

BRITISH JOURNAL OF
HEALTH CARE
MANAGEMENT

Volume 11 Number 11
November 2005



**"Don't cry - there'll
be another evidence-
free reorganisation
proposal along
shortly"**

IN THIS ISSUE

**Firmer foundations:
Michael Dixon and Bob
Sang make a case for
foundation PCTs**

**Dr Charles Webster on
Patricia Hewitt**

**Lessons on joining up
community care**

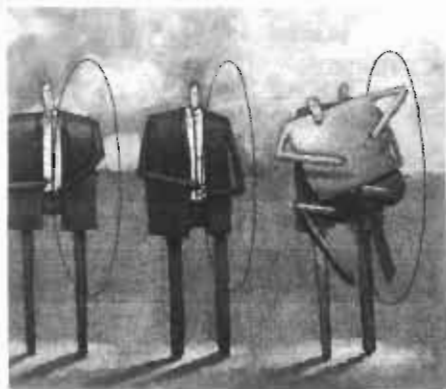
**Provocations: why big IT
procurement can be bad
IT procurement**

Bird flu (inevitably)

New classified adverts - see page 351

plus our glorious regulars

Andy Bell - Alan Maynard - Andrew Roth - Nicholas Timmins



Why Connecting For Health needs joined-up thinking

The 'Provocations' series returns with Connecting For Health in the sights of an IT supplier. CfH's aims for centralised IT efficiency are commendable, but keeping out niche expertise may prove a false economy in the end.

by Tom Rothwell

Connecting for Health (CfH) is an enormously challenging and complex framework for improvement. While its overall objective to cut costs and improve efficiency and patient care are commendable, nobody really knows how long it will take to achieve them. The pressing issue is this: what will happen in the meantime?

With most NHS trusts confused on the detail of what is to be delivered by the programme and by when, a deep-seated investment inertia has set in. The narrow approach to IT contracting and the associated procurement blight will inevitably have negative repercussions on levels of innovation and development in the sector, with new functionality having effectively flat-lined for the foreseeable future.

Connecting For Health's Chief Operating officer Gordon Hextall recently indicated that the original implementation schedules are now looking doubtful. There have been further indications that we may be waiting another two years before we see any of the core solutions come into practice.

Another as-yet-unanswered question concerns the recently announced reigning back of public spending on the NHS in 2007 – at a critical juncture for the programme. The more the programme suffers from delays, the longer the blight goes on and the greater the negative impact on overall creativity.

Abnormal market

We simply do not have a normal market for IT in the NHS England. The winners

in the CfH procurement now effectively control the market for IT, either by contract clause or the inertia brought on by uncertainty amongst NHS trusts.

Effectively, all eyes are on the Local Service Providers (LSPs). This is not a problem if what is delivered is what is expected and arrives on time; quite naturally those in the NHS are looking for CfH to provide a long awaited leap forward in IT to the benefit of patients and health professionals.

But it would be helpful if the LSPs were more open about what is coming and when? Why is this information not available? Could it be that CfH is only going to deliver a baseline of functionality, a common platform with little in the way of innovation and does not want to deal with the inevitable outcry if this is in fact true?

