, some unattributed:

‘If at first you don’t succeed, find out if the loser gets anything!’

‘Never mistake motion for action.’ (E. Hemingway)

‘There is nothing in this world constant but inconstancy.’ (J. Swift)

‘Success is 99% failure.’

‘We think in quantum leaps but implement in small steps.’

The keynotes on the following day were a contrasting pair: Dr Kenneth Robertson, Clinical Lead for IM&T, Scottish Executive Health Department, and Richard Granger, Director-General of NHS IT for England. Dr Robertson outlined the Scottish approach to clinical information, and their understanding that information is at the core of care delivery. The Scottish environment is one of increasing community health partnerships and managed clinical networks, which cross organisational and geographical boundaries; this requires the sharing of clinical information about patients’ medical history, laboratory test results, referrals, discharges, drugs, allergies, planned events, and so on. The primary requirement underlying such sharing is the acceptance across the whole of NHS Scotland of the use of the CHI number for patient identification;
there are cultural and change management barriers to such acceptance, but work is under way on tackling these. Scotland also has a National Clinical Datasets Development Programme, being devised by clinicians and informaticians working together to support both data architectures and communications. A patient-centred booking system (which is asynchronous, and finalises appointments four weeks ahead by telephone) has resulted in a 50% reduction in DNAs (did not attend).

In primary care where 85% of practices use GPASS, a further review of GP computing is under way (following that done two years ago), and a business case for change is in development. Preliminary work is happening in some practices on patient access by email for appointments, repeat prescriptions and test results. 2

All this and more is being done with a great deal of clinical input, Ministerial support, and a recognition of the absolute need for ‘ruthless standardisation’. The vision is for a single record for each patient in Scotland (questions still remain about whether it will include all or summary data, whether it will be virtual or actual, and who can access it with what controls), but the overall strategy is one of ‘Pragmatic Incrementalism’, developing to the single system by a process of planned migration. This seems to be a convergent strategy with that being rolled out in England.

What has Scotland learnt from the National Programme for IT? Courage and boldness, the necessity for a massive increase in spending (national and local), and a greater understanding in the supplier community of the needs of the NHS. Dr Robertson ended with the now familiar mantra that this is more about culture than technology, it is necessary to keep clinicians engaged, there are going to be issues with recruitment and retention of sufficient numbers of high-quality informaticians, and none of this can succeed without the ruthless application of standards.

Richard Granger, Director-General of the now-renamed NHS Connecting for Health programme, followed on with a situation report on the work of the National Programme for IT. He acknowledged that there were problems at this stage of the process: there had been a great deal of preliminary activity with as yet not a lot to show. He was sanguine about this changing over time, as deliverables began to roll out into the health environment and start making a difference to the practice of health care. The challenges of scale, timetable, complexity and perception were large, but significant achievements had been made during 2004: 10 000 people had been mobilised within the suppliers and the programme itself – there is still a need for many more; clinical and managerial engagement had begun, and would be increasing rapidly from now on. Much groundwork had been put in place on electronic booking, disaster recovery, the Spine, the Demographics service, security, messaging protocols, the email and directory service had 100 000 users, and the QMAS software had been successfully specified and delivered.

He saw the challenges for 2005 as increasing the level of clinical and managerial engagement, increasing support for the programme, picking up the pace of rollout in all programmes, the external environment (including a legal challenge to procurement), engineering delays, and ‘financing risk maturation’ (that is, penalties on suppliers for non-delivery). The actions to address these challenges were the appointment of a new Senior Responsible Officer – John Bacon, the start of performance management of the NHS, the appointment of clinical leads, extensive refinement of plans with suppliers to ensure deliverability, and some supplier replacement due to non-performance (as envisaged in the contract structures).

Mr Granger emphasised that ‘it will continue to be difficult’. He also announced that from 1 April 2005, the Programme would be called ‘NHS Connecting for Health’.

Alan Burns, then Director for Service Implementation for NHS Connecting for Health, presented the Accolade Awards, which for 2004 had the theme of ‘Quality information to improve patient care’. There were ten shortlisted organisations, and five winners, but all ten were of a very high standard. Every single one stressed the importance of people, teamwork, buy-in from clinicians, change management, co-ordination, linking information across sectors, and feedback – the technology was necessary but not sufficient.

Other speakers in plenary sessions were Ian Watmore, UK Government CIO and Head of e-Government Unit, and a number of the clinical leads for NHS Connecting for Health. Points emphasised over and over again were that this was a patient safety and clinical governance programme, and not about IT: the metaphor of the iceberg was valuable here (IT 10%, above the waterline, with technical support 15% and people, culture, and business process 75% below the waterline). It is not enough just to computerise what could be poor paper-based information systems; business process redesign to exploit the informatics potential would really make the difference in transforming the NHS into a 21st century healthcare system.

REFERENCES