DIGITAL DICTATION
Reporting on the benefits of digital dictation and speech recognition

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Examining the benefits of training staff in the health informatics environment.
The summer holidays are over and there is definitely a touch of autumn in the air – it’s time to get down to work.

We have a mixed bag for you in this issue – or perhaps I should say a cornucopia - which we hope will delight.

In previous issues we have described some of the changes to BCS Health. In this issue Chair of BCS Health, Matthew Swindells, sets out priorities for the coming year based on work by the group’s strategy community under the leadership of Dr Justin Whatling. A new government means yet another new opportunity for the NHS to get benefit out of its information systems. Will it take that opportunity? Matthew and his colleagues would be pleased to hear your views. You can email us via the editor at HINOW (see below for the address).

Digital dictation and telecare
The Northern Specialist Group has been active as always. In this issue, Phil Paterson reports on two of their recent meetings. The Clinical Advisory Team gave a roundup of some of the successful clinical informatics projects in the North West. In the second report, benefits being achieved from various types of digital dictation technology are described.

Keith Nurcomb gives a personal view on why telecare and telehealth have not delivered the benefits that should be available. He goes on to describe what might be done about the situation. We also have an article by Michael Bewel describing how coaching might help the health informatician in their professional and personal development.

Last, but not least, Philip Scott reminds us that lack of evidence does not necessarily mean lack of benefit. He explains why the evidence is lacking: few people are keen to carry out the evaluation that they have set out in their original plans, publications on the topic are poor and the academic literature describing robust evaluations is not readily accessible. Philip explains what might be done to improve the situation.

And don’t forget to check out the events section for BCS Health specialist group meetings coming up.

Sheila Bullas, Editorial Board Leader, HINOW, provides a glimpse of what’s in store for this issue.

HINOW provides an opportunity for you to exchange views or present your work. You might feel moved to submit an article or write to the editor. We are keen to hear from you. What do you find most interesting about HINOW and what would you like to see in future issues? Contact: justin.richards@hq.bcs.org.uk
The Northern Specialist Group reports on the use of digital dictation and speech/voice recognition in a number of hospitals around the UK.

Matthew Swindells, Chair of BCS Health, sets out the priorities for the coming year based on work by the Health Forum’s strategy community.

Philip Scott, University of Portsmouth, explains why the evidence for good health informatics is lacking and asks what can be done about it.

Keith Nurcombe, O2 Health, explains why he believes telecare and telehealth haven’t delivered yet.

Michael Bewell, Go MAD Thinking, takes a look at the benefits of coaching staff in the health informatics arena.

Phil Paterson reports on the Clinical Advisory Team’s roundup of some of the successful clinical informatics projects in the North West.

A roundup of forthcoming events.
The ability to monitor hospitals’ performance has perversely led to a decline in public confidence in the NHS, according to Matthew Swindells.

Matthew’s recent comments in National Health Executive coincide with a belief in BCS Health for the need for a mature and honest debate about the growing pains of the information revolution inside the NHS. Increased accountability, such as the opportunity to see mortality rate data, has resulted in higher standards of care.

However, the public’s positive view of the health service has in all likelihood diminished as a result of the statistics being published, said Matthew. Information has become a double-edged sword when it comes to administrative data, he believes.

He said: ‘On the one hand, we now have the ability to use data to track the performance of NHS trusts with regards to things like mortality rates and this has enabled the public to hold the NHS to account far more effectively than ever before. Perversely though, this has probably led to a reduction in public confidence in the health service.

Although the debate around the implementation of the national patient records system has tended to dominate the impression of ICT in the NHS, the last 10 years have yielded many advancements in administrating healthcare.

Matthew predicted that the next decade will see the use of ICT to identify and target patients, allowing clinicians to intervene earlier in their disease or risk profiles in order to keep them healthy, as opposed to reacting to when they fall ill.

Another advance will be allowing patient records to follow the patient, rather than it being the other way around.

Although this would enable care to be delivered in a more convenient way, he acknowledged that safeguards must be in place to ensure the quality of data.

He said: ‘You really do need to ensure that clinical information can move seamlessly around the patient. Otherwise you will have patients being treated in convenient settings, but in an unsafe way.

The future of Dr Foster Intelligence is under review

According to the DOH, one of the UK’s main providers of information, analysis and targeted communications to health and social care organisations is under review.

The review will explore strategic options for the future of Dr Foster Intelligence. This follows the recent white paper ‘Equity and Excellence: Liberating the NHS’, which stated the government’s commitment to the introduction of an NHS information revolution, providing patients with quality information and data on all aspects of healthcare.

