BCS Health Informatics Groups commentary

This is the BCS HIC commentary on the Report of an evaluation commissioned by the NHS Information Policy Unit and NHS Information Authority in Autumn 2001 and published in parallel to the ‘Delivering 21st Century IT Support for the NHS’ document from the Department of Health on 13th June, 2002.

BCS HIC commends the NHS IPU and NHS IA for commissioning this, the second, evaluation by the eminent observer, Professor Denis Protti of the University of Victoria, Canada. The report (referred to as ‘Protti2’ in this commentary) is couched in very pragmatic readable terms, with many analogies and quotations that make it also suitable for the non health informatician. We welcome the report and recommend the take up of many of its points.

The decidedly low key issue of Protti2 demonstrates the little attention to date paid to marketing good things. Protti’s highlighting of fragmented initiatives is therefore not surprising. This BCS HIC document looks at (1) Lessons which do not yet appear to have been learnt; (2) challenges that have to be faced and (3) Issues which are as yet unresolved.

Protti2 lays out (some of) the organisational change catalysts clearly and comments that so many of them are so young, under-developed and under-delivered (as yet). BCS HIC hopes that these are not used as excuses for non-delivery and slippage of targets. However, it is felt that they do contribute to making the NHS informatics environment so volatile and should be made more widely known in order to see if the government and other external agencies could be ‘encouraged’ (?shamed) into less frequent knee-jerk reactions and adherence to the flawed principle that ‘change is always good’.

**Lessons to be learnt**

There are a number of areas where not only have lessons not be learnt since the first Protti evaluation, but also from previous health informatics agendas including Korner, Resource Management, developments outside England, such as the commended Scottish work, Getting Better with Information (1992) and Making IT work (1994) before Information for Health (1998). The NHS should place more importance on gaining corporate knowledge and making itself a learning organisation. The history is very rich and contains useful factors (both positive and negative) that could impact on increased success for the future.

‘Official’ documents frequently belittle work to date. ‘Historically, the NHS has not used or developed IT as a strategic asset in delivering and managing healthcare’ (21st Century). It is a fact that the Burns round, the Bell era and the emerging Pattison portfolio could not have taken off from where they did without the Rogers preparations, and in fact the Korner work referenced in Protti2. Whilst we can be as critical as ‘Monday morning footballers’ of everything – there are lessons to be learned and progress to be recognised from each phase. Would it not be more motivational (both to internal and external audiences) to take that line?

In launching a new commercial product you do not junk the previous but stress the improvements of the new and how much better you will feel from owning it. To be told every
three years that what you have been doing to date is again all wrong is demotivating and not useful; we should be brave enough to learn and admit to learning from the past! As Protti2 states ‘learning is fundamental to enhancing local creativity and national cohesiveness’ – but you have to be brave enough to share knowledge of failures and successes in order to reap the benefits.

**Supplier partnerships**

The challenges of supplier engagement and cooperation still remain as does the difficulty of achieving clinician buy-in to informatics plans. The investment required to generate full informed commitment to managing the cultural and organisational changes related to informatics understanding and use has not yet been explicitly identified, although highlighted by Protti2 again.

To facilitate successful partnerships with suppliers, other agencies or colleagues, it is felt necessary to specify all targets and performance levels in more measurable ways. As Protti recognises, and BCS HI group members concur, many of the previous targets have been woolly and missed without major sanction or effect.

**A learning organisation**

Protti2 states that ‘...it has proven very difficult to align the IPU and the Primary Care branch information-related initiatives – let alone the NHS Direct work – with the IM&T agenda.’ This is a damning statement. If health informatics is being ring-fenced within and between NHS informatics agencies, what chance collaborative working with social welfare, within Europe (which has the potential to provide further external upheaval if not at least watched carefully), and with service delivery organisations outwith the DoH and government? Failure to communicate effectively will heighten the ‘lack of commonality … and barriers to technological and organisational communication due to incompatibilities between systems.’

**Procurement progress indicated**

On the positive side, the cumbersome procurement issues raised by Protti do seem to be addressed in ‘Delivering 21st Century IT Support for the NHS’ and this can only be welcomed.

