

The Organising Vision of Patient Access

Reflections on the New NHS Information Strategy by Healthcare Professionals

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ABSTRACT

In the UK, patient-centred care and patient empowerment have attracted much attention in the last decade through the introduction of new government strategies and the global advancement of related healthcare technologies. One of the initiatives that emerged out of patient-centricity claims has been the on-line patient access to medical records. The latest IT strategy document of the Department of Health (2012) puts forward various legitimisation claims about a future centralised database of patient records. Concerning this innovation, the study aims to explore the reflections of healthcare professionals on the IT vision of the government through the lens of the Organising Vision (OV) theory. Based on the analysis of the 7 interviews conducted, the author analyses the organising vision activities (interpretation and legitimisation) of patient access with the use of the four success factors of OV (informativeness, plausibility, distinctiveness & sense of importance) with preliminary conclusions on the overall compellingness of the vision and the visibility of the innovation.

Introduction

The patient centricity in the UK's National Health Service (NHS) is gaining more legitimacy over the years due to various IT projects that have been materialised. NHS National Programme for IT (NPFIT), also known as the world's biggest civilian IT project (Takian & Cornford, 2012), introduced some elements of patient self-management through initiatives such as online access to summary care records. Department of Health later proclaimed in the white paper (DOH, 2010) that "patients will be at the heart of everything we do. So they will have more choice and control" (Klecun, 2011).

Patient access to medical records exists in the form of local initiatives in many parts of the UK. In most cases these systems only contain the records of the patients who are registered at a certain practice, and the transfer of data between different practices is not always instant. The latest IT strategy of the government serves an initiative to close the gap in the interoperability throughout the country by creating a single centralised patient record access database: 'The Health and Social Care Information Centre' (DOH, 2012). There are various legitimisation claims made in the strategy document about why this in-

novation needs to be implemented and how it will benefit the healthcare professionals and the public in general.

In this study, the author will attempt to explore the different meanings attached to patient accessible on-line medical records from the perspectives of both policy and medical profession. The healthcare professionals' reflections on the current vision of this IT innovation can serve as valuable indicators in determining the future success of the adoption and the assimilation of these technologies.

Literature Review

Recent Policy and Strategy

With the introduction of a new information strategy document in May 2012, 'The power of Information' (DOH, 2012), the Department of Health sets out a vision to put "all of us" (citizens, members of the community, carers, patients or service users, healthcare professionals (HCPs), service providers, commissioners of healthcare services, IT specialists, system suppliers, information intermediaries) in control of health and social care information "we" need (DOH, 2012; E-Health Insider, 2012a). In the core of this strategy lies the introduction of 'The Health and Social Care Information Centre' – the online platform where all the NHS, social care and public health information will be kept (DOH, 2012). Prior to this, there has not been 'a single overall record'

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of people's healthcare history in the UK, which can be linked across organisations and are also consistent across the country. The Department of Health (DOH, 2012) expresses some of the main ambitions of the strategy, within a ten-year framework, as:

- "Information recorded once, at our first contact with professional staff, and shared securely between those providing our care – supported by consistent use of information standards that enable data to flow (interoperability) between systems whilst keeping our confidential information safe and secure."

- "An information-led culture where all health and care professionals (...) take responsibility for recording, sharing and using information to improve our care."

- "An information system built on innovative and integrated solutions and local decision-making, within a framework of national standards that ensure information can move freely, safely, and securely around the system."

Through this new centralised system, patient access to records is expected to bring significant benefits in the way patients manage their health, improve continuity and experience of care by sharing records with HCPs and carers, and identify mistakes in their records to avoid errors. Patients will also be able to book appointments and order repeat prescriptions, communicate with healthcare professionals using online communication channels, get in touch with support groups of choice, and see their full medical record including test results, letters, care plans, and needs assessments "by 2015 (by the end of this Parliament)" (DOH, 2012).

Success/Failure and Different Perceptions of Patient Access at NHS

The national programme (NPfIT) was ended by the current government in September 2010 (E-Health Insider, 2010), due to delays and the rising costs of the programme. The problems encountered during NPfIT implementation were always well-publicised; however NPfIT was also associated with some significant achievements (National Audit Office, 2011; Klecun, 2011). The Choose and Book referral system, GP2GP transfer, e-prescribing services and PACS have been noted as valuable elements of the NPfIT (E-Health Insider, 2012a; 2012b; Greenhalgh et al., 2008).

