

A Returned Exile – Reprint of eHealth Insider Article on Problems within the UK’s Approach to Integrated Health Information Systems (Connecting for Health)

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I am not a technocrat. My knowledge and interest in this sector comes from having been president and CEO of one of Canada’s largest hospitals, Sunnybrook Health Sciences Centre in Toronto. At Sunnybrook, in the late 80s to early 90s, we implemented one of North America’s first fully integrated clinical and patient management systems.

The approach we took there depended on clinician buy-in from the outset, aiming to use IT to support clear clinical and business objectives. The system at Sunnybrook was a key component in our broader strategy: to manage our institution more effectively and enable the organisation to be restructured around the needs of the patient.

Making sure timely and appropriate information was available at the point of care was paramount. We had to get away from dependence on written documents. The system took account of shifting centres of care, allowing professionals to have access in a variety of institutional, ambulatory or home settings, and from a management perspective it also allowed us to fully allocate and understand costs of the programmes of care we offered.

These were all important goals shared throughout the organisation. The information system was a means to an end -the end being to improve care for patients and effectively monitor the use our resources in a timely fashion.

But speaking as someone who left the UK and the NHS, it is distressing to now return to a system that is worse, relative to any other developed country, than it was 30 years ago.

'Catch-up'

Since my return to the UK in 2000 I have been simultaneously amazed and alarmed at the scope and approach of the NHS to its lack of effective information systems which culminated in its Connecting for Health project. I now see through numerous articles my worst fears being realised, as delays increase, the blame starts to be passed around, and companies and individuals cover themselves in silicon and run for cover.

The government claims Connecting for Health to be somehow a cutting-edge initiative. Content-wise, it is not. It is only unique in the scale of the investment being implemented through such a centralised approach. It appears to be a futile attempt to play catch-up by slamming in centrally designed technology. The initial lack of local commitment and front line involvement is now showing as its Achilles heel.

In Canada the only attempt to do anything similar was by two provinces -- Alberta and Saskatchewan --that attempted to implement province-wide health care systems. They similarly failed in meeting their stated goals for the same reasons; the systems were designed and implemented remote from the users (clinicians), and the individual provider institutions.

Crucially, the clinicians also saw no value in the systems and did not see how their day-to-day job of caring for patients was being made easier. So they therefore felt no commitment to the solution.

Blaming the dinosaur behaviour of certain professional groups and trade associations may be justified. But it is not the issue. Those professionals are “outside the tent” in the current approach and their hearts and minds will never be captured with the current top down approach.

The Department of Health’s central bureaucracy claim the purchasing process was a great success, saving £500m on the original estimated cost. This saving not only came from cutting out the cost of managing the change at the local level but also by not involving front line managers and clinicians in the decision process - a short term expediency which is now showing the long term consequence.

The WIFM factor

Clinicians want to see clinical content and value in the systems: the WIFM factor (What's In It for me). The Connecting for Health system appears to many to do nothing to improve their ability to care for patients in a more informed and effective way.

In Toronto in the 90s we were budgeting to spend 2-3% on health information systems. The money was invested locally and the priorities set locally. With an eye to creating community health information networks linking primary, secondary and tertiary care providers.

However, in today's world of standard protocols shared by all system developers, images (DICOM) and text can be accessed across the country. Hence the need for central control is meaningless, except to satisfy risk adverse politicians and bolster the un-devolved command and control culture that England seems to have convinced itself passes for effective oversight of public funds.

Solutions

My suggestions of alternatives are many, but I would return to the initial premise which drove our implementation at Sunnybrook. This is that the information strategy has to be part of a broader vision and strategy aligned to the needs of the local institutions and the populations they serve.

This requires true devolution, ensuring the strategy is owned by local organisations and clinicians. I would suggest centering the system around natural communities with a reasonably sized health economy, containing for example around 1m people.

Individual NHS trusts, foundation trusts and PCTs should have the ability to create their own local Information strategies and organisation to co-ordinate it, and also own responsibility for their part in the overall plan.

The design of the system should focus on the following overall goals:

- To provide integrated care across the health continuum;

- Ensure timely information is available at the point of care to the appropriate professional staff;

- Enabling new ways of working that optimise the use of professional time and enhance the patient experience;

- Provide good and timely information to inform the effective management of the "local health system".

Priority should be given to clinical content to support clinicians and enable knowledge at the point of care. Meanwhile, the central government role should be to provide common standards and protocols, strategic sourcing of products and technology that can be called off by the individual organisation, and some core content relevant to national policies and guidelines. Funds for this purpose should be devolved on a weighted population basis.

The local institutions should make their own investment decisions based on their business case which is based on the systems ability to enable health system improvements and cost savings.

Throughout the NHS system we now have a dog's breakfast of approaches that sees increasing command and control being exercised from the centre while responsibility for the outcome is being pushed down. I believe this paradox is blighting creativity within the system and devaluing the UK's healthcare reputation throughout the world.

For this reason I sometimes hope this system fails spectacularly, if only to expose the misguided nature of this approach and expose the 'control freak'-type behaviour that is equally damaging to other aspects of our neglected health care system.