The members of National Council all have substantial experience of health informatics. They also have sufficient mental retention to remember that this was not always so.

We have a duty (moral and professional if not legal) to encourage and educate new entrants to health informatics. National Council devised a scheme for entrants to be sponsored to attend the annual conference, see March 2007 newsletter. This resulted in six people having their expenses paid and a year's subscription to ASSIST. In return they have undertaken to write about part of the conference for the newsletter. The first of these by Diane Dawson is in this newsletter. Others will be included in the September issue.

Also in the September issue there should be reports about the Institute of Mathematical and its Applications conference on the “Quantitative modelling in the management of health care”. This looked at use of health data in France, implementing IT solutions in French hospitals, developing models to deliver the 18-week referral to treatment target and a different approach to meta-analysis. Not all of this is of direct use to health informatics practitioners but it does or will impact on the work we do.

John Leach

There is much to celebrate in health informatics as progress is made on many fronts. The progress is not as fast as we would like and certainly not as fast or smooth as our critics demand but the progress is acknowledged by Lord Hunt, the government minister with responsibility for CfH and by Richard Granger.

The winner of this year’s accolade for health IT is supported by an active ASSIST member in the North West; see the article about on-line remote consultations by Kathryn Hargreaves in this issue. Last year Pete Marsh, Director of Informatics at Wirral Hospitals, was awarded an OBE. There was an interview with Pete in the December 2006 issue of this newsletter. At the joint HFMA ASSIST conference in Blackpool earlier this year Pete Marsh was award life membership of ASSIST in recognition of his contribution to health informatics. This was presented to him by Frank Burns, former Chief Executive of Wirral Hospitals and the principal author of the 1998 national information strategy, “Information for Health”. Frank gave a substantial and glowing encomium of Pete’s achievements before the formal conference dinner.

John Leach

Four people who worked together at Wirral Hospitals at the HFMA ASSIST conference dinner in Blackpool; from left to right Paul Charnley, Pete Marsh, Frank Burns and Alan Spours. Pete Marsh is the only one who was still at Wirral at the time of the dinner.
The Semantic Web and e-health

Professor Nigel Shadbolt gave the opening address at HC2007. In his capacity as president of the BCS he started by stating that the society intends to be:

• Professional;
• Relevant;
• Independent, of commercial interests and government;
• Inter-disciplinary, the discipline is not fully defined. It is certainly not only academia but is about people, systems and processes and embraces socio-economic issues;
• Forward-looking.

The substance of his presentation was about the semantic web and how it could add value to the process of health care and promoting health. This is in the context that all the relevant agendas are inter-related and actions in one of them impact on the others. Thus the financial agenda impacts on the environment, which impacts on health though it also impacts on health through the housing agenda. The challenge is to identify developments in all these areas and understand what those impacts are likely to be.

The context also embraces the felling of problems with the brute force of computing power with some insight compared with the view of three decades ago that it was necessary to have a basic understanding of the problem before being able to compute the solution. He also noted that the computing power of the Sony Play Station is advancing more rapidly than Moore’s Law.

There is a myth that the semantic web is lots of smart software agents, doing lots of clever things though none of them can be shown just yet. It is about equipping the data on web sites with rich meta data, which enables machines to extract and build knowledge that mimics the way people glean and create knowledge. The information on web sites would need to be marked to indicate what it is describing. For example, if the site described an event, people would recognise it as such and expect it to have a beginning and end time and a location. If these were marked up, it would be possible for the web to be searched for events and some additional knowledge created. It does require an ontology to be available to share the meaning and provided a shared conceptualisation of the domain.

In health the ontology could be SNOMED CT and web pages that used it would also contain a link that would refer the other machine to the source for its meaning.

This could allow a range of specialists treating a patient or group of patients to share information more effectively. The specialists all use language differently, have different world views, are trying to keep abreast of the latest research and attempt to link data across locations and time. If this could be automated by using patient ontologies to link the data the human effort could be reduced or redeployed. It could enable people to share meaning, reduce ambiguity and make explicit what is presently implicit. It could integrate the information so the whole is greater than the sum of the parts. It could enable clinicians to spot relevant events and assess the effects of interventions. It would lead to intelligent web services and information use.

The same technology is being used in e-defence to extract meaning from vast amounts of data.

There is a central role for enriched web content and use. This does require trust, confidence and confidentiality. There are personal digital information rights and it is probable that people will start to assert these rights.

In the discussion that followed Professor Shadbolt stated that for SNOMED-CT to be used it would require modularisation so that there were self contained sub-sets that were fit for use. The challenge is to make SNOMED-CT operational.

He was asked for his opinion about the temporal aspects of medical ontologies. He replied that in artificial intelligence interval calculus is used to look at events through time. It was not clear if this was the point of the question. It could have referred to the changing view clinicians take of the world through implicitly redefining what is classified as a disease.

John Leach
I recently received my annual reminder to re-register with UKCHIP, which prompted me to reflect on how far UKCHIP has come over the last two years, and why we embarked on the journey in the first place.

As long ago as July 2002 an initial workshop was held in London under the banner “Pathways to Professionalism” with the aim of exploring levels of support for accreditation and regulation of informatics specialists working in and for the NHS. All this had come about as a result of a growing recognition by the Department of Health, NHS Information Authority (NHSIA) and professional associations like ASSIST, that developing informatics specialist capacity and capability would be central to successful healthcare modernisation and the achievement of national health policy and strategy objectives.

Raising the profile and status of informatics staff was identified as a key issue in addressing both recruitment and retention concerns, identified in the 2000 national workforce survey commissioned by the NHSIA and reinforced again by the ASSIST workforce survey conducted last year. These surveys clearly showed that pay was not as big an issue as some had expected, but the lack of defined career pathways and access to personal and professional development opportunities, together with a lack of appreciation of the important role of information and ICT in healthcare was a barrier to both personal and professional advancement and the ability of organisations to retain good staff. The NHS needed high calibre, flexible, respected, proactive staff who were well qualified in their specialist area, who understood the business of healthcare, could communicate effectively with clinical professionals from a position of understanding care processes and clinical issues.