Combined with the right support, the aim is to increase the use of healthcare informatics to create better care, outcomes and reduced costs. The review will ensure that Dr Foster Intelligence is best placed to meet this challenge.

Dr Foster Intelligence was launched in 2006 as a joint venture between the NHS Information Centre and Dr Foster Holdings LLP. The NHS Information Centre transferred its shareholding to the Department of Health on 9 July 2010.

This review is in line with the government’s policy to maximise the value of assets and commercial opportunities as explained in the findings of the Arm’s Length Bodies Review.

Health Minister Simon Burns said: ‘In the white paper Equity and Excellence: Liberating the NHS, we set out a vision for an information revolution to give patients greater choice and control. We will publish our information strategy paper in the autumn. This review will ensure that the Department of Health is making the most of Dr Foster Intelligence.’
The new NHS Wales internet site launches successfully

The new Health in Wales bilingual website provides a single point of access for those seeking information about the health of the people of Wales and information about the health and social care services provided by NHS Wales.

www.wales.nhs.uk is designed to complement NHS Direct Wales, which provides information for individuals and their dependents on personal health and health service needs.

The website has been developed and will be supported by Public Health Wales in partnership with a web team that is part of NHS Wales Informatics Service.

Among the main objectives of the site are to promote public and patient understanding of the NHS in Wales and to signpost opportunities for public and patient involvement in the NHS in Wales.

The website was officially launched in March 2010 and has since been running successfully alongside the HOWIS (Health of Wales Information Service) internet – the website it was intended to replace. This has allowed time for full testing to take place.

A SUCCESSFUL LAUNCH

Delivering dictation and document management in Suffolk

West Suffolk Hospital has elected SRC to deliver trust wide digital dictation and document management.

SRC, recently announced it is completing a trust wide deployment of the Winscribe digital dictation system to 350 users, across 29 specialties at West Suffolk Hospital (WSH).

As well as deploying digital dictation, SRC is also providing a full integration with the Trust’s Clinical Correspondence system. The system, which has been developed by strategic partner Bluewire Technologies, is already deployed and supported throughout the trust by SRC.

By integrating digital dictation and clinical correspondence, SRC is providing the Trust with a complete document management solution. Clinicians can create new dictations whilst reviewing patient details from within an application that complies with Microsoft Health CUI standards for patient safety. Dictations, along with patient, hospital and GP data are then automatically sent to secretaries for completion. Draft documents can then be electronically reviewed, approved and delivered to the GP or the end recipients. The solution also provides the trust with a full document repository and audit trail facility.

Nick McDonnell, Head of IM&T, WSH said: ‘In two months, the solution has enabled us to cut turnaround times in cardiology and ENT by 2.36 days on average per letter. At the current rate of improvement, we predict turnaround times will be reduced even further by the end of 2010.’

A COMPLETE SOLUTION

Renal database

Russells Hall Hospital is benefiting from greater efficiency in renal patient management with the installation of new specialist software. The eMEDRenal application from Mediqal H.I. was installed as part of Dudley’s 15-year IT services Managed Equipment Service (MES) agreement with Siemens Healthcare.

Siemens Healthcare and Mediqal H.I. worked to ensure the smooth implementation of the software, which is a clinical patient database for renal specialities. eMEDRenal manages patient information from first referral through to dialysis, treatment and transplants.

Technology at core

A consortium of 10 NHS Trusts has put technology at the heart of accelerated progress towards ‘cost per patient’ spending control, in line with deficit linked public sector budget cuts.

County Durham & Darlington Foundation Trust is extending its web-based e-procurement platform to 6,000 users and 3,000 suppliers, adding e-auction capabilities and planning online supplier management.

Full integration of its web3 best of breed procurement solution with Oracle Financials, allows this procurement organisation the freedom to use advanced purchasing technology with seamless internal process. This is the latest stage in the culmination of a targets led 10 year plan to increase spending efficiency at CDDFT.

Motion sense

Motion sensing technologies, such as the Nintendo Wii Remote, could be used in the rehabilitation of people with aphasia – a language impairment, often caused by a stroke.

The research is being carried out at City University London, in collaboration with The Stroke Association and funded by the Engineering and Physical Sciences Research Council (EPSRC). The aim is to develop an affordable, computer-based technology to help stroke survivors, who have limited spoken or written output, learn how to ‘gesture’ independently at home. The project will create a prototype system that enables users to practice.
The speakers at the Group’s meeting in February were Margaret Cosens, then at NHS Connecting for Health and previously Programme Manager at The Countess of Chester Hospital, and Keith Richardson, PACS, DD and VR Lead, Chief Information and Knowledge Office, NHS North West.