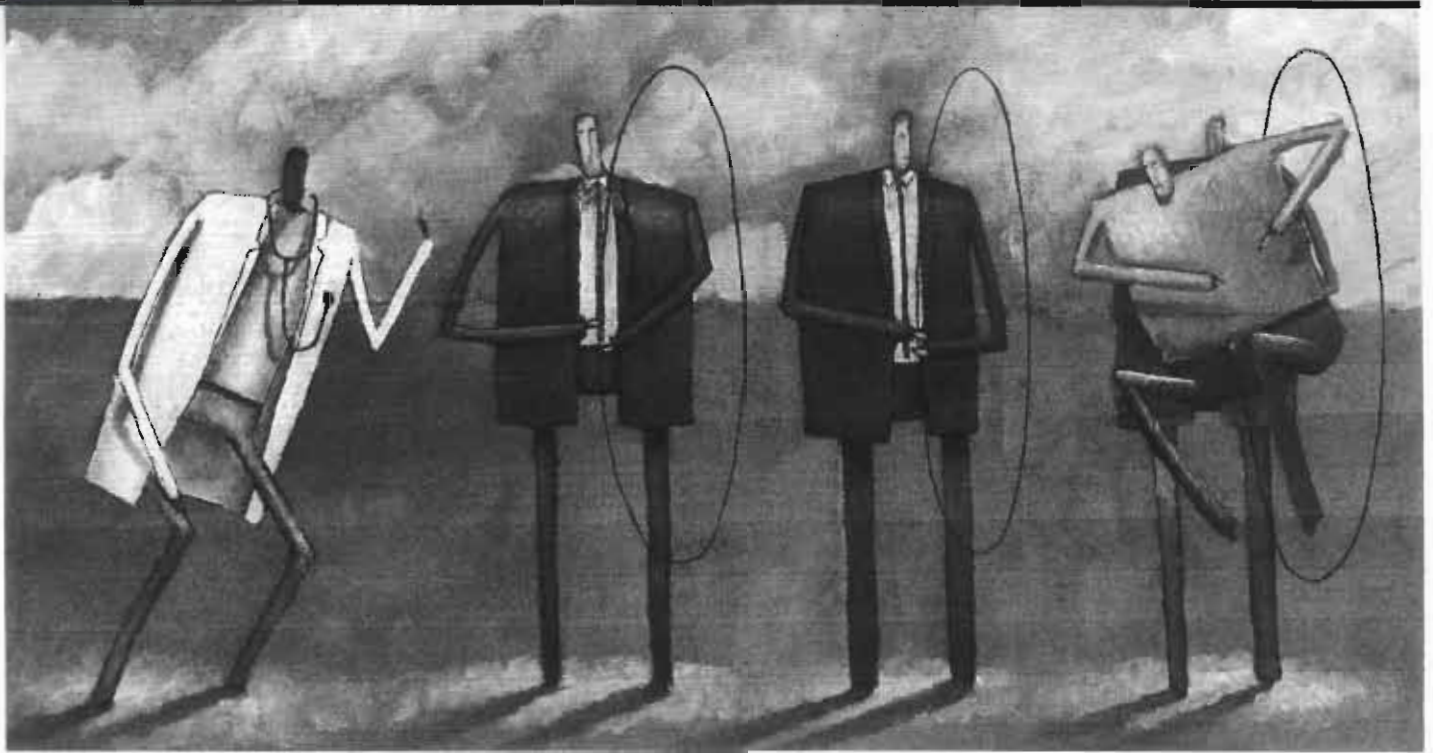
Waiting for delivery

While this is played out, trusts await delivery. Standing still in IT terms actually represents a major shift backwards, a problem the NHS has already suffered from for a number of years. CfH is a 10-year programme – it would be a missed opportunity of immense proportions if the period were characterised as having established a common approach, but lacking in real innovation and progress.

While there is a strong desire to move forward and make improvements (with abundant justification for doing so), in reality, only a small number of maverick trusts have been willing to strike out on their own. With the market trapped in imposed stasis, the smaller IT players are hit hardest.

Yet it is precisely these specialist IT

Tom Rothwell is Managing Director of Medisec Software



companies who have already developed best practice examples within their niche areas. While all efforts to save money through centralising core IT functions should be applauded, why is the choice of solution being so heavily restricted to redeveloped and unproven products and suppliers?

Despite the claimed 'payment on results' deals, large sums appear to have been spent so far, with few significant results in primary and secondary care. It has always seemed to us wasteful not to use the best of what has already been implemented and proven, and at the same time, to introduce unnecessary risk into the equation.

Instead of waiting for the major players to catch up and re-invent the wheel, the niche operators could help take the Local Service Providers up to the baseline quicker and fuel more change faster, while the reference solutions are brought to full steam.

After all, quicker solutions would mean an earlier release of funds, producing the best solution for all parties involved.

Niche know-how

Small specialist companies offer a number of clear benefits, not least of which is their proven technical expertise in integration issues.

Efforts to impose a one-size-fits-all solution are seriously hampered by the fact that each of the UK's hospitals oper-

ates a different patient administration system (PAS), ranging from highly sophisticated integrated solutions to home-spun systems maintained on a shoestring.