Establishing a registration body, now known as the UK Council for Health Informatics Professions or UKCHIP, was supported by ASSIST, the BCS and the NHSIA as one piece of a bigger jigsaw, designed (with the specialist community itself) to provide a way of assuring the professional status of a wide range of information and ICT specialists. In designing the approach, research was undertaken into professionalism in general and existing examples of professional accreditation bodies and systems. Finance, HR, IT, scientific and engineering models were examined, and elements of some adapted for application in the complex and disparate domain that is “health informatics”.

Like most, if not all, professional/registration bodies, the benefits of joining the UKCHIP register hinge around the independent assessment of an individual’s fitness to practise. To join the register at any of the three levels, applicants have to demonstrate an appropriate level of educational/academic achievement, along with a breadth and depth of experience in informatics and healthcare delivery; as well as agreeing to abide by a national Code of Practice and undertake a programme of continuous professional development. A revised set of standards for registration, based on a qualifications framework has been developed and now signed off by the UKCHIP Council and will be built into a transition plan over the next weeks and months.

All of us should be interested in demonstrating that we are competent and capable and, importantly, that we understand the potential impact of our actions at work on patients and clinical outcomes. For some the link is more tenuous than others, but there is an increasing catalogue of examples of both “good” and “bad” informatics. Information and IT systems are at the heart of everything we do and as new systems and technology become even more important, being “safe” to practise is similarly more important. In a world where electronic records are the
Continued from Page 3

norm and other care processes are digitised, high calibre, qualified, flexible and experienced practitioners will increasingly be required to ensure system design, deployment, development and management is safe. Consider:

- The importance of data quality and integrity as paper records are migrated to an electronic environment
- Technical aspects of data migration
- Information governance
- The importance of designing systems to minimise the risk of prescribing and transcription and other human errors
- The importance of effective disaster recovery systems and processes
- The need to provide 24/7 support and services
- Dealing with legacy and feeder systems
- Increasing use of ICT systems in diagnosis and well as treatment
- Payment by Results and the importance of accurate coding and audit
- The key role of effective training in systems use and security and confidentiality

The wider informatics specialist workforce development strategy “Making Information Count” of which the establishment of UKCHIP was a part, is almost 5 years old now. The strategic approach to building capacity, capability and the informatics community will be reviewed in 2007, following the joint Information Centre/NHS Connecting for Health review of informatics due to report any time now and in the context of developments like the National Local Ownership Programme (NLOP), 2006 workforce survey (ASSIST) and other research.

The emergence of the Cabinet Office sponsored “Government IT Profession” activity and establishment of a Health Sector Steering Group adds further weight to the drive towards professionalism and a further dimension to possible career pathways and opportunities for learning and development and needs to be factored into the new jigsaw.

None of us, I suspect, are very good at taking time out to think about our professional development and reflect on the year past in terms of learning and development. Re-registering for UKCHIP has certainly given me that opportunity.

Registration for me is not about discounted magazine subscriptions or reduced price access to conferences or, although tempting, the current opportunity to win a PDA (www.ukchip.org.uk). It is a more important longer term ambition to see all informatics specialists receive the status and recognition they deserve that drives me, and I suspect a large proportion of the other 999+ registrants to take time out to complete the on-line registration form. Charles Hughes, President of the British Computer Society is quoted as saying:

“Professionalism is essential for all those working in IT in positions of trust or authority. It enhances our reputation and capability and underlies our commitment to work for the public good”.

Registration might currently be a bit of an act of faith, but it is important to bear in mind that professions take time to grow and develop and, all things considered, UKCHIP has done extremely well and at a time of major NHS reorganisation, uncertainly, change and financial constraint. 1000 members are not enough, but it’s not at all bad. UKCHIP cannot completely succeed without being part of a wider strategy which must include employer support in the interests of supporting safe, high quality care. Developments like the Government IT Profession will certainly help.

It’s a bit of a “Catch 22”. Needing to raise the profile of the profession and secure employer regard and support is largely dependent on us demonstrating our commitment to act in a professional manner – and one way to do this is to join the now public register and the growing number of colleagues who share a common concern. Registration with UKCHIP has started to appear in a small number of job personal specifications and we must work to increase this practice over time, perhaps as a wider drive to ensure that Health Informatics Services and teams are also “fit to practise”.

All professions take time – perhaps decades - to grow and become mature. Like all others before it, UKCHIP rightly continues to reflect on its scope, role and structure, and will take time to establish a clear and universally understood identity.

In a nutshell, registration is a public statement of your professional status and your commitment to practise safely and in accord with a stated Code of Practice, including a commitment to continuous professional development.

Other benefits do exist (see www.ukchip.org.uk) and others will accrue over time. As far as I am concerned, though, the former is quite enough!

I still retain my membership of ASSIST too, of course, and ASSIST national council and other members continue to be deeply involved in the direction and development of UKCHIP.

No-one said it was going to be easy ………

Di Millen
Doing the Right Thing - Managing benefits from your IM&T

David Waller of Tribal at the Yorkshire and Northern seminar on Benefits Management.

‘Benefit’ is a word that risks being worn out by the health sector at the moment. There is a tremendous drive to see benefits; from IM&T programmes, service improvement and many other initiatives. Yet often we lack a reasonable understanding of what the benefits actually are and how they can be delivered successfully.

In April, David Waller of Tribal gave a comprehensive lesson in Benefits Management to Yorkshire and Northern ASSIST. David has been managing benefits for over ten years now, having assisted Cranfield University’s original research into Benefits Management in the mid 90’s. His positive seminar showed what a rigorous Benefits Management method can achieve.

‘Benefit’ Defined

We can’t manage benefits if we can’t recognise them. If the finance people see benefits only as cost savings and the IT people see new features as benefits (it’s faster, has three extra fields in each record…) then we won’t get very far. We have to be clear on our definition.