Margaret Cosens led a project at the Countess of Chester Hospital to implement speech recognition in radiology. The results far outstripped expectations and led to other hospital clinicians asking to be included in the implementation. She contended that NHS trusts now have a tool available to:

- reduce turn around times;
- help deliver the 18-week and other waiting times;
- reduce administrative costs – by a great deal;
- free up skilled staff;
- enhance the delivery of high quality patient care.

Keith Richardson is leading a project across the North West to promote the digital management of correspondence [clinical letters, workflow, digital dictation, voice recognition and electronic discharge management] in all 63 acute, mental health, and community trusts. Keith spoke about the current usage in the North West and the scale of the benefit that could be realised within the context of QIPP (quality, innovation, productivity and prevention).

Margaret Cosens demonstrated speech recognition by speaking to the audience and giving control commands to the computer alongside her, such as ‘Open’ and ‘Close’. The software included Microsoft Word and Outlook. Her words appeared on screen in a Word document immediately after she had spoken them. This demonstration was performed using Talking Point software. One of the control commands is ‘change language’ which allows the user to switch from plain English to special terminologies such as clinical terminology for radiology reports.

Margaret started on digital dictation and speech recognition at the Countess of Chester Hospital where speech recognition was deployed as part of the PACS (Picture Archiving and Communications System) project. The Speech Recognition System linked the PACS with the Radiology Information System (RIS) and became a treasured tool, providing the rare combination of clinical benefit and business benefit.

The Countess of Chester Hospital was the first in the North West and West...
The workload for the remaining staff went up in terms of numbers of reports each, but with digital dictation and speech recognition making the job so much easier there were no objections.

Business benefits were achieved through a big reduction in staff costs. The annual cost of radiology department staff to type reports, etc was reduced from about £120,000 pa to £45,000 pa. Secretaries left naturally, but were not replaced. The workload for the remaining staff went up in terms of numbers of reports each, but with digital dictation and speech recognition making the job so much easier there were no objections.

Take up
Digital dictation users have got a mix of two products, Winscribe and Talking Point. Take-up was fast and there was a 30 per cent saving in costs. The speech recognition take-up was slower. The key to the success of speech recognition was PACS. Speech recognition suddenly became beneficial as radiologists could write their own reports alongside the scanned patient images in their own office.

The hospital moved on to hospital-wide digital correspondence, the principal drivers being:

- to reduce the time for key clinical information to get to GPs or other requestors to within 24 hours;
- to release senior secretarial staff to manage patient care activities and the overall business;
- to reduce staff costs by providing support for typists.

The Hospital uses MedisecNET, which captures clinical letters from PAS (e.g. outpatient clinic letters) and sends them to over 100 GP surgeries in Cheshire. The implementation rollout needs handholding, personal support, and encouragement to clinicians. Speech recognition results in reports being ready the same day, at the end of a clinic, produced and signed off by the clinician. Digital dictation results in letters being signed off a few days later, but it too speeds up the typing process.

There are challenges:

- funding for the products and the people – needs a commitment to support the implementation before the benefit is delivered and to the ongoing, recurring costs, as well as finding the capital;
- vision – letting others catch it, the heart of change management;
- time – resisting the pressures to pull away from it.

The big positive is that the technology works and, with a robust approach, every trust could reduce their turnaround times, help deliver waiting time targets, reduce administration costs by a great deal, free up skilled staff and enhance patient care.

Transformational projects
Keith Richardson explained that he was now working at the NHS Northwest Strategic Health Authority, but that he had also worked at the Countess of Chester Hospital and was a supporter and enthusiast for digital dictation and voice recognition. This area has been identified by NHS Northwest as one of the ‘Top 10 Transformational Projects’ under the QIPP Programme.

The NHS in the North West produces about 15 million letters per annum, about half of which are dictated by a clinician. Some 63 NHS trusts communicate with 1,315 GP practices which receive an average of 5,750 clinical letters a year each, or 110 per week.

The consequences at the GP practice are that practice staff currently spend about five hours a day processing and scanning paper clinical letters received from hospitals into their GP computer systems. In the North West that equates to 812 staff, costing about £16.25 million a year, simply processing hospital-generated paper.

