MANAGING THE MAELSTROM: TRUST AND LEADERSHIP
DURING IT-LED CHANGE IN THE UK NATIONAL HEALTH
SERVICE – ‘A RISKY BUSINESS’

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ABSTRACT

This paper discusses the UK government ‘Connecting for Health’ (CfH) agenda, an ambitious and far reaching 10 year IT investment programme. CfH is analysed in the context of trust and leadership during IT-led organisational change drawing on case study research of an Acute Care Trust within one (of 5) regional UK National Health Service (NHS) clusters. We frame our discussions to build on understanding of the generic issues well-known to scholars of Information System (IS) ‘failures’ and offer insights for progress from the current crisis point. At present those involved are attempting to unite conflicting cultures and expectations and are ‘managing a maelstrom’ defined as a situation marked by confusion, turbulence, strong feelings and even violence and destruction and this indeed sums up the CfH experience to date.
INTRODUCTION

This paper is the start of the story about how leadership and trust have such an impact on all that we do and all that we are in the UK National Health Service (NHS). It discusses the UK government ‘Connecting for Health’ (CfH) programme described as the largest single Information Technology (IT) investment in the UK to date (NAO 2006). This ambitious and far reaching 10 year programme is analysed in the context of trust and leadership during IT-led organisational change drawing on case study research of an Acute Care Trust (ACT) within one (of 5) regional UK NHS clusters. Imagine that you have been working in an organisation for twenty years, an organisation such as the UK NHS, a large and unwieldy organisation made up of micro cultures and climates, delivered through personal behaviours and abilities, when a decision is made to fundamentally change the strategic direction of the organisation all at once. Here then we have the CfH agenda – in a ‘nutshell’ a ‘risky business’ (Quigley 2006).

In one typical week in the life of the NHS 6m people will visit their GP\(^1\); 360,000 will have an x-ray; 250,000 will attend their first NHS hospital outpatients appointment and pharmacists will dispense 13.7m items on NHS prescriptions (NAO 2006:9). The vast amount of data transactions these activities represent will be delivered on paper or through haphazard and multifarious computerised systems procured, developed and installed locally with little integration or common interface. It takes little imagination to wonder on the impact that this distorted and unsystematic communication between health care professionals has on care of patients. In this context the CfH programme was conceived.

CfH is a ten-year programme to be completed in 2010, aiming to have a major impact on the way the NHS in England uses information through various IT strategies and Information System (IS) developments. These involve the computerisation of patient records so that they are available electronically to be accessed by GP’s and hospitals anywhere, at anytime. This large and complex system is designed to hold records of 30 million patients (Wachman 2006). CfH also includes a computerised vaccination record system, digitalisation of x-rays through a picture archiving and communications system and electronic transfer of

\(^{1}\) General Practitioners – community based doctors
prescriptions. A later addition is the ‘Choose and Book’ system whereby GP’s and patients can electronically select a hospital and book an appointment on-line.

This paper investigates the development of the CfH programme in one Acute Care Trust in the UK NHS. Our work-in-progress draws on analysis from interviews, discussion forums and questionnaires from a wide range of staff. We situate their experiences and understanding of CfH within their workplace context and as one policy implementation amongst many that affect their everyday working lives.

Whilst substantial progress has been made with the CfH programme significant challenges remain. There is a mismatch of cultures with lack of trust that the promised improvements to patient care and choice will materialize. There are technical issues well known to scholars of IS ‘failures’ that are presenting themselves on a daily basis. These include issues of system robustness, meeting user requirements and the integrity and security of data so crucial in a health service setting. We suggest that the means to progress lies in strategic leadership to restore trust to a beleaguered yet dedicated workforce.