A benefit is a result that a stakeholder perceives to be of value.

There has to be a clear statement of what makes it worthwhile. We are talking about improving patient health, reducing waiting lists, stopping un-necessary procedures, not improving network performance, reducing down-time and stopping legacy systems.

Mapping the Benefits

Benefits Management makes the links from the solution, through business activities and benefits to the organisation’s overall drivers. A great strength of the method is that it shows just how much change effort is going to be needed to deliver the selected benefits. More benefits implies much more effort.

Objective setting in health communities

As we work more and more in multi-agency communities we find that agreed common objectives are crucial to success but don’t come easily. The purpose behind any course of action has a direct and significant effect on the way it is undertaken. The motives behind a project affect the ways we go about it. David’s ‘Acme Health’ table exercise gave us a practical demonstration of the challenges we face in agreeing objectives with our colleagues.

Picking the right programme / project

Managing the benefits helps you to produce a convincing business case. The business case is a logical argument to spend money. The strength of the method is that it creates a compelling reason for the project sponsor to act. The project will have been chosen because it meets a valid need. All the numbers in the business case will have been put there by the stakeholders with evidence to back them up and an owner committed to their delivery.

The benefits won’t be delivered overnight though. This has to be planned for and expressed clearly in the business case. A recent study of European e-health programmes revealed that on average they took five years for the benefits to outweigh the costs.

Benefits Management needs a thorough understanding of the stakeholders. Who are the key ones who have a significant influence on the project? What business changes will they make for the project to be successful? Most importantly, what benefits and disbenefits will they get, what’s in it for them?

Benefits Management does not replace existing programme and project management processes. It complements them. It draws on a number of other management methods, tools and techniques such as: Business Policy and Strategy models, Change and Performance Management. David’s method fits well with the Office of Government Commerce’s Managing Successful Programmes and Prince2.

David concluded by reminding us that we cannot rely on rational processes like BM alone. We have to apply psychology as necessary. We must have the right sponsors with the right commitment, plan for stakeholder motivation / de-motivation and be realistic in the goals we set. And finally remember that simple always works best.

Chris Shovelton
Yorkshire & Northern ASSIST
Five Years of the National Programme

At the ASSIST annual conference Richard Granger, Chief Executive – NHS Connecting for Health (CfH), reviewed the first five years of the national programme. He commented that the programme is hitting a rapidly moving target. At the outset there was homogeneous ownership of the health care system; now the NHS has Foundation Trusts and independent providers. There is still the need for informatics in health to make the transition from the machine room to the boardroom and to move to real time information. The systems on which much of the health service still relies are based around batch, paper-based processes, and CfH programme activity is constrained by these factors.

It was noted that nevertheless, some systems and deployment activities are making inroads into the required step change. CfH’s registration authority has notched up 350,000 registrations with smart cards for use with new systems. There has been the separate development of the electronic staff record (ESR) however, which means that there is now a programme of work in place to integrate the identity management aspects of the two systems.

Choose and Book was perhaps an unfortunate place to start and with 20:20 hindsight the elements to go first would have been PACS, GP2GP and N3. Currently the priority activity with Choose and Book is to address the availability of slots (an outpatient capacity issue) rather than the functioning of the technology. With the electronic transfer of prescriptions (ETP) nearly 120 GP practices are being linked each week though this must rise to 200 to 250 per week.

The Care Record Service (CRS) is subject to a house of commons, health select committee inquiry. Work in the North West pilot implementation indicates that only 0.23% of the population have concerns about it. There continues to be much work regarding its content. It is clearly a prerequisite that care professionals, the public and government agree on the contents. There are 102 systems accredited to run over the spine, so there is progress at the technical level. Richard Granger said that he is determined to avoid the error of other civil IT programmes that have built expensive English specific solutions. These have not only been expensive to implement but the costs of ownership and later replacement have become prohibitive. Systems are deployed in a specific geography and it is probable that vendors will wish to invest in marketing these elsewhere. This is also true for clinical terminology and there are exciting developments in clinical coding at an international level taking place.

NHS mail is not a swanky, all singing all dancing mail system but it costs a mere 24p per month per user. Richard Granger said that it is suitable for his needs though some people tell him that it is not adequate for their needs. There is a potential cost saving to be gained from its use compared with trusts and PCTs running their own systems.

The GP2GP transfer of records is tortuous but popular with GPs. There was an issue with QMAS in April when 4,000 practices were all processing end of year data and the system slowed down. This indicates that there is a need to schedule this activity in future as it is likely that it is not appropriate to make additional investment simply to handle this annual peak load.

He stated that the additional OJEU procurement (Additional Supply Capability & Capacity) that started recently is to provide additional functionality and provide contingency for LSP core products. It is a refresh of procurement five years into the programme and it is to be expected with any large programme.

In answer to a question he stated that data held in the NHS is critical for care in other environments, e.g. social care; the independent sector. People will want access to NHS data but this raises information governance issues. One solution might be that they will be able to subscribe to the NHS infrastructure. This is not a foregone conclusion as the details will require careful consideration.

In answering a question about links with other national systems, e.g. Wales, Scotland, he stated that the national programme had put together a suite of international standards for interoperability, e.g. HL7, SNOMED and he would like to see other countries adopt these standards. Further details can be found at http://www.informatics.nhs.uk/cgi-bin/item.cgi?id=2295

In the same session Mike Bainbridge spoke about the common user interface, which is based on Windows XP and Office. This will give a consistent user interface for all clinical systems, so helping with training implications. It is aiming for consistent navigation and a safe handover.

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between shifts. The date format has been agreed so there should be no confusion between American and British formats. More details can be found at www.cui.nhs.uk

He also showed a flat keyboard that can be wiped clean with a single alcohol wipe and a flat screen that has RFID, infrared connectivity, a bar code reader, voice recognition and is wipeable.