The consequences for hospitals are that staff are employed stuffing envelopes at a cost of about £60,000 a year per hospital. About 75 per cent of letters are sent with hospital transport such as the pathology tests pickup van but the rest are posted – costing about £1 million a year per trust for postage.

One option is to try to move the trusts and GP practices to improve on the traditional, paper-based process. Digital dictation offers more methods for dictation, at the office or home or on the move, with reports going onto a computer network, with an interface to PAS for demographics and reference data, which gives more options for typing – again at the office, home or remote. After initial transcription what is required is an editor more than a typist, who can email a
Digitised reports and letters enable the concept of an integrated clinical communications hub between hospitals and GP practices, routing electronic letters to the right place.
The publication of the white paper, ‘Equity and excellence: Liberating the NHS’ in July 2010 promised ‘an information revolution’ to drive better care and reduce cost. It also promised an information strategy for the NHS, which is being written at the moment, due for publication in the autumn.

This presents an opportunity for the NHS to adopt an approach that places information at the heart of transforming the delivery of health care, the planning of health services and, perhaps most importantly, the empowerment of patients to take control of their own health, the care they receive, and to hold the NHS to account.

BCS Health wants to place itself at the forefront of this revolution. We see the government wants to build its information revolution is not of as high a quality as we would want. However, BCS Health believes that the only way to improve data quality is to expose it to clinicians, managers and the public. However, this is a risky approach, with the potential that the public or media may jump to conclusions that can’t be sustained by the data.

BCS will proactively try to smooth progress and build an understanding in the NHS, the supplier community and the public, anticipating and expecting that information will be wrong at first, but that we have to work through that phase to get the benefits, without a witch hunt.

We will also support the creation of a robust information governance and consent policy – no one has yet achieved this and it is critical to progress.

2. Driving integration and interoperability through opening up systems

Alongside open information comes the need for open systems. The redesign of health systems, optimising care pathways and delivering more care outside hospitals will all require collaborative working between institutions and the sharing of information. This cannot be done by simply standardising the software vendors; it will require integration and interoperability.

BCS will encourage the mandatory use and publication of interfaces (APIs) for all informatics systems used in the NHS. BCS will pragmatically support the use of existing standards to release rapid benefits.

3. Patient engagement and self service

The step change in productivity that the NHS needs will require patients to become more involved in managing their own illnesses and reducing their health risk. Patients will expect and need tools for self-service of the same standard that they see in other sectors. BCS will help articulate the value proposition for patient engagement, helping them understand the benefits and risks and enabling them to take a balanced view on their level of engagement.

This is an exciting agenda for informatics professionals in health. BCS will be doing its best to advise the government, support the NHS and develop informaticians to meet the challenge. I hope you will look for ways in which you too can contribute.
Firstly, only a small proportion of informatics innovations in the NHS are properly evaluated or reported. Even though standard project management methodologies include post-project reviews, it is common knowledge that they seldom occur and, even more infrequently, get placed in the public domain. We call this the missed evidence problem.

Secondly, the academic literature is not readily accessible to policy makers and service managers due to its volume and sometimes impenetrable discourse. The purpose of some academic publication seems to be more about satisfying research-counting exercises than disseminating knowledge. We call this the lost evidence problem.

Thirdly, the published research evidence in health informatics is of variable quality and limited provenance. One literature review noted that approximately 80 per cent of the evidence base is from the USA, of which about 27 per cent is from six leading institutions with decades of experience with home-grown systems. Along with the complex nature of the healthcare environment, this has prevented the robust inference of general recommendations. We call this the incomplete evidence problem.

We suggest that there are two key weaknesses underlying all these evidence problems.

Knowledge-sharing culture
There is an active community of health informatics academics and practitioners who voluntarily share knowledge through publications, events, websites and professional associations. However, it must be acknowledged that it is often more or less the same group of enthusiasts who are seen populating conference programmes and organisational committees across BCS, the Faculty, ASSIST and UKCHIP. Outside this relatively small group of volunteers, there is not perceived to be much incentive to share knowledge.

Evaluation standards
The principal standards now competing for the support of the international health informatics community are STARE-HI, adopted by the International Medical Informatics Association (IMIA) and the
Informatics Marketplace in Bristol and the annual Southern Institute of Health Informatics conference in Portsmouth are good examples. Another approach worth considering is to disseminate knowledge packages by clinical pathway or specialty. The idea is that, by linking the informatics evidence to a particular clinical need or area of practice, it becomes more relevant and therefore more likely to be well received and acted upon.