As PAS have evolved over the years, two types of system have emerged, each offering distinct benefits and drawbacks. Integrated systems allow additional patient information (for example, from pathology or radiology departments) to be added directly to the core system. This restricts choice to the same supplier of the system, and may not necessarily provide the optimum solution for all departments' functional needs - but it does save staff from having to re-key the same information several times at different patient contact points.

With modular systems, individual departments either develop their own bespoke software packages for collating information or cherry-pick 'tailor-made' packages, each distinct from the main system. As such, systems are usually very rich in functions which are specifically needed by that department. This means that stand-alone modules usually produce correspondingly higher-quality patient data. However, they can often pose major integration challenges with the core system and corresponding problems in maintaining data integrity.

The problems of integration are amplified when one looks at how the NHS communicates internally; for exam-

ple, between primary and secondary care (and then further complicated when external links are involved, for example between secondary care and social services). This has not been tackled historically at a national level, yet it is within the scope of CfH.

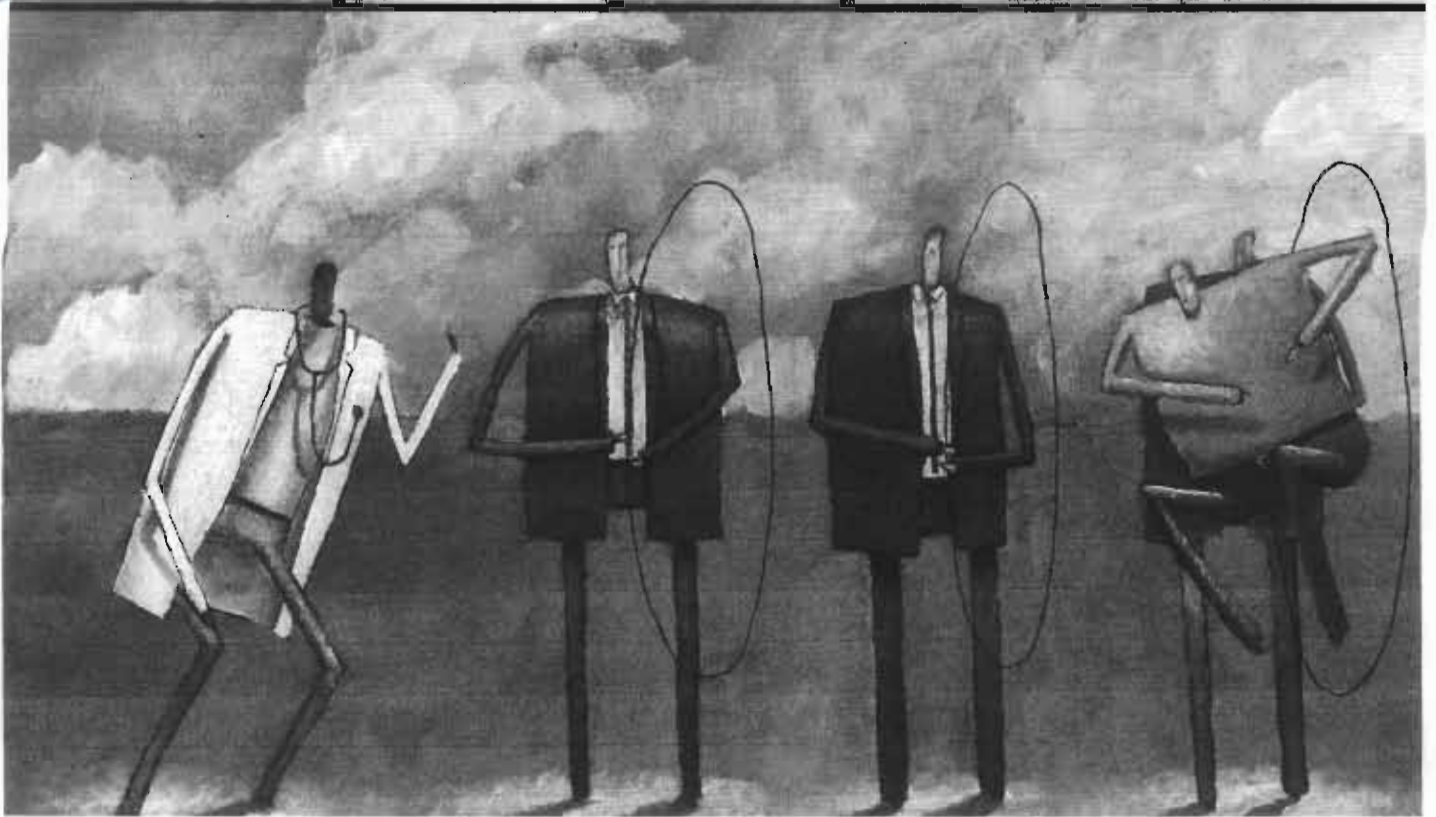
Smaller suppliers have solved many of these integration issues and working solutions are evident; knowledge, experiences and valuable technical information is available for the programme to utilise.