The same enthusiasm was not seen concerning the record access element of the programme, namely summary care records (SCR) which were planned to be operated under the HealthSpace website. Due to low uptake (E-Health Insider, 2011), 2 years after its launch, the government has announced that, which coincides with the publication of 'The power

of information' document, HealthSpace will be closing down in the next 12 months (E-Health Insider, 2012b), but the best features of it will be incorporated in the new portal of patients as proposed in the latest white paper.

The concerns over SCRs by the early adopter general practices were mainly related with workload and consent. GPs expressed concerns about increasing workload that results from adding information to records one by one, about the security of the system and the trust issues between patients and the practices, and about the patient understanding of the choices patients were given to make (Greenhalgh et al., 2008). In general, many healthcare professionals have expressed concerns about Record Access in the past, concerning the length of consultations, potential for litigation, the ways that the records are written and the potential of patients accessing irrelevant and inappropriate third-party information (The Royal College of General Practitioners, 2010).

In the light of this information, the author presents the research questions as follows: How do healthcare professionals reflect on the full patient access to data? How compelling is the organising vision of patient access and what are the explanations behind its level of visibility?

Theoretical Framework

The theoretical lens underpinned in this study is of organising vision (OV), coined by Swanson and Ramiller (1997). Organising Vision can provide important means to examine and explore various claims and meanings attached to an innovation, and what activities these meanings had emerged out of. The main concepts that the study will look into are the compellingness and the success of an organising vision.

This study adopts the notion of organising vision with an emphasis on the 2 functions served by the theory (Swanson & Ramiller, 1997): interpretation (a common story that describes the nature and the purpose of the innovation) (Klecun & Cornford, 2002), and legitimation (a shared rationale on why it should be adopted and used) (Greenhalgh et al., 2012). Since the study focuses on an innovation whose material realisation is still at a tentative state, the mobilisation function (activities that promote and materialise the innovation) will not be examined in the analysis.

For an organising vision to be successful, it should offer a novelty over existing practices or products (distinctiveness), be clear about why a specific technology is needed and what it can do (informativeness), be free of exaggerated statements about

the expected outcomes (plausibility) and attach a perceived practical value to the technology (sense of importance) (Swanson & Ramiller, 1997; Greenhalgh et al., 2012; Klecun & Cornford, 2002). These 4 elements constitute the factors of success of an organising vision.

Previously, the organising vision theory has been adopted and found to be useful by a number of researchers both in business and healthcare studies. To illustrate, Currie (2004) studies the process-oriented analysis of application services provisioning (ASP) in business and remarks how valuable the organising vision lens is in the understanding of the adoption and the diffusion of an emerging IS innovation. Reardon and Davidson (2007) explore the role of the OV of the electronic medical record (EMR) in small physician practices and how this vision shapes the perceptions of the physicians. It has been stated in the same study that the OV theory is shown to be applicable in healthcare IT innovations, and that analysing the perceptions of the organising vision can provide useful insights into the diffusion process of the healthcare technologies.

Methodology

In this study, semi-structured interviews with open-ended questions were conducted to explore the reflections by healthcare professionals about patient empowerment, perceived benefits and challenges of patient access to data, and general thoughts on the IT strategy of Department of Health. As the study deals with the visions set out by the government, several relevant policy and strategy documents were analysed by drawing some elements from the content analysis approach, which then led the author to divide meanings and claims mentioned in the documents under the 2 categories: interpretation and legitimation activities. These documents were gathered from the UK Department of Health website (DOH, 2012b).

Initially, seven semi-structured interviews were conducted over a period of two weeks in July 2012, including GPs, a nurse and an epidemiologist, who are actively engaged with NHS patients or with public health topics in general.

To analyse the interview data, the reflections of the HCPs were categorised under interpretation and legitimation activities and analysed through the 4 factors of OV success: plausibility, distinctiveness, sense of importance and informativeness. Based on the analysis, some preliminary conclusions about the level of compellingness and the visibility of the government's IT vision were made.