The February 2010 national e-prescribing forum was an exemplar in this respect. Over time, this might lead to the development of health informatics sub-specialties to strengthen and consolidate expertise and help to avoid information overload.

Evidence repository
An important tool to support knowledge dissemination is a central resource to index and access relevant evidence. The UK Faculty’s research repository has been established for this purpose and offers a good opportunity to build a recognised and trusted evidence base.

There needs to be debate about governance and access rules to the repository so that it balances openness with protection of commercially sensitive or organisationally embarrassing information that otherwise might never be seen at all. The repository should aim to be more than just a cupboard of reports. Actively gathering, documenting, quality reviewing and disseminating the evidence and evaluating the effectiveness of its communication requires adequate resourcing. This would require further work to develop a business plan for an ‘evidence service’ for health informatics. Eventually, this may migrate to become a specialist collection within NHS Evidence.

Professionalism
Health informatics is an unregulated profession in the UK and therefore has no mandatory educational requirements for practitioners. Educational standards have been proposed by IMIA and minimum professional standards have been proposed by the UK Council for Health Informatics Professions.

As long as these standards are merely aspirational, anyone can work in and manage health informatics regardless of their lack of specialist knowledge. This seems likely to reinforce the vicious circle of uninformed, unevaluated projects. We believe that awareness of the evidence of what has not worked in health informatics is crucial and emphasises the need for at least a minimum educational requirement.

Education, training and development
We believe that to build the professional capability and capacity needed in UK healthcare there is need for further promotion of health informatics education, training and development (ETD). This applies at both the formative stage and in continuing professional development.

We suggest that this should expand beyond traditional academic routes and explore more vocational approaches such as forms of apprenticeship or boot camps for people who want to move quickly into health informatics work.

There may be opportunities for ETD partnerships between NHS Trusts, suppliers, academia and employment agencies that could be pump-primed by Higher Education Innovation Fund (HEIF) or Knowledge Transfer Partnership (KTP) funding.

We believe this should be explored with the Department for Business, Innovation and Skills, UKCHIP and BCS Health. Such partnerships might also foster knowledge-sharing networks.

Research and development: incentives
We believe further work is needed to identify the most useful incentives for busy NHS staff to participate in active knowledge-sharing in health informatics. We expect the incentives to link with the professionalism and ETD themes discussed above.

We would also like to see a requirement for organisations to demonstrate participation in the knowledge economy, for example, by including presumption of published evaluation in scrutiny frameworks and gateway reviews for informatics projects.

Research and development: evaluation
We suggest that a light form of evaluation that is achievable for routine usage in resource-stressed NHS organisations should be developed and mandated. We recommend the approach to develop this should be a modified Delphi method of iterative expert consultation as used by the
Despite changes in approach to the National Programme for IT, health informatics has remained a central pillar of NHS policy as an enabler of service transformation.

The future
Despite changes in the approach to the National Programme for IT, health informatics has remained a central pillar of NHS policy as an enabler of service transformation.

This is subject to changes of direction as governments come and go, but in some form will have to endure to achieve the needed efficiency gains and safety improvements. This is consistent with the strategic objectives of other programmes in Europe and North America.

The NHS’s aim is that health informatics should interconnect citizens, patients and clinicians with the right information, reduce operational costs and support new models of care. Yet health informatics projects have often failed to deliver their anticipated benefits, both in the UK and elsewhere.

Many of the reasons for failure in complex IT projects are well known but nonetheless recur. We believe that our recommendations for an evidence-based approach go some way toward addressing this situation.

References


For more information please visit: www.bcs.org/health
For many, telecare and telehealth are just about giving mobile phones to nurses, doctors or patients. They see technology as the solution to all their ills without actually thinking about what it can deliver, what it can enable people to do.

So how do we realise the huge untapped potential to help patients manage their own care and to create more time for healthcare workers for patients?

I believe these changes will only be realised by putting patients first. But to genuinely improve care we need to get right under the skin of how an organisation works, how their staff work and what they could be doing differently to provide a better service to patients, often at a reduced cost.

This means forging genuine partnerships with healthcare providers to gain a deep understanding of patient care challenges. Only then can we enable patients and healthcare providers to find new ways of managing their care in their own home or releasing staff from the burden of unnecessary administration.

It also requires healthcare providers to start thinking of digital technology as something that enables better patient care when used in the right circumstances, not something that is the solution in itself.

**Case study**

It is an approach that O2 have taken and one that is already delivering results. Last year Portsmouth Hospitals NHS Trust community midwives cut their high levels of unnecessary administration after O2 joined them on their rounds. By shadowing the midwives it was realised that they were doubling their admin time through manually writing notes in situ, and then typing them up when they returned to the hospital.