Mark Farrar spoke about the Microsoft enterprise wide agreement (EWA) that has resulted in £330m in savings to the NHS. Win98, Win NTL and Office 2000 are still deployed despite them being unsupported. It has become clear that there is a need for a better asset and renewals register to gain more benefits from these EWAs. He also highlighted that the Novell EWA has resulted in £75m saving also to the NHS. The infrastructure maturity model devised by Gartner indicates that 70% of IT spend is on infrastructure. These EWAs are an attempt to reduce those costs.

John Leach

Elephants at the conference

Sarah Fraser spoke at the HfMA ASSIST conference about why it is difficult to spread good practice. She covered five topics and we could see how they were interrelated.

Pilot culture

Conference attendees recognised the problem of running a successful pilot but not being able to roll it out into the rest of the organisation. Often the people who are involved in the pilots are those people who are keen to innovate in a particular area. Most other people regard these people as having additional skills, expertise or passion in the area where the pilot is being conducted; consequently most people view the pilot solution as not relevant to them. If there is a need to innovate as a precursor to spreading the practice throughout the organisation, it has to be done with those people who are not seen as having a particular bent for the topic. This will reassure others that the pilot is relevant to the whole organisation. It will also enable those running the pilot to learn and understand the language of the majority of people rather than that of the enthusiasts.

Ideas bias

There is a tendency to push for a single solution regardless of the diagnosis, data or context. Often only one idea is considered for political (P or p), ego authoritarian or influence reasons. We can see this in the debate about operating systems, DVD formats and the merits of the PC versus the Mac. Further it is possible to gain funding or sponsorship for a specific idea but difficult to garner it for a range of ideas to explore the strengths and weaknesses of different approaches.

There are assumptions that:
1. good theory will translate into good practice,
2. good practice + good practice + good practice becomes best practice.

It is often easier to gain acceptance to good ideas rather than good practice or local best practice or industry best practice, since people are attracted to the possibilities of ideas. In contrast they select all the details in best practice that needs adjustment if it is to work locally. There is something about the detail that provokes resistance. There followed an exploration of actions that can be taken to deal with ideas bias. First, test out the idea for real, in its proper context. If there is resistance, it may be for a rational reason in addition to the natural response reaction to maintain homeostasis. To get the idea adopted, or at least considered seriously, the world view of the person questioning the idea needs to be explored and understood, so those concerns can be addressed and the idea adapted to be more applicable. Thinking about the adaptability of the idea and implementing the adaptations is vital. It can be useful to have a review group of critical friends who will provide feedback. Further, alternative ideas should be tested, as there could be a need for change but the original idea might not be the best approach.

With whom to work and how?

The population can be categorised as enthusiasts, visionaries, pragmatists, conservatives and sceptics. However one person can be an enthusiast for one idea yet a sceptic for another. If there are many changes with many ideas one person could be in every category. Whilst the enthusiasts innovate and we need their

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enthusiasm, it is the visionaries, sometimes called the “early adopters” who use their influence to break with the past. However, it is the pragmatists who protect the organisation and ensure that the ideas are implemented smoothly and do not cause chaos.

It is possible to work with the enthusiasts as a group. Their enthusiasm is infective and self-reinforcing. However, it is best to work with the visionaries individually. This allows their concerns to be addressed separately. If their concerns are addressed in a group discussion their doubts can be bolstered by other people’s concerns that they had not previously identified.

Leadership
Leadership factors can be critical when making changes.

First, there is a need for curiosity. This includes being inquisitive, seeking new ideas and ways around problems and deciding whether to customise or copy. Curiosity is the opposite of apathy. There is the need to encourage or give heart and the need to have courage. Courage is required to take some risks, such as facing up to what needs to change, taking the lead that may be unpopular and customising good ideas to fit the local context.

There is also a need to remember that without passion we are deserted and we desert others. Remember not only who inspires you but why. When we communicate with people 7% is content, 38% is tone of voice and 55% is body language. The enthusiasm and zeal with which we deliver messages is crucial.

Sarah finished with a story about cleaning a goldfish bowl. Whilst the bowl was being cleaned the goldfish was put in a bath full of water but it continued to swim in small tight circles as if it was still constrained by the goldfish bowl. The call to action is to help people break free from their perceived constraints and we have to develop the plans to do that and implement them.

John Leach

Secure on line remote consultations

Background
Several years ago we (at Marple Cottage Practice) developed our website for patients. Since then we have been keen to use the website for patients to communicate with us electronically. Patients have also enjoyed the use of the on line EMIS Access facilities including appointment booking and prescription ordering. (see www.emis-online.com/products/access/)

Although we were in favour of email consultations, they have been restricted as far as content is concerned for confidentiality reasons. They also require double entry to complete the patient record because the emails are not integrated with the patient record.

Patient relationship management
With chronic diseases, worsening symptoms can occur before the planned review date. We wanted to develop the means for our patients to ask advice or alert us for further help without having to attend the surgery. This is all about giving timely advice that could prevent worsening conditions, serious events or admissions to hospital.

Our own clinical audit of long term conditions has repeatedly demonstrated the need to improve access and not necessarily just by capacity, but by offering varied modes of communication that suit the differing patient needs.

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We recognise that web based access to services is an important part of our overall service provision because, not only does using the internet fit in with many people’s current lifestyle, we want to make health choices available to all our patients, which includes providing the means to do so from home whenever that is more appropriate than a face to face consultation. Feedback from patients has also confirmed that contacting us via the website would be far more convenient at times.