#	Position	Interview Type
1	Full-time General Practitioner at a hospital in Sussex who runs a part-time private clinic in London	In-Person
2	Full-time healthcare informatician at the NHS Connecting for Health and part-time nurse in London	Telephone
3	Retired GP who runs a private clinic in London	In-Person
4	Full-time GP at a hospital in London who runs a part-time private clinic	In-Person
5	Epidemiologist / healthcare researcher at the University of Sheffield	Telephone
6	3 rd year Senior House Officer at a Yorkshire hospital	In-Person
7	Full-time GP at the University of Sheffield Health Service	Telephone

Table 1. Basic Anonymised Data about the Interviewees

Findings

The motivation for this chapter is to explore the meanings that have been attached to the online patient access. These findings include answers from healthcare professionals concerning their reflections on patient empowerment through the new IT strategy, perceived benefits and challenges of this innovation, general thoughts on the strategy, and some recommendations that have been vocalised.

Patient Empowerment

The interviewees expressed positive attitudes towards the idea of patient empowerment and saw it as a valuable asset in the continuity of care.

"It is advantageous to have knowing patients on your side. There is a higher chance they will follow the treatment plan better and pay less frequent visits to the clinic for unnecessary questions." [Interviewee #4]

Even though the idea of patient centricity in healthcare received positive insights, the patient access to full medical record was not perceived as the best approach in empowering patients. Interviewees expressed reflections on what the white paper (DOH, 2012) expresses as "The more information the better":

"More information is better on the doctor's side, not the patients'." [Interviewee #1]

"Giving access to records does not necessarily empower patients. It's all about the patient interests. Only a really small number of people are interested in this. The rest prefer when doctors and nurses take control." [Interviewee #2]

Perceived Benefits and Concerns About Patient Access

As expressed in the 'Power of Information' document (DOH, 2012), the future centralised system will include the functions of online appointment booking, online repeat prescriptions, online communication with HCPs, access to support groups and patient access to full medical records.

Positive reflections have been noted concerning the appointment booking and online drug prescription services as all the interviewees believed that it could save time and money. They saw these functions to be valuable for both HCPs and the patients.

However, the reflections on patient accessible medical records were not as optimistic as the previously mentioned functions and many concerns were expressed in this topic. In general, the interviewees believed that the access to a full medical record should be limited to the healthcare professionals who diagnose/treat/care for the patient, and that the patient should only see a summary of their record which contains the most relevant data. One of the most vocalised concerns by the interviewees about patient access to data was the likelihood of confusion and increasing anxiety on the patient's side because of being overwhelmed by data.

"Doctors take notes and keep records about their patients using a special terminology which will not be comprehended fully by the patients when they access it from their homes." [Interviewee #5]

"It'd be quite worrying to deliver bad news over cyberspace rather than during face-to-face consultations." [Interviewee #2]

"The patients should not see everything but only a summary of the most relevant data. The big challenge is deciding what set of data it is going to be." [Interviewee #5]

Several interviewees also had concerns about the shifting focus of continuity of patient care. They stated that trusting an online account should not overcome the relationship between the healthcare professional and the patient. As the interviewees remarked:

"GPs should make a balanced judgement of what is on the screen and what they know about the patient. Therefore, the traditional patient-GP relationship cannot and should not be replaced by any sort of mechanical initiatives." [Interviewee #3]

"The data from the patient's online record can only be complementary." [Interviewee #1]

Shared EMRs between hospitals and the GP2GP transfer services were favoured as better ways of sharing data between healthcare professionals, over creating a central database in the cloud where patients can also see and edit their records. Security, confidentiality and litigation issues were vocalised under this topic.

"Data linkage between hospitals should be reinforced instead of centralising everything." [Interviewee #5]

"People appreciate the use of data as long as it is confidential. Ethics committees should govern the central database, but even this is not a guarantee that our information will be kept safe." [Interviewee #2]

Reflections on Value and Timing of the Strategy

During the interviews, the interviewees emphasised that the strategy was rushed due to political factors and government pressure, rather than having a driving need for implementing it coming from patients or healthcare professionals.

