SUMMARY CARE RECORD
INDEPENDENT EVALUATION

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WHAT WE ARE CONTRACTED TO DO

- Describe what happened in the Early Adopter phase of the SCR implementation
- Offer interpretation (not judgement)
- Draw insights that will inform the SCR roll-out in Fast Follower PCTs and more widely
WHAT IS ‘EVALUATION’ IN THIS CONTEXT?

• NOT monitoring
• NOT audit
• NOT financial accounting
• NOT the evaluation team passing judgement on CfH or the PCTs

• We aim to produce **ILLUMINATION** so that stakeholders can make their own judgements
EVALUATION FOR ILLUMINATION

• Mainly but not entirely qualitative
• **Attending** meetings, **interviewing** both senior and junior staff (and patients), **observing** practice
• **Analysing** documents (e.g. letters sent to patients, minutes of meetings, press articles)
• Preparing our **interpretation** of events and then feeding it back and asking “have we got the right picture here?”
National context and drivers (policy, CfH, professional bodies, IT companies, NGOs etc)

Local project group e.g. PCT

Team / workgroup e.g. GP practice

Clinician

SCR

Patient

The Summary Care Record is a national programme, not a plug-in technology

LINKS between CfH, PCTs & IT companies

LINKS between PCTs & GP practices

LINKS between patients & their GP practice and other sources of advice
DATA SOURCES

• Formal semi-structured interviews
• Informal discussions
• Observation visits to GP surgeries
• Analysis of documentation e.g. minutes of meetings, letters
• Analysis of statistical data
• Analysis of press cuttings, blogs etc
THE NATIONAL CONTEXT

• SCR = nationally mandated programme of high political significance

• CfH’s ethos and ways of working
  – Gantt chart culture
  – ‘Make it happen’ management style
  – Reporting and statistics valued highly

• Professional bodies (BMA, RCN)

• Press and public
  – High-profile ‘data loss’ stories
  – Civil liberties movement
CROSS-CUTTING THEMES IN THE PCTS e.g.

- Relationship of PCTs with CfH
- Software suppliers
- Operational complexities and how these were addressed
- Data quality
- Consent model
- Communication
- Skills / training
- Local politics
THE ACADEMIC DIMENSION

• How to theorise our findings
• How to align two key objectives
  – Provide CfH with recommendations to inform this programme
  – Produce generalisable insights that might be applied to any large-scale IT programme in healthcare
Raw data

Identifying initial themes or concepts

Sorting data into themes or concepts

Summarising or synthesising data

Refining categories and themes

Establishing typologies

Finding patterns

Developing explanations

Seeking application to wider theory

Low level of abstraction

Level of abstraction

High

Data management

Descriptive accounts

Explanatory accounts
POSSIBLE THEORETICAL LENSES

- Utilisation focused evaluation (Michael Quinn Patton)
- Technology structuration (Wanda Orlikowski)
- Technology in practice (Marc Berg)
- Ethnography of infrastructure (Susan Leigh Star)
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UTILISATION FOCUSED EVALUATION

Before an evaluation begins – and as a critical part of its design – three questions must be addressed:

• What is the purpose of this evaluation?
• Who are the audience(s) for the evaluation?
• What use will the audience(s) make of the evaluation?
UTILISATION FOCUSED EVALUATION

• What is the purpose of this evaluation?
  – To inform the wider roll-out of the SCR

• Who are the audience(s) for the evaluation?
  – CfH
  – PCTs
  – BMA, RCN
  – Defence societies
  – Patients / public
  – Voluntary sector groups e.g. Terence Higgins Trust
UTILISATION FOCUSED EVALUATION

• What **use** will the audience(s) make of the evaluation?
  – CfH – strategic planning
  – PCTs – operational planning, troubleshooting
  – Professional bodies – political negotiation
  – Patients and public – personal decision
  – Etc

• We orient our final report to the needs of different stakeholders
Andy Ven de Ven

Challenges the assumption that making your research useful and relevant to practitioners is ‘dumbing down’
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Social structures for technologies-in-practice
(rules and resources brought to bear in the use of technology)

Other social structures enacted in the use of technology

Structures of signification (e.g., knowledge, assumptions)
Structures of legitimation (e.g., norms, professional ethics)
Structures of domination (e.g., resources, power)

Ongoing, situated use of technology
(what people do with technology on a moment-to-moment basis, including articulations and workarounds)

Orlikowski’s model of technology structuration
“The SCR will improve the quality and safety of healthcare”

“The SCR will improve efficiency and save money”

“A good doctor would want to provide efficient and evidence-based care”

“A good nurse would keep accurate records”

“If we put data quality in the QoF or introduce a LES, the GPs will do it”

“If you give us some plasma screens for the GP surgeries, we’ll cooperate”

“We’re not playing ball with the SCR because we just lost the battle over extended opening hours”

“The SCR will damage the traditional GP-patient relationship”

“The SCR will erode public trust in the NHS”

“A good doctor would protect privacy and confidentiality”

“A good nurse would not let red tape interfere with patient care”
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TECHNOLOGY-IN-PRACTICE

• Don’t think polarised dualisms e.g.
  – ‘Formal’ versus ‘informal’
  – ‘Social’ versus ‘technical’
  – ‘Model’ versus ‘reality’

• Think critical, dynamic tensions e.g.
  – The skilled and creative work that links ‘model of clinical reality’ with ‘actual clinical reality’
  – The focus of analysis becomes ‘the workaround’
SOME PARADOXES IN THE SCR PROJECT

Ministerial Task Force Report Dec 2006: The SCR programme must be

1. Implemented as fast as possible and implemented at a pace commensurate with clinical engagement

2. As simple as possible and incorporating numerous bells and whistles (e.g. HealthSpace, multiple access points, multiple use scenarios)

3. Driven by informed, engaged, questioning patients and oriented particularly towards the poor, the sick, the old, limited English speakers, and the socially excluded
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“THE SOCIETY FOR PEOPLE INTERESTED IN THE STUDY OF BORING THINGS”

Ethnographers should become interested in “….the design of networks and their import for various communities, the fierce debates about domain names, exchange protocols, or languages. Their is not the usual sort of anthropological strangeness. Rather, it is an embedded strangeness, a second-order one, that of the forgotten, the background, the frozen-in-place.”

Susan Leigh Star
“Study a city and neglect its sewers and power supplies (as many have) and you miss essential aspects of distributional justice and planning power. Study an information system and neglect its standards, wires, and settings, and you miss equally essential aspects of aesthetics, justice, and change. Perhaps if we stopped thinking of computers as information highways and began to think of them more modestly as symbolic sewers, this realm would open up a bit.”

Susan Leigh Star
SUMMARY

• The Summary Care Record Early Adopter programme is politically sensitive
• CfH need timely, pragmatic insights and recommendations for the policymaking cycle
• But that doesn’t mean we should be light on theory or analysis
• ‘Utilisation focused evaluation’ is an example of what Van de Ven calls ENGAGED SCHOLARSHIP
SUMMARY

• The theoretical lenses through which we will analyse our complex and fascinating dataset include
  – Orlikowski’s technology structuration theory
  – Berg’s theory of technology-in-practice
  – Star’s approach to the ethnography of technological infrastructure

• We are confident that a creative combination of these approaches will add to the knowledge base AND MAKE THE STUDY OF ICT IN HEALTHCARE LESS BORING
Thank you for your attention

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Tanja Bratan
Katja Stramer