**Challenges identified**

The BCS HIC feels, as Protti2 does, that more attention should be paid to developing a culture that can learn from the past. The utilisation of effective informatics in the health domain requires the involvement of many players within and outside the NHS. Skills and know how must be shared to ensure that the relationships made, for example between the service and its suppliers can realise maximum benefits for patient care.

Interestingly, Protti2 makes the tangential leap from electronic health records strategy as currently presented to an electronic ‘Events record’ grounded in the ‘Exeter’ system (already GP used). He also touches on an ‘integrated care record’ that can support a single multi-professional assessment, increased subject patient/client direct record input and the convergence of health and social welfare per se. BCS HIC endorses further development along such lines.

Looking out for a particular specialty by creating its own silo-focused dataset and record rather than as a synergistic component of an integrated record to support effective healthcare will not benefit overall patient outcomes. This direction as expressed, does not bode well for a later
successful merger of health and social welfare on the pathway to individual wellness and lifestyle management.

**Infrastructure and standards**

'Infrastructure breeds impatience. It is important to note that the provision of infrastructure is an enabling mechanism. The infrastructure itself will deliver some benefits but the main outcomes will be achieved by the provision of additional applications and services'. The BCS HIC endorses the position that more needs to be done, and welcomes areas in Delivering 21st Century where this challenge is acknowledged.

The problems of standards are in fact that those that have already been developed are not properly understood and used. The BCS HIC encourages further exploration into how the NHS can be encouraged to use what it already has access to rather than just invent more. It must be noted however that much of the standards work is cross-sectoral and multi-national and requires the NHS to ‘work outside its box’ to gain maximum benefits.

**Issues**

The distinction between information to support day to day care delivery and to support retrospective governance requirements is interesting. Could the apparent shift arise from Pavlovian responses to Shipman, Bristol and (in Social Services) Beckford, Clunis et al? Is there an insurance / damage limitation exercise in train? A better balance is encouraged between being seen to be able to demonstrate that we did it right and the safe, effective, efficient operation of healthcare delivery and patient management. There is a perceived danger in the implied shift (expressed in the 21st Century document) further from the Körner principle ‘of data only being available to other levels if it is required at the operational level’. Fragmented datasets to address particular non-operational requirements in an ad hoc way are not recommended.

**Informed Consent**

This is an ongoing issue about ‘who has access to what portions of the electronic health record’. Protti indicates, and BCS HIC agrees, that amongst other factors around this topic, situations where organisations are currently at ‘legal risk’ still need resolving. The informed consent issue will not diminish as the record itself becomes more complex and number of legitimate users of the ‘care record’ increases.

**Collision or controlled convergence**

A key question that arises in Protti2 is the convergence of health and social welfare that he sees as happening now, being necessary and synergistic. The BCS HIC questions why this view is sidelined in the 21st Century Plan even when talking about single (clinical and social) assessment is being discussed openly in the field. ‘The challenge is …. effective patient-centred systems that operate across transient organisational boundaries’ – and that is both intra-NHS and across health and social welfare sooner than some appear to be prepared to address.

**Education in what?**

Protti2 continues to stress the need for education and training, but it should be noted that the service model of informatics delivery (mooted in the 21st Century Plan requires field staff to be different animals than are currently in-post. They will need to major on performance
specification, monitoring and management rather than implementation and the operation of applications systems. Plans should be revisited and refined accordingly.

**Summing Up**

Professor Protti’s report is welcomed by the BCS HIC as highlighting many issues of today, making pragmatic suggestions for the future whilst recognising the impact of the past.

**Postscript**

In his general observations, Professor Protti touches on the previous failed attempts to hypothecate funds for informatics. Could a useful tactic to secure funding in the future be to proactively flood the public with GOOD stories where informatics has undoubtedly brought about better care, rather than focus on damage limitation? Commercial companies market rather than factually describe their products and services. If informatics is not to continue to be sidelined against the needs of direct patient care, its benefits in support of care must be trumpeted!

**July 2002**

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