1) Annex 1: Interview with Frank Burns

January 2002

In September 1998 a document was released on the NHS which would outline a vision of how Information Management and Technology (IM&T), if properly implemented and resourced, would change for the better the way healthcare is delivered. The document was "Information for Health" and its author was Mr. Frank Burns CBE, the Chief Executive of Wirral Hospitals NHS Trust.

Four years on, and three years before the major milestones, identified in that document as a measurement of progress, were expected to be delivered. I interviewed the author to assess his views on progress to date.

Do you think that setting targets in Information for Health was a "good thing to do?"

Yes. If we had simply written a document, a vision of where we wanted to go, it would just have been that – a document. I still believe we were right to put in place a mechanism for measuring our progress towards this vision.

We all acknowledge that the NHS has been very slow to embrace IM&T, and yet there are examples of where this is not the case, and it is usually where the Chief Executive has been the driving force. What evidence did you need to see that enabled you to actively support these IT systems in your hospital?

Look at any successful EPR sites. They all have buy-in from the top, but more importantly, there is always a good bunch of senior

clinical staff and quality IT staff. If you can get that mixture right in a particular location and they can deliver some sustainable local advantage from investment in IT, then the Chief Executive will be interested. In my case, I didn't decide to invest in the EPR system we ultimately developed. That decision had been taken before I took up the post. And that decision had been made because of the enthusiasm of the clinical and IT staff. My only decision was that this was not going to be another NHS IT failure that was going to drag me down!

I came to this Trust when that decision to invest considerable amounts of money in the IT system had been made when similar large IT projects were going up in smoke all around the country. I learned from others mistakes and so I decided it needed my personal attention and interest if it was to succeed.

It was more about me doing my job as a Chief Executive properly i.e. to protect public investment on a considerable scale. It was more that that initiated my interest and involvement at the beginning rather than any knowledge or skills I brought to the party at the time.

So what was the driver behind Wirral's decision to invest what you described as a considerable amount of resource into IT, at a time when similar projects were going pear-shaped?

Let's be very clear about this. You don't buy clinical information systems to save money. They are an investment in the same way a CT scanner is. They are part of the clinical infrastructure of the organisation. You can't possibly impose cost reduction burdens on IT that you wouldn't impose on any other section of the business. These systems will deliver whatever savings they are capable of delivering but they are not an efficiency measure, they are part of the clinical infrastructure of the organisation – a clinical tool. Its like

an operating theatre. You wouldn't NOT buy an operating theatre because it doesn't save you money.

Would you advocate a National EPR Solution?

I do get nervous that there are people far away from the reality of implementing the strategy and very far away from the culture in the NHS who have this notion that they can simply contract at a national level, for a national solution. I am sure there are still people who think that.

I personally think it would be a disaster if ever such an approach were attempted.

Integrating healthcare records over the lifetime of an individual, through a whole series of ill-health events, involving a combination of agencies and dozens of different professionals is complex and requires excellent technical solutions and vast degrees of cultural and organisational change.

To suggest you can build that and roll it out in the same way that you would roll out a supermarket check out system displays, to me, incredible naivety that would make you seriously concerned about their understanding of the complexity of healthcare.

My great concern is that any national solution would have to be watered down to make it nationally acceptable, and, for instance, they would drop out the prescribing component of any national EPR solution because the prescribing component is so culturally difficult. You have to work at this with the local community, so my worry would be the higher the level of centralization the lower the spec. So it would be a complete shell, a national e-mail system instead of what was intended.

In the Audit Commissions recent report " A spoonful of Sugar" they reinforce the importance of the inclusion of Electronic Prescribing in

the EPR mandatory targets, but one of their recommendations is a national prescribing solution. Does that worry you?

Let us firstly separate the specification of a national solution from the provision of a national solution.

I have no problems with a national specification and indeed Electronic Prescribing lends itself nicely to such an approach. But then the process of selecting the modules and the order of their implementation should be locally determined. Project Management and procurement should be a local decision but I have no problems with a national core specification.

Electronic Prescribing was included in the mandated targets because of its ability to significantly reduce potential harm.
What people seem to forget is that there are principally two ways to do harm during the delivery of healthcare. Through surgery and through medicines. The giving of medicines in the NHS is not a peripheral process, almost every patient receives medication in one form or another and so the potential to do harm is great. That potential is greatly increased today with the complexity of drug regimes currently used and so now the giving of medicines should be considered as dangerous as surgery.

But it is not just in the reduction of risk, that electronic prescribing brings benefit, but also in helping identify what works and what doesn't. Supporting clinical processes is one aim of IfH. The secondary use of such information will then enable us to decide what works and what doesn't and there was never a more important time to assess the efficacy of effort.

So do you think this would enable us to reduce the bureaucracy of procurement?

Yes, if we agree a national core spec and accreditation of systems. On two levels. You need innovation and creation and you will stifle that if you only impose national solutions. I would say that if you are procuring against a nationally defined milestone or target, you should procure against accredited systems. But if you are procuring ahead of them then you should be free to innovate.