CONNECTING FOR HEALTH IN CONTEXT

The CfH programme needs to be discussed in the context of the NHS as a massive public service organization that has been subject to multiple major reforms over recent years. From the creation of an ‘internal market’ in the late 1980’s this has been strengthened through the introduction of detailed service standards and so-called practice-based commissioning. Through the ‘Agenda for Change’ staff contracts have been reformed and there is strict financial budgeting. There has been extensive outsourcing of medical services and through the Private Finance Initiative closer ties with the private sector. Many hospital building programmes and non-medical services like catering and cleaning are provided by long-term contracts with the private sector (Pollock 2004). This has to be seen in the context of a deeply ingrained collectively understood NHS culture emanating from the conception of the NHS in 1948 as being a public service financed through National Insurance and taxation and being free at the point of delivery ‘from the cradle to the grave’ regardless of the wealth and income of recipients. Hence private sector involvement represents a major cultural shift in the mind-set of the UK population.
Further reform has been driven by intentions to place choice, access and information in the hands of patients through the policy of ‘Commissioning a Patient led NHS’. Sitting alongside this 10 year plan, the UK government through the National Programme for IT introduced one of the largest IT projects in the world – Connecting for Health.

At a national level in the NHS, CfH is facing many problems familiar to scholars of ‘IS failures’. Typically in the IS literature lists of factors are presented against which success and failure can be measured – often involving project aspects like not meeting time and budget deadlines; system aspects for example systems cannot be used in the way intended and user aspects – customers are not satisfied and end-users resist it - with the failure to meet expectations a key theme (Wilson and Howcroft 2002). As Markus (1983) spelt out in her influential article, people resist IS implementation for a variety of reasons and understanding these factors are crucial in guiding strategic leadership during IT-led organizational change. She summarizes these reasons being related to individuals own internal factors, because of poor system design and because of the interaction of specific system design features with aspects of the organizational context of system use (1983:430). The CfH programme is presenting distressing symptoms from all of these 3 areas and although yet to be added to the list of failed IT projects, many leading Computer Scientists in the UK feel that it soon will be (FoF 2006). We place the generic issues raised in understanding IS ‘failures’ in the NHS and CfH context in table 1 below:

<table>
<thead>
<tr>
<th>Generic issues associated with IS ‘failures’</th>
<th>NHS and CfH context</th>
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<tbody>
<tr>
<td>Systems being delivered late</td>
<td>Currently the electronic patient record system is 2 years late.</td>
</tr>
<tr>
<td>‘Creeping’ scope</td>
<td>e.g. ‘Choose and book’ is an additionality regarded as meeting political rather than patient need (FoF 2006)</td>
</tr>
<tr>
<td>Software not reliable and robust so</td>
<td>e.g. the vaccination records of 24,000</td>
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patchy success. children have been ‘lost’. The serious health implications of not being able to tell who has had what vaccination or not is clearly not understood by ‘technical’ people

Software not delivering the promised functionality

This has resulted in slow take up, lack of confidence in the new systems and includes a large group of GP’s who have boycotted CfH (YaY 2006)

Lack of integration and effective interface with legacy systems

IT system implementation in the past has been haphazard and CfH systems are finding problems with integration.

Escalating costs

From a £6bn estimate to currently a £12bn cost and rising

Lack of consultation with ‘users’ or ‘stakeholders’

In the NHS case particularly lack of consultation with clinicians. Rhetoric of empowerment and involvement is unfulfilled in reality

Data integrity and confidentiality issues

Patient records currently can often be accessed by non-clinical staff in open settings

Poor knowledge of the system and lack of suitable training

NHS clinicians are generally not computer literate and have a distrust of IT systems following previous NHS IT project failures. Clinicians in our study report lack of knowledge of CfH and skill implications.