"This strategy is a non-starter: There should be changes at the policy level first. Patients and clinicians need to see the value in such systems and this will take time. At the moment, patient access should be low in priority and more attention should be paid to GP2GP services instead." [Interviewee #7]

"The motive behind standardisation is purely political. The government is aiming to create a 'McDonald's Healthcare Service'." [Interviewee #2]

Another area of criticism was related with the coherence of the document and its failure in explaining responsibilities of relevant stakeholders during the implementation period.

"The Power of Information document is clear about what exactly is desired, but very ambiguous about how to do it." [Interviewee #7]

The findings show that there are varied meanings that have been attached to the same system by healthcare professionals, but the main areas of shared criticism have been observed to be the timing and the origins of the government's IT strategy.

The next chapter will deal with the analysis of clashing and overlapping interpretations of the patient record access between the policy level (IT strategy documents) and the medical profession level (interview data).

Analysis and Discussion

The interpretation and legitimisation activities set out by the government in the strategy documents will be compared and contrasted with the actual perceptions (actual interpretation/legitimation activities) of the healthcare professionals. At the end of each interpretation and legitimisation activity described in the following sub-chapters, a statement about the relevant OV success factors - *informativeness, distinctiveness, plausibility, perceived practical value* - will be included to identify the success of the activity. The comparisons made between the interpretation and legitimisation activities, and the categorisation of the OV success factors will then be used to draw conclusions on the current success and the compellingness of the vision.

Interpretation

Before the interviews, most of the professionals were not aware of the government's strategy on future centralisation of all records under the Health and Social Care Information Centre by 2015. This finding shows that the vision has not yet reached a high level of informativeness in the first few months after its publication, even though it has been explicitly stated on the first page of the document that healthcare professionals and the public are the target audience (DOH, 2012).

The strategy has been defined as *"a shared, coherent vision for information across healthcare (...)* This is a collective strategy rather than a centrally driven programme" in the white paper (DOH, 2012), whereas research findings collected through the interviews mainly show us that the biggest criticism about the strategy has been the isolation between the policy level and the healthcare professionals. Based on the reflections of HCPs, this particular interpretation by the policy makers is of low *plausibility* due to the exaggerated statement. Moreover, the main buzzword that has been used by healthcare professionals to interpret this IT innovation was 'government-imposed', which conflicts with the policy makers' interpretation of a 'ready culture' who will embrace innovations readily. The findings reflect that the coercive pressure will be a powerful element in the nation-wide implementation of this innovation. Without the political pressures concerning the legislation of the technology, the *plausibility* and the *perceived practical value* of the innovation might be seen as low by the HCPs.

All the interviewees showed good knowledge of the NPfIT programme or of the innovations that have been introduced within this programme. The concerns that the interviewees expressed about a possible failure of the new IT strategy were mainly based

on the failure of NPfIT and the cost of this failure. Due to the trust issues that have been vocalised, the *perceived sense of importance* attached to this new IT innovation has been observed to be low.

The *distinctiveness* of the patient record access as a form of innovation was also challenged during the interviews. Some interviewees gave the example of EMIS-PAERS patient access system (EMIS Online, 2012) and stated that making such a system nationwide would not make the new IT strategy *special*.

Legitimation

One legitimisation claim put forward in the strategy document is that patient record access will benefit HCPs by making the length of consultations shorter and the patient visits less frequent, therefore it will improve the quality of their practice. However, all the interviewees expressed concerns about increasing patient demand due to confusion of the patients after seeing their own records. They also expressed a need for more pilot studies to see whether the expected benefits are being met. This legitimisation claim by the policymakers could prove to be plausible in the future but the current findings show that the *plausibility* is low on this claim.

The legitimisation claims made on the need for online appointment booking and ordering repeat prescriptions from the patient's side were observed to legitimise the innovation more than the mere claims made on the advantages of patient record access. The *plausibility* of reducing unnecessary patient visits to GPs or hospitals due to online booking and order prescriptions is high as well as the *perceived value* and *informativeness* attached to these systems.

