No job for the spineless

Michael Cross talks to Mike Pringle as he stands down from his role in the NHS information technology programme

“Three years in the firing line” is how Mike Pringle describes his time leading the world’s largest information technology (IT) programme’s belated attempt to win NHS clinicians’ hearts and minds. As one of seven clinical leads for the NHS in England’s national programme for IT, Pringle, professor of general practice at the University of Nottingham, was the focus of professional opposition to government plans to make patients’ electronic health records accessible throughout the NHS. He has no regrets. Although critical of the way the programme was originally set up, he remains convinced it is the right thing to do.

Sceptics, however, who include both main opposition political parties, are likely to seize on his criticisms in an increasingly charged debate over “big brother” government databases.

Unlike several of the programme’s leading figures, recruited from management consultancies rather than the NHS, Pringle was already known in the healthcare informatics community when he signed up. He has been an IT enthusiast since the 1980s, when his Newark practice was one of the first to be computerised. As a former chair of the Royal College of General Practitioners, he was also steeped in NHS politics.

Unlike some of his predecessors, Pringle stayed the course. “We were the fourth attempt at clinical engagement,” he says. The seven clinical leads were recruited in 2004 after three previous clinical directors had come and gone in less than three years. One consequence of the turnover was what Pringle describes as “a detachment” between the IT programme and health professionals.

Connecting with general practice

The seeds were sown at the outset, when the programme was conceived after the 2002 Wanless review of NHS funding. “It was originally seen as a contracting process. That’s why they brought in an ace contractor [IT director Richard Granger] to run it. Then it was seen as a technology project—and then they realised they needed to get clinical engagement.” As a result, the effort to bring clinicians on board was “late and under resourced.”

Pringle shared the challenge of building bridges with general practice with Gillian Braunold, a London general practitioner. “I realised it was potentially a very difficult position, that I would be seen as ‘going over to the other side.’ However I felt secure enough in my profession to take the risk—someone at an earlier stage might have taken a different decision,” he says.

One immediate clash was over the presumption that practice computer systems would be replaced by standard technology supplied through local service provider contracts with a budget of £4.9bn (£6.7bn; \$10bn). This approach not only clashed with the culture of general practitioners, who had traditionally chosen their own systems, but

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alienated some of the most IT literate clinical professionals in the NHS. “We had to persuade them that throwing out the entire base

accumulated over 20 years was not a good idea.” It took more than two years, however, for the new approach, called General Practice Systems of Choice, to become reality. This allows practices to stay with their present system, provided that their supplier keeps up with technical developments. That policy change was crucial, Pringle says. “If

Mike Pringle: continuing exposures of government incompetence in safeguarding personal data could undermine public support

we had seen the system suppliers destroyed, we would have been going backwards not forwards.”

Pringle says that a similar policy change is now needed in secondary care, which started from a lower base and where the IT suppliers have failed to deliver systems on time. “The bit I find difficult to understand is the regional monopolies. I think the model has failed to get the benefits for secondary care. The evidence is that it hasn’t delivered the systems needed for secondary care,” he says.

Electronic records

An even more pressing task, however, is resolving the confrontation between the NHS and medical professional bodies over summary care records shared through the NHS’s electronic data spine. At the programme’s outset, the government assumed that the benefits of shared records would be self evident and uncontroversial. As a result, Pringle

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2007, when two discs containing personal details of every family with children in Britain went missing in transit between two public agencies. While no such disaster has yet hit the systems developed under the national IT programme, such incidents risk undermining public confidence in the management of data by large centralised services, Pringle says. “Rightly, the public will need reassurances and we’ve got to be very vigilant.” However, he dismisses arguments that the scale of the NHS electronic care records service will make it a target for deliberate attack. Even if an intruder could gain access by sabotage or coercion, they would find it “remarkably difficult” to extract anything of value, he says. And any such intrusion would be recorded. “If I wanted to explore an individual’s personal details, I could find easier ways than trying to coerce access to

electronic health records.”

As for doctors, “Most doctors were, and are, not hostile to the aspirations of the programme, but many were and remain either sceptical of its delivery or hostile to its methods. The value of sharing clinical information will not be fully realised until the public and the professions are fully won over to the cause. This can occur by attrition or by a positive process of partnership. The latter is clearly preferable but is demanding. Let’s hope it is not too late for the summary care record.”

Pringle insists he left the programme on good terms—including with Granger, whose own contract ended in December after five years in which the former management consultant was often accused of driving the programme’s confrontational approach. “I always found him very personable,” Pringle says, “I have a lot of time for him as a manager, as a leader, and as a friend.” But he says that there are two sides to Granger’s personality. “I’ve always found his public persona very difficult to equate with his private one, in that he can come over as diffident, lacking in confidence, and aggressive.”

World leader

He also says the programme has much of which to be proud. “We should not forget from where we have come. The majority of the NHS was still paper based, and where computerisation had occurred the clinical information was locked away in silos. This was not an effective or safe way to deliver patient care or manage services—something had to happen and it had to include action at the national, as well as local, level.

“When you look at other countries, we’re actually doing rather well. It’s quite difficult to identify another country about which to say, ‘here is the future of informatics in health.’ It seems like quite a straightforward proposition but it’s technically very complex and clinically very challenging. It’s politically astoundingly difficult to put the systems in place to give patients the best possible care. The state of informatics in British health care is well ahead of anywhere else in the world.”

Whether this view is widely shared is questionable. But Pringle says the message is getting across. “I think the public supports the programme’s aims but is rightly cynical about value for money.” As for the government, despite the current review of the programme now under way, “I can’t see there’s any alternative to continued support. We could end up in 10 years’ time with blood tests still being repeated, patients still being given the wrong drugs. We can’t go on with that for very much longer. I think it’s unreasonable to continue to put patients at risk. I’ve no doubt that the politicians will support the programme’s intention, the only debate is on the mechanism.

“In time the national programme may be regarded as a white elephant or the start of the process that led to the NHS being one of the most effective, efficient, and safe health systems in the world. Some of the responsibility for deciding which it will be now rests with the NHS and our profession.”

Pringle himself hasn’t quite left the firing line. Apart from his academic work, he is a director of the UK Biobank research initiative and remains on the General Medical Council. He’s also working with the Royal College of General Practitioners on recertification. “That’s another project to make me unpopular, but I like personal challenges.”

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says, “The fundamental building blocks of consensus weren’t put in place. I hold myself partly responsible. By the time we tried to build the consensus, there was also a head of steam behind the opinion that we had an unacceptable product.”

Some hostility was motivated by genuine concern about the integrity of the general practice record, he says. But he detects a more cynical agenda. “Some see the summary care record as the most vulnerable aspect of the programme and therefore the best route to attack it. Others fear that sharing such information will threaten their pivotal position in the NHS. That’s why for the past 18 months there’s been such confrontation.”

Pringle remains convinced of the benefits of sharing summary care records, and says the argument is being won with the general public. “When patient groups see it, many are amazed that it doesn’t happen already.”

What could undermine public support, he says, is continuing exposures of government incompetence in safeguarding personal data about citizens. Such leaks have regularly led news bulletins since November