Team involvement
As part of the practice asthma review the full clinical team discussed how asthma in particular would lend itself to remote consultations. We therefore agreed to aim to provide a mechanism for remote asthma reviews, which needed to include:

- Patient’s ability to ‘push’ information to the GP/nurse, which was simultaneously documented in their medical record
- GP/nurse single entry consultation in the patient’s medical record, including personalised self management plan

Objectives of the initiative
- Improve asthma management
  - Encourage patient education and motivate self management
  - Reduce the number of exacerbations and admissions to hospital
  - Reduce the demand on acute appointments
  - Reduce medication usage / appropriate stepping down of asthma treatment

- Provide an additional service that is matched to our face to face consultations and our existing written asthma reviews
- Increase access and access choice
- Ensure the development can be replicated to other long term conditions and health improvement

Overcoming the obstacle
This “remote consultation” initiative is innovative in that we have overcome the obstacle of secure e-communication for patients by working in partnership with EMIS to be able to add our remote consultation to the EMIS Access technology.

Asthma nurse provides the patient with personalised self-management plan

Either printed copy or available on-line via secure access to the patient’s medical record

Patient follows the personalised self-management plan

Patient needs to consult with the asthma nurse according to the self-management plan

Patient completes consultation questionnaire via secure website access

A message in the inbox alerts the nurse that she has received information from the patient

Nurse studies information submitted by the patient and updates the medical record based on new information received

On-line Consultation

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National Agenda
Our remote consultation is aligned to the NHS Improvement Plan and can be clearly referenced to many of the national standards. Some examples of this are:

• Clinical and Cost Effectiveness (e.g. ref D2)
The remote consultation provides the patient with (written) personalised information to self-manage their care based on evidence and provided by their nurse of doctor.

• Governance (e.g. ref D6)
This initiative is a clear example of using integrated IT to support and enhance the quality and safety of patient care, choice and service planning.

• Patient Focus (e.g. ref D10)
Our remote consultation facility encourages patient initiated long term condition reviews and self management.

• Accessible and Responsive Care and Care Environment and Amenities
The ethos behind our development and use of our remote consultation fits these standards.

Transferability
Once we were able to test the product for our patients, EMIS would be able to offer it to other practices as a ready product.

Also it is now simple to apply it to other long term conditions as well as health screening data, which we have already set about to do.

Value for money and impact
The chief project outlay has been staff time and good will.

As we are working in partnership with EMIS on this initiative the return on effort and time will be enjoyed by other practices and their patients as and when they start to use the service.

At the practice we have already had a substantial return on effort and time spent because the planning stages of this initiative formed a major element of our mainstream asthma management. We developed and trialled the remote consultation in paper form and have used this as major component of asthma management ever since.

Because we had taken a step wise approach to the development of this initiative, we were able to estimate the impact on patients. We had received positive feedback from patients about the convenience of not having to come in to see the asthma nurse face to face.

We are geared up to different types of consultation which meant that there is no immediate impact on staff. We have planned for the asthma nurse to be able to respond timely to patient initiated remote consultations as part of our complete asthma management service. Although feasibly this may have put additional strain on our already stretched resources the more longitudinal result of better controlled asthma and fewer exacerbations would mean reduced demand for acute appointments together with the necessary follow-up appointments.

Measurable outcomes
Our future asthma audits will in time provide us with our own statistics, which would reflect the impact of the remote consultations. For example:

• Numbers of acute exacerbations
• Numbers of admissions to hospital

How we would spend the prize money
The work so far on this initiative has been done without additional resources or funding from the practice team, and the prize money will be spent to help us progress in these areas of patient self care and on line reviews of long term conditions in the following ways:

1. To fund further development of the existing online asthma consultation product to enable automatic READ coding into the patient record
2. To fund replicating the on line asthma consultation for other long term conditions, for example COPD and diabetes, and for health promotion and screening.
3. To fund creating a private area, with suitable IT hardware and internet connection, for patients to access our on line services in our surgery building (i.e. aimed at those patients who do not have a PC at home but do not require an appointment)

Kathryn Hargreaves
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Ed. This won the first prize in the NHS Leadership in Health Informatics Accolade Scheme 2007. Details about all ten shortlisted entries can be found at http://etdevents.connectingforhealth.nhs.uk/eventmanager/uploads/accolades_brochu_20071.pdf

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The ASSIST National Conference

My name is Diane Dawson and I attended the ASSIST national conference in Leeds on 22 May 2007.

There were exhibitors present at registration. One of them is UKCHIP (the UK council for health Informatics Profession). It invites us to apply for registration, there is a cost involved.

The opening address was given by Andrew Haw ASSIST chairman. He stated that things were going well. This is always good to hear. He advised that users be involved in the projects for best results. He said it is best to take a measure of the present system prior to implementation. This shows results obtained after implementation.

The next speaker was Richard Grainger the Chief Exec of NHS Connecting for Health. We were showed the new hand held computer that can be used on the wards. It is portable and wipe clean. The keyboard is a special new design it can be cleaned free of bacteria and germs with one wipe of a cloth. Normal keyboards are known to harbour germs so this is important for ward use and use in contaminated areas. It is a powerful and high spec design and has the state of the art capability but is also light weight and easy to carry.

Lord Phillip Hunt was the next speaker. He is the minister of state for quality, department of health. He went through the work that has been achieved by Connecting for health. He believes that there has been a huge amount of progress.

The next speaker, Dr Denise Lievesley, Chief Executive of The Information Centre for Health and Social Care said they are developing a kite mark for quality data.

After lunch I attended a workshop, “Café Society”. We were requested to discuss “the top 3 or 4 most challenging issues facing Health Informatics teams or services today”. The issues mentioned were:

- Privacy and confidentiality and security, i.e. the data protection act and illegal use of health data records.
- Relating data quality to patient care.
- Public perception of the role of health informatics.
- Resources, are they available?

Then came the 2007 Accolades Awards. One in particular caught my eye. PACS Museum Builder. This is a web based tool for teaching readers of x ray films the difference in using films and digital results. My department is radiology and the department are still using x ray films but are moving to digital in the future.

The next speaker was Bernard Crump the Chief Exec of NHS Institute for Innovation and Improvement. This is something that sounded very supportive and I will be looking at the web site to find out more about them.

Then after thanks to Andrew Haw the conference closed.