Table 1: IS generic ‘failures’ in an NHS and CfH context
CASE STUDY – ‘CAMBOROUGH’ ACUTE CARE TRUST

To illustrate the story so far we provide a case study from the Acute Care Trust (ACT) of ‘Camborough’². Camborough ACT is part of a regional cluster with a population of 12.3 million and 276,000 NHS staff. Interviews were conducted during 2004-5 with frontline staff, clinical managers, technical staff, IT managers and ACT board members. Extensive case study material was also derived from attending ‘road shows’ set up as a mobile ‘champion team’ in 2005 designed to advertise the CfH programme and answer NHS staff questions and concerns. An extensive questionnaire was also designed and sent out to clinical staff from the Camborough Primary Care Trust, Mental Health Learning Disabilities staff, ACT and Ambulance workers with a return of 72 respondents by early 2006. The questionnaire asked about the level of training received in IT, whether staff had been consulted and knew about the CfH programme and views on how staff felt the various elements of the programme would benefit or otherwise patient care.

Primary research analysis is at its early stage but up to now many groups of clinicians can see the potential benefit of ‘joined up thinking’ within the service including more easily accessible patient records that could therefore reduce delays and improve the quality of care. However our research also reveals dissonance between the ethos and rhetoric of CfH from the centre and the experiences and expectations on the ground. Confidentiality and security of data was a theme often raised with a lack of trust in the systems and their control. Cultural barriers remain and trust is further eroded with widely publicized difficulties and possible financial irregularities faced by one of the major software providers - iSoft and escalating costs during a time when ‘front line’ service providers are facing job and service cuts.

What has been gapingly clear throughout this IT strategy has been the absence of the clinical view in relation to actual success criteria, and the process of consultation. We found some evidence of consultation through the employment of clinical change agents in Camborough ACT. However our research also shows that clinicians on the front-line are not committed to IT because they do not see or feel the benefit and lack understanding how the amounts of money continue to be

² Name has been changed for reasons of confidentiality
spent when they are required to address cost improvement, decrease staffing levels, lose ‘non essentials’ and make ends not just meet but cut those ends to meet local cost improvements targets.

The second gulf is that of perceived differences in culture. IT is a second career for clinicians and our forum discussions often showed that IT staff are not tolerant of the inability of clinicians to grasp the fundamentals of IT applications. Clinicians at Camborough ACT define themselves as basing their skills in emotional creativity and suggested that IT is contrastingly analytical, introvert and dealing with concrete practice. Although not necessarily an accurate assessment of either career path nevertheless from interviews both technical staff and clinicians feel they are part of two distinct and diverse cultures and there is resistance to coming together and sharing and learning. Consultants and clinicians speak of their frustrations with IT and their real concerns about where the money is going and technical staff of their frustrations that clinicians cannot appreciate the positive change that could come about if CfH were championed. However all involved are facing cuts in staffing levels in order to meet financial savings requirements and wait in dread of the next budgetary discussions due to be held in 2008. In these discussions all NHS Trusts will be assessed on the national health care standards and will have to formulate financial balancing programmes. Again discordance on the ground lies in the perception that these standards seem rarely about quality care and do not feature information sharing and technology use. Yet within this arena substantial money seems available for Information Technology but not other essential equipment.

CONCLUSIONS AND LESSONS TO BE LEARNED

In this section we consider some of the specific problems faced by CfH nationally and within Camborough ACT. We then consider aspects of trust and leadership to highlight important issues that need to be considered generally during IT-led change.

The introduction of the CfH programme has to be seen in the context of ‘change overload’ faced by the NHS. Within Camborough ACT a shortfall of £4m has to be found and clinical redundancies are being discussed despite a perceived acute shortage of clinical staff on the ‘front-line’. The £12bn and rising CfH expenditure
thus contributes to an erosion of trust and lack of shared vision by Camborough ACT clinicians. There are major national and local problems with the CfH programme and it could be described as being at crisis point involving currently an ‘upgrade from hell’ (Wachman 2006). Press coverage of CfH concurs with our findings in Camborough ACT. The consultants and clinicians have not been adequately consulted (Wachman 2006). Two-thirds of NHS Trusts due to have installed the electronic patient administration system to ‘choose and book’ by the end of October will not meet the deadline (Doward 2006). The troubles at financially stretched iSoft – one of the subcontracted software suppliers - illustrate what happens when one firm’s fortunes are so closely tied with a single client - iSoft has been referred to the Financial Services Authority for possible accounting irregularities (Wachman 2006). Two partners on the project that iSoft is involved with suggest that the software has ‘no believable plan for releases’ (Bowers 2006). What is lacking is careful project management and projects are being rushed with unrealistic deadlines. The targets set for suppliers are too tough to meet (Wachman 2006). The technical concept of a national database has been criticized for over-centralization with politicians suggesting that the NHS is in danger of ‘sleepwalking to disaster’ and wasting billions of pounds unless the project is scaled back (Doward 2006).