O2 recommended that the midwives use digital pens and paper, linked to a BlackBerry. The pen encrypts and sends data to the smart phone via Bluetooth, which is then transmitted directly and securely to the Trust’s patient record system.

After testing, the pens were rolled out across 130 community staff with great success. The change has freed up more time for midwives to care and, most importantly, it has helped improve patients’ experiences, as they get a copy of the midwives’ reports. Electronic copies are backed up on the system.

It’s also helped the Trust to save £220,000 per year, halving the time that midwives spend on administration. If deployed nationally to all the midwives across the country, the NHS could be looking at efficiency savings of around £50m, and that’s just through the efficient use of one simple piece of digital technology.

**The big picture**

It is these kinds of savings that the whole of the NHS is going to have to deliver if they are to meet the government’s target of making £20bn of efficiency savings while delivering care that is patient focused.

The technology already exists to make this target achievable – we’re not talking about tomorrow’s world here.
The UK Council for Health Informatics Professions (UKCHIP) states that professionalism is about applying the right perspective and professional behaviours as well as demonstrating responsibility and leadership within your specific field and in the wider informatics community.

Traditional courses are great in covering the technical skills needed to be an informatics professional, however, they do not typically address the way we confront our issues, achieve our goals or how we demonstrate leadership in our work. It is in these areas where coaching adds real value to an individual to enable them to grow holistically.

There are three reasons why coaching is a great approach to professional development for both individuals and organisations.

1. Individuals can develop holistically and improve their performance using a coaching approach.
2. Coaching enhances the impact of learning.
3. Coaching makes financial sense by providing a great return on investment.

According to the International Coach Federation coaching can benefit an individual by improving its communication model and their understanding of others. It can enable people to make better and more effective decisions, develop clearer visions or specific goals, generate increased flexibility and an ability to view problems from new perspectives to find better solutions.
Additionally, coaching stops procrastination, addresses stress, low self-esteem or lack of confidence, problems in communicating and performance issues.

Financial sense
Importantly, coaching makes financial sense. Coaching gives a return on investment of at least 5.7 times the outlay 1 and when used to augment traditional training, the improvements in productivity are four times greater 2. At an organisational level, coaching is a valuable approach in developing a learning culture.

According to The Harvard Business School over a ten year period companies that intentionally used coaching outperformed organisations that did not 3.

I believe coaching to be ‘the art of facilitating the learning, development and performance of another’. It is about supporting the reflective learner and their journey of self discovery. Mentoring on the other hand is about directing someone’s learning from the viewpoint or model of the mentor.

Solution-focused
In contrast to mentoring, coaching is more structured and focused on helping an individual firstly define a specific agenda and then, within that, clear development areas or issues to be addressed. The coach will then enable the client to be solution-focused in their thinking to achieve personal and organisation goals within their agenda.

The types of developmental outcomes I have seen from my own experience in coaching in the health informatics sector include:

- Removing self doubt and installing new approaches to handling and communicating with other people to get better results.
- Developing more effective thinking to create a stronger foundation for change by generating a wider array of possibilities and options for planning.
- Breaking through assumptions and stopping procrastination to cut through to the root cause of a problem, enabling action to be taken.
- Moving work out of a stuck state by changing perspectives and, by understanding relationships at work, to align them and develop specific and meaningful targets.
- Describing complex situations clearly and transparently to enable effective decision making.
- Motivate individuals by aligning individual development with organisational goals.

Personal experience
In my own experience outputs from coaching can be quite varied. In one case, following their ongoing frustration with a process in a customer-facing informatics service, a client produced and presented a business case that included cost and reputational risks to the organisation they worked for, if appropriate action was not taken.

In another case a client was struggling to operate at the required strategic level when working with a DH-customer to establish requirements for an informatics project. Through coaching, they identified their strategies that were problematic and designed and installed new ones – to good feedback.

Although coaching is not a new concept within health informatics, it is not as widely used as might be expected. However, pressures within the health environment and from those of the wider economy too suggest that a different approach is required when it comes to developing the workforce.

Applying the same approaches will yield the same old results. This cannot be an option.

Coaching offers a proven approach to develop people, organisations and solution-focused thinking to bring about cost-effective performance improvements. The stage is set for coaching to really make a difference in health informatics, if the opportunity is grabbed by individuals and organisations now.