Diane Dawson one of the recent entrants to health informatics at the annual conference.
Quality and Patient Safety - a Minister's view

What was interesting about Lord Hunt's presentation to HC2007 was his focus on IT helping to raise the quality of patient care and improve safety. He also predicted that all pillars of the national programme would be implemented by 2010.

He commented the NHS has moved from being run centrally to more local management providing choice. Local management teams have incentives to perform and there is effective commissioning. This is held together as a national service by:

- National standards;
- Regulation by the Health Care Commission;
- Money following the patients, and;
- IT underpinning the information flows.

There is a need for the national programme to be centrally driven so that the change would be delivered within the required timescale. Now that we have got that change the programme can be devolved but NHS Chief Executives and boards need to see IT as a top priority. Although it was not explicitly stated it was implied that funding for IT-enabled service improvements should not be plundered for a quick fix of an immediate problem in the way they were prior to the national programme.

Lord Hunt said that they had learned that they had tried to do too much too quickly and the programme is focusing on those areas where there would be the greatest benefit with immediate impacts.

The message that the national programme is about patient safety was repeated at the ASSIST annual conference in May. At the annual conference Lord Hunt compared the current expenditure on the national IT programme with the public health measures of the nineteenth century. It is clear that he is one of several influential people who expect the use of IT in health care to transform the health of the nation in a similar way to the introduction of clean water, the safe disposal of sewage and the removal of rubbish did in the Victorian era.

At the annual conference Lord Hunt thanked the practitioners for their efforts implementing the national programme and stated that it is crucial to deliver:

- 18-week referral to treatment times;
- the choice agenda;
- practice based commissioning
- integration of services both within the NHS and with other caring services;
- safe patient care.

He noted that some critics of the national programme had said that it should all be stopped. Given its breadth and wide-ranging impact, this could only harm patient safety.

In answer to a question about the relevance of the national programme for mental health, he was able to list several initiatives that are being taken to improve those services but did not demur from the statement that the national programme is primarily focused on primary and secondary care rather than mental health.

John Leach

Benefits of ASSIST Membership

There are a range of benefits of being an ASSIST member. Many of us avail ourselves of some but not all of them. That might be an explicit choice but often it could be due to lack of knowledge about the range of benefits available.

ASSIST arranges a series of educational seminars and conferences to help members with their professional and career development - see forthcoming events at the end of this newsletter. As ASSIST members we have admission to the Institute of Healthcare Management IM&T forum on the same terms as their members. Further there is a discounted subscription rate to the British Journal of Health Care Computing and Information Management. The free networks on www.informatics.nhs.uk which include various health informatics special interest groups are often led by active ASSIST members.

The partnership arrangement with BCS means that ASSIST members are also affiliate members of the BCS. This brings the following additional benefits:

- The BCS Online Library - Free access to relevant IT related information whenever you need it. Members get access to EBSCO databases - a range of journals and magazines on the subjects of IT, Science and Technology. Two new Forrester IT related research reports each month as well as access to a range of 200 IT related e-Books from Books24X7.
- Career Development Services - Free access to SFIaplus3 the most accepted and widely adopted IT skills, training and development model. SFIaplus3 allows you to identify career paths and plan training and development.
- Information Services - Free subscription to "ITNOW" the BCS membership magazine and "eBCS" the weekly IT newsletter. Members also benefit from discounts of up to 25% on a range of topical books that span the boundaries of IT and management.
- Events, Lectures and Seminars - BCS Affiliates have access to an extensive range of additional local and national events that ensure members stay up to date with the latest IT developments.
- Exclusive Member Offers - Massive discounts on Microsoft software (personal use only). Extensive discounts also on Macromedia and McAfee products and IT publications from leading suppliers.

Access to these BCS affiliate member benefits can be gained via http://www.bcs.org/server.php?show=nav.5787 and this link is also available from the ‘Join ASSIST’ web page.

Members also receive “ASSIST News & Views” (this newsletter) and there is an opportunity for reduced membership fees for the first year of ASSIST members becoming full members of the BCS.

John Leach
International Conferences

One of the benefits of technology is that it can transform the way we do business. This includes increasing access. An area that could benefit from transformation is conferencing. All too often it is the fortunate few who are able to attend when many more people in an organisation would benefit from listening to one or two sessions. This is even more pronounced with international conferences which incur additional travel and hotel costs.

It may be necessary for a few people to travel to an international conference location but many people could attend a satellite session, or sessions, from their home country as, for a similar expenditure, conferences were run in multi-centres. In doing this they would save on travel time, travel costs and hotel accommodation.

At each centre people could network and continue to discuss presentations informally as well as debating issues of concern that they were tackling in the workplace. The people attending these satellite conference sessions would have to shift their working day to that of the principal conference site but they would have to do that if they attended the main conference.

With video-conferencing questions could and should be taken from all of the sites on which the conference is being held. Those people who wished to be in “attendance” for only one or two sessions could do so from their workplace though perhaps discussion technology has yet to advance sufficiently to be practical. For some people it may be useful to follow the events at a later time; this would be particularly useful if the main conference is in a different time zone.

The health informatics community is often seen as enabling transformational changes to be inflicted on other people. Conferences are an opportunity to lead by example. The health informatics community in the UK should establish a location for a British conference centre for use by future international conferences with video-conferencing and other technology.

I am pleased that National Council has endorsed this proposal. There is now a task of convincing BCS HIF that this should be pursued, so that more people can participate in these conferences. An additional bonus is that it will reduce our collective carbon footprint.

John Leach

AGM

The crucial element of the 2007 AGM was the review of the association’s partnership with the British Computer Society (BCS). National Council had undertaken a survey of all members, asked for the views of branch committees and considered its own experiences before making a recommendation to members at the AGM.

It has been a tumultuous year in terms of the bringing together the administrative routines of the two organisations. ASSIST did not receive regular budgetary information. This caused National Council to act with budgetary prudence and curtail much of the activity that it had planned. Surprisingly this resulted in an under spend over the year which could have been avoided. However this has now been remedied and National Council plan to deliver more activities and benefits to members during the coming year.