One of the mistakes we made with the strategy was the notion of "levels" of EPR, in that it implies levels of difficulty. If a Trust is starting from scratch, then level 3 implies a considerable degree of difficulty. I understand where the model came from and it was useful in identifying the notion of a logical sequence of events, but it implies degrees of difficulty. A "level 3" EPR is the very least we should expect our NHS Trusts to have. It is fundamental basic functionality. In hindsight we should have called it Basic EPR. So "level 3" delivers Basic EPR, followed by Intermediate and finally Advanced.

The term EPR also implies the sole objective is to produce an electronic version of the paper record, whereas the real intention is to support clinicians with IT. That is where the real benefits lie. What may have been a better term is Electronic Patient Care Management systems or Patient Care Information Systems.

What other obstacles are there to implementing IfH?
A major obstacle has been the diversion of additional funds, which had been intended for the implementation of IFH. The fact that this has been allowed to happen poses questions as to the desire of Chief Executives to deliver IfH and casts equal doubt over the part of the Department of Health and Ministers.

We should also not allow ourselves to be diverted from the aims of IfH with uncoordinated Department of Health additions to the priorities. These are often piecemeal and stand alone solutions

including NHS Direct, booked admissions, Emergency EHR for example.

Taking the last example, the Emergency EHR has been promoted in importance to the locally derived EHR's (fed by the EPRs). This inversion of importance is seriously flawed in that the Emergency EHR (in the absence of the local EHR and EPRs) will be of actual benefit to relatively few patients. We have clearly defined what we have to do, let us give the suppliers and the NHS community a stable target and not constantly chop and change it.

Part of your solution to deliver IFH was the disbanding of the Information Management Group and the establishment of a new structure –the Information Policy Unit (IPU) and the Information Authority. Has this worked as you envisaged?
In some ways there is an apparent lack of leadership. This may be a perception but that perception may be due to the inability of the IA and the IPU to agree their respective roles.

The original strategy quite clearly placed upon the IA the responsibility for co-ordinating and leading national implementation. The IPU was intended to be a small high powered clique operating within the policy side of the DH to ensure IfH implications of new policy were properly considered and fed through to the IA as necessary. There is no visible high profile champion for this strategy at national level and the NHS needs one.

As you stated earlier, the NHS is in a constant state of re-organisation. We are now facing another with the removal of the Regional Offices (who were central to your IfH implementation process) and the Health Authorities to be replaced with the Strategic Health Authorities. Who now owns the IfH implementation?

I refer back to IfH. It called for the stripping out of unnecessary processes at Regional and National levels. If Strategic Health Authorities are to be trusted with a total NHS spend of £billions, then surely they can be trusted to manage all the IfH investments without reference to Regions, Department of Health or the Treasury. But someone within that new organisation should be charged with ensuring the momentum for IfH does not falter.
Whilst it is reasonable that IFH implementation is performance managed and coordinated at SHA level (collaborative procurements etc.) it would be a huge mistake to try to force local clinical communities into single SHA wide projects. SHA's are strategic bureaucracies, they are not natural clinical communities and are too remote to deliver locally owned solutions."

We still have (almost) four years in which to deliver the major milestones in your strategy. What needs to be done in that time to ensure these targets are met?

There needs to be a reinforcement of the political will to make this happen. The target dates must be reinforced. We need to see an urgent reduction in bureaucracy as outlined before.

The funding issues must be resolved and the promises of extra resources must materialise, fulfilling the sums notified in advance. As author of IfH, I support the ring fencing of monies for the implementation of IfH. As a Chief Executive I am less enthusiastic for it. However, as a Chief Executive I would conclude that if the deliverables are at the core of the modernising of services, and they are profoundly important in improving clinical outcome, and if they are fundamental to the implementation of NSF’s, then the implementation of Information for Health must be a very high priority to Chief Executives. Therefore, some sort of ring fencing or earmarking is useful.

Finally, given your time again, would you do anything differently?

I still believe the strategy has fulfilled its purpose – in defining a vision with clearly defined measurable markers of progress. It is rewarding to see a common IT goal for all the NHS and even if it takes ten years instead of seven it is like putting in the plumbing in: once it is in there it will serve its purpose.

There has always been a degree of re-conceptualising especially at the academic end of interest. But we shouldn't lose sight of the difficulties that have to be overcome for this to be a success. It is actually very difficult to do, and anyone who thinks otherwise has yet to do it. I hope we can stop re-conceptualising and all get down to putting these basic building blocks in place. We need basic clinical systems in place at the GP end of the service and in our hospitals and these local implementations of IfH will support local agendas. Let us not focus on standalone projects such as the Emergency EHR, but rather put more effort into ensuring the basic building blocks are in place such as the local community EHR. These will then feed these national projects.

The document never attempted to define how IfH should be delivered (in technical terms) and I believe it has stood the test of time and is just as relevant to the NHS in 2002 as it was in 1998.

I still believe that its fundamental principles are a "no-brainer" and there is still time for it to be delivered in a way which will fundamentally improve the delivery of clinical care, which was after all its primary objective.