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About the author
Michael Bewell is a Go MAD Thinking accredited coach (www.gomadthinking.com) and a Master Practitioner of Neuro Linguistic Programming (accredited by Helford 2000). Michael also operates (following in the style of Shelle Rose Charvet) conversational coaching with NHS IC colleagues who approach him with issues they are really ‘stuck’ with and he works informally with them to open their thinking to different possibilities.

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‘Who exactly seeks out a coach? Winners who want even more out of life.’

Chicago Tribune
Dr Andrew Coley, a Senior Clinical Adviser to NHS North West and a practising GP, reminded the audience that between 2003 and 2006 there were various national health informatics initiatives, but there was always a mismatch between IT products/developments and the style in which they were offered to clinicians and what clinicians really wanted.

Historically, IT project failures are usually more of a behavioural change problem than an IT problem. In health informatics the big problem is that clinical change management has always been missing. The introduction of health informatics to clinicians needs behavioural management for transformational change.

The aim of the HICAT is to provide ‘world class health informatics with clinical leadership’ and ‘delivering improvement through clinical engagement’. The team’s approach is based on seven key beliefs:

1. Genuine engagement occurs most effectively following debate at a local level.
2. One must place the patient at the centre of a cultural move towards a new care pathway.
3. Changes must be evidence-based.
4. Local clinical leaders are essential – they are likely to be respected and seen as honest brokers by colleagues.
5. Local evidence is often more compelling than ‘remote’ national evidence.
6. Success means aligning roles and responsibilities between clinical leaders and managers.
7. Requesting a clinician to change working processes will produce dissonance, leading to disengagement, or, if the product is good, engagement – the latter being the aim.

In order to achieve impact with clinicians across the North West Dr Coley appointed a multi-disciplinary team of five clinical leads to work with him, one each for diagnostics,
Historically, IT project failures are usually more of a behavioural change problem than an IT problem. In health informatics, the big problem is that clinical change management has always been missing.

through the innovative and efficient use of information technology.’

He outlined a history of health informatics to show that it is not new. It started back in the 1950’s. IMIA (the International Medical Informatics Association) had its grass-roots in an IFIP Technical Committee formed back in 1967, resulting in it being officially recognised in 1989; and Medline has been around since 1965.

Mr Roy illustrated how the domains of clinical work, information communications technology and the organisation of medicine and healthcare all overlap.

Industry statistics show that disastrous, runaway IT projects are characterised by being well over target delivery time and estimated budget, whilst delivering much less than the intended functionality. Many large IT projects are likely to fail.

The most frequent reason for failed and unwanted computer projects is poor requirements. If the stakeholders are not happy with the IT, there is usually something wrong with it and the organisation ends up paying a substantial premium on every project.

It must be remembered that organisations and requirements are dynamic, not static. Auditing projects for requirements or defects could cut the failure rate of projects by up to 80 per cent.

There have been some NHS successes. NHS Mail started off as being unpopular, but it got better. It was approved as secure, offered mobile access and provided an SMS gateway. Why did it work for the NHS? The requirements were ‘simple and accurate – email requirements’.

PACS is now available in all hospitals, it is interlinked in the North West and it has expanded to other media. PACS has been a great success in the North West and is a good example of the acceptance of changing requirements and clinician involvement where needed.

The key to success in both cases was the simplicity of the requirements, accurately specified. Alas the requirements specifications are not all there to the same extent for all other large IT systems.

Digital dictation for clinicians – a success story

Dr Asad Sadiq, a consultant psychiatrist from Bury and Mental Health IT Lead, is a full time clinician who is an enthusiast for IT in his spare time. He does not operate on patients, but talks to them and listens to them during his consultation process, which could last for an hour or more per patient.

It is important that he listens and it can be inappropriate to write notes at the same time. However, he needs to document the important points of each consultation.

After seeing a demonstration of digital dictation at the HC2009 Conference at Harrogate, Dr Sadiq organised a meeting at Bury involving consultants, the IT manager, secretaries and the admin manager and a digital dictation pilot project was initiated.

The pilot went very well and everybody, even the older clinicians, engaged and liked it. The key success factor was the interaction between the lead clinician and the IT director.

Problems with the old analogue dictation system included cassettes being lost, so consultants had to re-do letters, urgent letters were hard to find on the cassettes and the poor quality of old cassettes meant that medical secretaries had difficulties hearing the dictation. Dictaphones also had problems. The administration manager of the typing pool of medical secretaries could not tell who was doing what.

With digital dictation the dictation goes straight to the secretary. The clinician dictates and is then freed to focus his mind on the next patient. The admin manager can check the workload and see who is doing what. The voice quality is much better than before. It is safe, quick and efficient.