Another issue that is being addressed is the amalgamation of the ASSIST membership database with that of the BCS. This has been more problematic than anticipated but is now being addressed with vigour and determination. Carole Archer, who is the treasurer of the Yorkshire branch, has been co-opted onto National Council to help work through the necessary business processes.

The resolution that ASSIST continues the relationship with the BCS with National Council reporting to the 2008 AGM with a review of its functioning was carried unanimously.

Andrew Haw has served for three terms of one year as chair; this is the maximum allowed under the constitution. He continues to be a member of National Council as the immediate past chair. Brian Derry was elected as chair, Simon Anderson, Ian White and Adrian Purcell were elected as three vice chairs whilst Rupert Davies was re-elected as treasurer and Pam Hughes as secretary for National Council.

John Leach
Fostering independence through personal tele-health solutions

David Whitlinger described, at HC2007, how the Continua Health Alliance is developing a personal health eco-system where many diverse vendors can combine their products into new value propositions. This effectively means that there is an attempt to set interoperability standards so many vendors can collaborate to bring products to the market place and lever the benefits and cost reductions associated with volume production. The alliance was formed in mid 2006 with 22 companies participating; now more companies are interested and are participating.

He outlined three areas where such cooperation could underpin services that rely on remote monitoring:

1. Health and Well Being, where vital signs (e.g. weight, glucose, blood pressure) would be monitored so there were baseline measurements.

2. Disease Management, where vital signs would be monitored, which would result in early intervention to adjust treatment and reduce the number of "frequent flyer" admissions to hospital.

3. Aging Independently, which will provide reassurance for older people and their children, next of kin and friends that they are well and nothing untoward has happened. If there is an incident help could be quickly dispatched.

The idea is that the monitoring equipment would be consumer electronics friendly yet the standards would allow interoperability between various pieces of equipment. Many items of consumer electronics already have functionality that many owners do not use. In future some of the functionality of equipment (e.g. phones, digital TV, electronic scales) could provide remote monitoring functionality. The products would work “out-of-the-box” and cost savings would come with volume production.

Eventually there would have to be government regulation; not to restrict the market but to ensure that the devices are safe. The industry needs to work on the re-imbursement model so suppliers have confidence there will be a return on investment.

It emerged during the discussion after the presentation that the Continua Health Alliance is focused on the interoperability of the devices at a machine level. The ontology of the data they pass between them and its meaning is another issue. Both of these issues will eventually need to be addressed, however it will be a great advance if in a few years time we are able to use consumer electronics to monitor people’s health remotely and provide them with greater freedom, flexibility and independence than at present.

John Leach

Dirty Data Costs time and Money

Those members who spend their working lives grappling with information governance might occasionally be tempted to look over the fence to see how other people tackle similar issues. ‘The answer is, with as much difficulty, if an article’ in the newsletter of the Operational Research Society of 21 March 2007 is to be believed.

This reported that a survey by Gartner (an analysis and consultancy group) found that 25% of the critical data used by Fortune 1,000 companies is flawed. This dirty data will cost businesses time and money!

Gartner expects that three-quarters of large enterprises will make little to no progress towards improving data quality until 2010. However, it seems companies are now discovering that data quality has a significant impact on their most strategic business initiatives, not only sales and marketing. Other back-office functions like budgeting, manufacturing and distribution are also impacted.

Further it recommends that organisations should consider creating “data stewards”; that is people who are responsible for the quality of the data.

It struck me that the NHS is ahead of US private companies on this issue. If the NHS were operating in a truly competitive environment it would be selling its expertise to private companies.

John Leach

Commissioning Specialist Services

Jon Develing and Phil Hayward described the arrangements that are in place to commission specialist services and the reasons for these arrangements to the annual HfMA ASSIST conference in the North West.

Specialist services are those that serve a population of more than one million. There was pressure from many special interest groups (e.g. renal care, cancer research) that payment by results (PbR) would destabilise specific services, such as renal services, specialist mental health and tertiary cancer care. There was an independent review performed by Sir David Carter that was published in 2006. This recommended that ten specialist service groups (SSGs) be established that are coterminous with the strategic health authorities (SHAs) but working for the PCTs.

Nationally 8% of NHS expenditure is spent on specialist services though in the North West it is between 9% - 10%, partly due to the presence of Ashworth Hospital within the region. This is equivalent to £36.2m per PCT or £127 per capita per annum.

The expenditure on the 6 biggest specialist services in the North West is as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>% of expenditure on specialist services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist mental health</td>
<td>18%</td>
</tr>
<tr>
<td>Tertiary cardiac services</td>
<td>18%</td>
</tr>
<tr>
<td>Tertiary cancer services</td>
<td>16%</td>
</tr>
<tr>
<td>Specialist children’s services</td>
<td>15%</td>
</tr>
<tr>
<td>Renal</td>
<td>11%</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>8%</td>
</tr>
</tbody>
</table>

The issues include:

- Access to data, as the SSG is not statutory, it is not entitled to relevant data and there are cross boundary flows that affect the viability of provider units;
- Data quality;
- PbR is destabilising for specialist children’s services;
- Value for money for each PCT when the per capita spend is contrasted with the need for services.

The agenda for the SSGs revolves around:

- Ensuring that (expensive) treatments do not drive out prevention;
- Funding developments that have been approved by NICE.

There is a need to know the population who will need specialist services. For example 30% of people who will ultimately require end stage renal care are known within the health care system yet the service is so chaotic that they are not on a pathway that might prevent the need for such care in the future.

John Leach

National programme in the North West

Alan Spours provided an update of the national programme in the North West to the annual HfMA ASSIST conference in Blackpool. The initial phase has largely being about getting the infrastructure in place on which to build; replacing legacy PASs with an iSOFT product from CSC Alliance. However the strategic product (Lorenzo) is not yet available and will not be until 2008. There is now a need to concentrate on delivering benefits to the clinical staff.