The strategy document expresses a strong view on the idea that the more information healthcare professionals and patients can access, the better service patients will receive. This statement has been in conflict with the answers from all interviewees who expressed concerns about increasing levels of anxiety and confusion on the patient's side, but meanwhile this innovation was seen as a valuable asset if it is only accessible by the healthcare professionals, much resembling the system of shared EMRs. The general conclusion was that no data should be interpreted by patients in the absence of HCPs and that the continuity of care can be provided with the enhancement of the GP2GP services. This second legitimisation claim of the policy makers has therefore been interpreted to be medium in its *distinctiveness* and in its *perceived practical value*, because HCPs believe that this technology can help them to easily access information about their patients, only not in a completely novel way.

The lack of publicly announced pilot studies is another factor that puts a restriction on the legitimisation claims about patient empowerment. The study findings reflect that the *informativeness* of this vision can be increased by conducting more pilot studies and publishing reports on the benefits that patient access brings to patients.

The Compellingness of the Organising Vision of Patient Access

The analysis of the strategy documents and the interview data reveals that the organising vision of centralised patient record access has been shaped as a product of political pressures. Based on the perceptions of the sample interviewed in this study, it could be argued whether the adoption process of the organising vision of patient access is going to meet the expectations of the policy makers.

This organising vision is still in its early days of existence, but so far it seems to be struggling to convince the healthcare professionals with the messages it gives. This could be mainly because of lack of informativeness in the interpretations of technology and the meanings that policy makers have attached to it. The strategy document has been found to assign a “highly transformative meaning” (Klecun, 2011) to the IT innovation, especially with the legitimisation claims based on the direct causal links between patient empowerment and online patient access to records.

The reasons why the plausibility of the centralised patient access has been undermined could be because the current organising vision does not fit the “pre-existing frames for thinking” (Swanson & Ramiller, 1997) in the domain of medical profession (due to different agendas compared to those of policy makers). The current perceived practical value of the centralised patient record access was found to be lower than the value attached to those of other IT services (online appointment booking, online repeat prescriptions) presented within the strategy document. This could be partly due to the lack of adequate interactions with that particular technology in its *social context* (the nation-wide system for patient access is still conceptual), and this perceived value could rise or fall further later “in the light of mobilisation activities” (Swanson & Ramiller, 1997).

“The ambition is bold, and it will take time.” (DOH, 2012) is how the vision was defined in the strategy document. It can be interpreted that the legitimisation activities of the Department of Health will be ongoing in order to increase the informativeness and the distinctiveness of the vision. Success factors may vary over time due to new mobilisation activities, and the compellingness of the organising vision

may fall or rise accordingly. The author believes that the organising vision of patient access could become more compelling over time if conflicts and tensions between the policy and the medical level are resolved on the way.

Conclusion

The organising vision of patient access is still under constant construction. The perceived practical value, informativeness, plausibility, and the distinctiveness of the government’s patient record access strategy have been observed to be lower than the strategies concerning other online systems such as online appointment booking and ordering online repeat prescriptions. The interview data analysis, on the other hand, presented positive attitudes towards the patient empowerment movement, but only not through the patient access to full medical records.

The analysis of the documents and the interview data makes a point clear that the organising vision of patient access in the NHS, whether readily adopted by HCPs or not, will not easily come to its demise, due to political forces. The question that could be asked here is how to find an accommodating ground between the enthusiastic policymakers and the more realistic healthcare professionals to ensure a smoother implementation and assimilation in the future.

The author suggests that the competing discourses about patient access could be accommodated if a “more effective inter-stakeholder dialogue” and “cross-sector learning communities” (Greenhalgh et al., 2012) are created in the NHS. The vision can be embraced and owned by the stakeholders if they are more vocal in the process of formulation of the organising vision. By creating a broadly coherent organising vision, the sustainability of the technology could be guaranteed.

For the vision of patient access to be realised at a wider level, some recommendations can be put forward for consideration at the policy level. Informativeness as an OV success factor is a crucial element that can affect plausibility, distinctiveness and the perceived value of the organising vision at later stages. For greater informativeness, the legitimisation claims made about patient access to data could be supported with more pilot studies particularly conducted on the patients by exploring their reflections on this IT innovation. Without a doubt, more research is also needed to explore the meanings attached to the innovation by different stakeholder groups.

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