Whereas Simpson (2002:24) suggests that organisational learning has occurred when there is a balance between culture, technology, communication and organisational structure, the imbalance of these elements in Camborough ACT heralds many problems for the successful implementation of the CfH programme. We have set our case research in the context of intra-organisational trust, leadership and risk and suggest that the technical, social and organisational aspects of the CfH programme that will need to be addressed both nationally and locally to overcome the many barriers that currently exist. In common with all IS development projects in many settings, it is the effective interaction between people and organisational culture as well as hardware and software issues that are vital to success. As Sauer (1993) suggests the level of support for a project is a crucial factor and ‘failure’ should be seen as a process rather than a single discreet event – hence accountability for failure is a problem. Indeed the notion of failure itself is problematic in that it betrays a belief that human, organizational and
cultural factors can be managed [author emphasis] (Mitev 2000:84). So the disagreements over technical changes within CfH are in fact an inevitable feature of organizational life not necessarily a consequence of poor management or user resistance. Our research agrees with Mitev (2000) that change is a political process and so there is a need to mobilize resources of power for effective strategic change management to take place.

What is important is consideration of organizational context. As Sauer (1993) observes, sponsors of the IS project often see success as the survival of the project. However this is based on view of the organisation that is consensual with all groups adhering to a common goal. In Camborough ACT this notion of a common goal in relation to CfH has yet to be realised if it is ever possible to do so. An important concept here from the social shaping of technology literature is ‘interpretive flexibility’ whereby (in this case) problems and solutions associated with a technology present themselves differently to different groups of people (Wilson and Howcroft 2002). The perceptions amongst Camborough ACT technical and clinical staff of diverse cultures within their organization certainly bears this out.

Leadership is the important underlying attribute required by any organisation when setting out on a journey of change. If we accept that to drive through change requires vision and courage, then the idea of leadership will of course bring conflict in relation to the process of change (Morgan 1991). The kind of leadership that is important can maintain focus and discipline while coping with characteristically complex governance and diffuse power structures (Caulkin 2006). The challenge for the NHS is to transform its purpose and its direction based upon not only transformational leadership (Wright 1996) but to develop a global cultural shift in terms of trust. This by simple definition implies an explicit and shared vision of where the organisation is going and the importance of decentralising some of the power base to frontline staff without losing its sense of direction and financial probity. With CfH questions remain however how the systems will affect staff, when the change will come about and whether the capabilities are there to meet the challenges – both in terms of IT skill training and management of the devolved power.
Whilst substantial progress has been made with the CfH programme significant challenges remain. These include delivering systems on time, NHS organisations to embrace CfH and engage staff to use the system in such a way as to have a positive impact on service improvement (NAO 2006). Our case study research suggests that much needs to be done to address technical shortcomings of the various IS developments but also to discover the role of leadership and to restore trust particularly the clinical front line worker. As Grey and Carsten (2001) point out, trust is a social process through which control is affected in the sense of rendering people and events relatively predictable. Currently predictability is not a recognisable word in the CfH programme or the NHS generally. Presently we are ‘managing a maelstrom’ defined as a situation marked by confusion, turbulence, strong feelings, even violence and destruction and this indeed sums up the CfH experience to date.
REFERENCES