After a shaky start the implementation of PACS has been successful in terms of bringing such benefits to clinical staff. It will be rolled out to all acute trusts by the end of the calendar year.

During the next two years the focus will be on implementing ICM an interim strategic clinical information product, so the clinicians at least have access to electronic orders and results, clinical letters and gain some benefits. There is a need to link this with other products from CSC Alliance and with legacy systems. There is also a need to resolve what the national programme means for GPs in terms of providing them with either a Lorenzo product or a system of choice. There is also a need for convergence between the two parts of the programme (secondary and primary) and clarity for GPs.

John Leach
**Forthcoming Events**

### National

- **11 June 2007**, 1.30pm - 5.15pm, Royal Statistical Society, Health Statistics User Group Conference, “Are GP data fit for good PCT and Practice Based Commissioning?” RSS, 12 Errol Street, London, EC1Y 8LX

- **12-13 June 2007**, Primary Health Care Specialist Group, Summer Conference, Heythrop Park, Oxfordshire. See www.phcog.org.uk


### London & SE


  **Note:** The July Health Informatics Forum seminar has been cancelled


- **27 September 2007**, 5.30pm (refresherments) for 6pm. Speaker to be confirmed, Health Informatics (London and South East) Specialist Group at BCS, 5 Southampton Street, London. http://www.hils.esg.bcs.org.uk/events.htm

- **2 October 2007**, 12.30pm for 1.30pm. End: 4pm. Health Informatics Forum seminar at BCS, 5 Southampton Street, London, WC2E 7HA. To reserve your place, email: christine.mayes@hq.bcs.org.uk

- **22 November 2007**, 5.30pm (refresherments) for 6pm. Speaker to be confirmed, Health Informatics (London and South East) Specialist Group at BCS, 5 Southampton Street, London. http://www.hils.esg.bcs.org.uk/events.htm

- **17 January 2008**, 5.30pm (refresherments) for 6pm. Speaker to be confirmed, Health Informatics (London and South East) Specialist Group at BCS, 5 Southampton Street, London. http://www.hils.esg.bcs.org.uk/events.htm

- **22 January 2008**, 12.30pm for 1.30pm. End: 4pm. Health Informatics Forum seminar at BCS, 5 Southampton Street, London, WC2E 7HA. To reserve your place, email: christine.mayes@hq.bcs.org.uk

### North West

- **6 June 2007**, 6.15 pm for 7pm., Health Informatics (Northern) Specialist Group, AGM + Smart Garments, Manchester Conference Centre, University of Manchester, Sackville Street Campus, Manchester, M1 3BB. http://www.bcs-nmsg.org.uk

- **Wednesday, 20 June 2007**, ‘PACS Site Visit’, 2.30 p.m., Countess of Chester Hospital (preceded by ASSIST Branch AGM)

  This event will be hosted by Margaret Cosens, PACS Project Manager and Dr Robert Etherington, Consultant Radiologist at the Countess of Chester NHS Foundation Trust, who will describe how the Trust planned for and implemented the first live NHS Connecting for Health PACS Project in the North West and West Midlands Cluster, the business benefits to the Trust from PACS and speech recognition technology, and the improved patient experience. There will be an opportunity to see PACS in action on site.

  Picture Archiving and Communications Systems (PACS), which enable images such as X-rays and scans to be stored, communicated and viewed electronically, are being rolled out throughout the North West and are expected to contribute to healthcare improvements by delivering more efficient imaging processes. The NHS Connecting for Health PACS rollout is being hailed as a success but some issues are still being raised by staff affected by it. This event provides an opportunity to hear first hand how to implement and benefit from a PACS project, drawing on the experiences and lessons learned at Chester.

  To book onto this event, please go to the following link and select ‘book me onto this event’. http://www.nmconnect.nhs.uk/profile/events/showevent.asp?id=560&catg=IMT. The links can be followed from the NW pages of the ASSIST website.

- **Thursday, 12 July 2007**, ‘NHWS NPM - COINs, Wireless and New Technologies’ 2.00 p.m., Wrightington Conference Centre This session will cover the following topics:

  COINs in the North West – different approaches: Gus Harlley (North West SHA) and John Billington (North Mersey HHS) – joined for a panel Q&A session at the end by Anne-Marie Jones (North West SHA, ex-Greater Manchester SHA) and Stephen Brooks (St Helens & Knowsley HHS)

  The Vocera wireless project at Royal Liverpool Hospital (case study): Tom Lanigan, IT Manager, Royal Liverpool and Broadgreen University Hospital Trust

  New BT developments for NHS infrastructure (N3, VOIP, etc): Paul Mason, Dave Smith and Bill Cookson, BT Health and Rachel Duncombe, NHS Connecting for Health and Mike Hampson, N3 Cluster Manager – North West, NHS Connecting for Health.

  To book onto this event, please go to the following link and select ‘book me onto this event’. http://www.nmconnect.nhs.uk/profile/events/showevent.asp?id=554&catg=IMT. The links can be followed from the NW pages of the ASSIST website.

- **Tuesday, 11 September 2007**, ‘Informatics and the 18 week wait - Follow up workshop’, 1.30 p.m., Wrightington Conference Centre

  Professor Denis Pronti returns for his annual lecture to the North West ASSIST Branch, where he will facilitate an interactive workshop based around Informatics and the 18 week wait target. Further details will be available in due course.

  To book onto this event, please go to the following link and select ‘book me onto this event’. http://www.nmconnect.nhs.uk/profile/events/showevent.asp?id=560&catg=IMT. The links can be followed from the NW pages of the ASSIST website.

### Midlands

- **27 June 2007**, Microsoft – common user interface; NHS WARP – neighbourhood watch for NHS IT security; Fujitsu – NHS and the business benefits to the CBL social care integration, Branch AGM at Trinity Park near National Exhibition Centre, sponsored by BT.