Grass-roots engagement

There has already been significant criticism levelled at CfH about the lack of consultation with the user community. Richard Granger himself has admitted that one of the biggest challenges facing the programme will be engaging with clinical and management staff.

A recent paper by the British Computer Society's health informatics forum concluded that clinicians involved in the CfH programme rapidly become divorced from the grass-roots requirements and issues unless wider consultation is ongoing. They claimed that "... clinicians see that informatics will improve healthcare but have yet to be convinced that the products under development will reflect their requirements and realise operational benefits".

Who, of course, can blame clinicians if their priorities lie outside of the IT arena?



How can we possibly expect them to embrace yet another task on their action list or to change habits of a lifetime unless we have consulted with them in the first place? Can we really guarantee that every consultant will feel pre-disposed to a universal solution imposed from above, which could remove systems they value?

Specialist companies understand such issues on a very pragmatic level and already know how to overcome the significant problems of integration, both on a purely technical level and also on a human level. They might not know all the answers, but they have at least already been through the process.

It must be almost impossible for change managers to convince clinicians of the need to change working practice in lieu of new IT systems being implemented or to instil confidence in the process to be adopted, when the detail of what is to be delivered and when is not known.

Using the best of existing systems brings with it clinical buy-in and injects pragmatism and some thrift in the process of improving patient care.

Progressive solution

As the situation stands, health care managers may well have identified pressing problems now, but are effectively shackled from any attempts to solve them for some

time to come.

It is patently obvious that in cases where a trust is offered additional revenue for installing new CfH-compliant IT, only the brave few will doggedly stick to their guns, retaining (and continuing to pay for) bespoke systems, rather than replacing them with a funded one-size-fits-all version.

Yet GPs and consultants alike will surely not want to give up a tried and tested computer system for something they have doubts about?

Necessary next steps

Nobody wants Connecting for Health to fail. As the biggest civil IT project in the world, it is set to redefine the face of medical informatics and has all the right reasons at its core.

So how can the programme engage with specialist suppliers and make use of proven solutions in a way which is lined up with CfH objectives and promotes a healthy market for IT?

Smaller companies drive innovation, but they need room to operate and rules of engagement that are open and well-understood. Niche players have a proven solution, but limited resources to perform large volume implementation. Might the most progressive solution for improving patient care be to introduce some joined-

up thinking, using both CfH resources and proven niche technology?

There has been some hope on the horizon. Whitehall appears to be making something of a policy shift after the delays to the programme, announcing intended plans to 'deploy some stand-alone technologies'. This move reflects a healthy injection of pragmatism certainly, but communicating the meaning of the changes in practical terms is now essential.

Director General of NHS IT Richard Granger is telling trusts that they should not be cutting their IT spending because of Connecting for Health, but many are still confused over what falls outside of the programme - and about which items they will and won't have to fund.

Effective communication has not been a trademark of the programme to date. The information about progress in CfH has to date leaked out or is known only to those at the centre. Targets seem to be moveable items, depending on what has actually happened on the ground.

Openness is essential if there is to be a positive engagement with those currently outside the programme. Making known what is going to be delivered and when will enable managers to manage and planners to plan. Only then can the gaps become opportunities for action that can be pursued with certainty.