Dr Sadiq concluded by emphasising that full-time clinicians who just use IT have higher credibility with colleagues than clinicians who work full-time or part-time in IT. It is imperative to engage the front-line clinicians in order to achieve a successful IT implementation. It needs clinicians to pull rather than managers to push.

Patient empowerment through health informatics

Dr Amir Hannan, a GP from Hyde and Primary Care IT Lead, focused on patient eMPOWERment. The ‘MPOWER’ stands for ‘Medical patient and the Public’ communication, World wide web.
Electronic Record. Dr Hannan’s aim is to put patients at the heart of health informatics by empowering, educating and enabling them to make informed decisions about their own health through accessing personal and clinical information.

Dr Hannan is encouraging the involvement of his patients with their own records and giving them access, via the practice website, to information to help them manage their own conditions better. Thankyou letters from patients confirmed their appreciation of this approach.

The NHS Choices website and Map of Medicine are good examples of the provision of information for patients.

Medical records can be shared with patients through electronic access functionality that is already available, or soon will be, in most versions of the commercial GP computer systems used in the North West.

The challenge is about changing the culture of healthcare and re-balancing relationships between people who use services and those who provide them.

Dr Hannan and two GP colleagues have recently produced documentation on clinical engagement for ‘Enabling Patients to Access Electronic Health Records: Guidance for Health Professionals’ which will be released to GPs by the Royal College of General Practitioners (RCGP).

Dr Hannan’s Haughton Thornley Medical Centre’s website www.htmc.co.uk contains lots of useful information for his patients and is ‘open 24 hours’.

The future

Patient access to more information will impact beneficially on the work-life balance of GPs. Some patients are very appreciative of it and take greater responsibility for their own healthcare as a result.

Further, 24 hour access to information means that patients are not left waiting helplessly for access to their GP and pressure on GPs is thereby relieved, counterbalancing the increasing demand for GPs’ time caused by increasing numbers of elderly and chronic disease patients.

Currently, 12 GPs in the north west are giving patients access to their own records. The target is 100s.

In today’s world of immediate communications, if the population likes something new and takes it up, it can make an impact immediately.

Further information

HICAT can be contacted at: www.northwest.nhs.uk/whatwedo/hicat

The challenge is about changing the culture of healthcare and re-balancing relationships between people who use services and those who provide them.
October 2010

Primary Health Care Specialist Group
11 - 13 October
30th Annual Conference
Distributed Health Informatics - is this the new Holy Grail?
Crewe Hall, near Chester
www.phcsg.org.uk

ASSIST
13 October
Annual General Meeting
NHS Information Centre, Leeds
www.assist.org.uk/

November 2010

ASSIST: North West Branch
4 November
The Adoption of Digital Dictation, Voice Recognition and Clinical Correspondence Management Systems
Alexandra Business Park, St Helens
www.assist.org.uk/

ASSIST: North West Branch
23 November
Electronic Management of Health Records
North Staffordshire Medical Institute, Stoke-on-Trent
www.assist.org.uk/

December 2010

Health Informatics Interactive Care SG
4 December
Medicine on the edge, with surgeon Captain Peter Buxton, OBE
BCS, 5 Southampton Street, London
www.hiicsg.bcs.org/events.htm

ASSIST: North West Branch
10 December
Web 2.0 in Health
The University of Liverpool, 126 Mount Pleasant, Liverpool
www.assist.org.uk/

Special events

Paul Richardson will give a talk for the Open Source Specialist Group (OSSG) around his recently created shi-uk.com which is an expression/discussion focal point on the adoption of open source by the NHS.

This event is free and open to all and will be held at BCS, 5 Southampton Street, London, on 30 September. It will start at 1800 and is expected to finish around 2030. There will also be a free buffet and refreshments available on the night.

Additionally, a health informatics conference will be hosted and organised by the Open Source Specialist Group (OSSG) on 27 October from 1000 to 1700 hours, also at BCS office in London.

This event is also free and open to all. Provisional speakers (subject to confirmation) include:

- York University, on behalf of CFH, on their research project re: establishing an open source ecosystem in the UK for health informatics;
- Malcolm Newbury of Guildfoss on open source integration and collaboration software;
- Ben Tebbs of Pentaho;
- Paul Richardson on general vision, plus practical steps.

To book a place to attend either of these events, or if you are interested in speaking at the October event, please contact Mark Elkins via: Mark_elkins@bcs.org