Choose & Book – A Report from the Streets

The author, who wishes to remain anonymous, is a CAB project manager within the London Cluster

By luck or judgement CAB is a very good product to launch the NPfIT programme. Its purpose is clear and relatively easy to understand by patients and health professional alike. The process it is designed to improve does indeed need to be moved into the 21st Century.

For most of us the journey to the hospital, when told we will be referred, is a two, three or four month wait on the sofa until a letter drops through the door - almost “congratulations! - you’ve won an appointment with …, on ….” This is not patient-centred care and certainly does not make it easy for the patient to ask for a more convenient date for their appointment.

With Choose & Book the mechanics of the referral process have been separated into two parts – booking the appointment and adding the referral letter. The patient is able to make their appointment, without reference to the hospital or its consultants, at a date and time convenient to them. The hospital still reviews the appointment and can accept it, reject it or move it.

What Has Gone Well

Choose and Book is a piece of software that doesn’t try to be too clever. It is not an answer to all health-based IT problems, but in the right circumstances it provides a simple improvement to one part of the health care process. As this is at one of the main points where primary and secondary care interface it can help to reduce the friction between the two.

Typical benefits are that the referral letter and appropriate notes are electronically glued to the referral and much harder to loose. A patient may be seen without their full medical history but at least we can move on from hospital staff calling the practice to ask for the referral note to be faxed over as it was never sent, while the practice staff are still holding the fax transmission slip saying successful transmission.

Some GPs are reporting a noticeable drop in the amount of time spent discussing previous referrals during consultations and practice staff spend less time at the fax machine.

Patient reaction has been mixed but the first reports on the use of CAB are getting much better reactions from GPs and GPs who have absorbed CAB usage into most of their daily activities – as they are finding it quicker, easier and (horror) more reliable – and those that are making one or two bookings a week/month. There are several reasons for this.

The most obvious is a practice’s inclination to adopt new technology, but beyond this the greatest factor is the state of play at that practice’s main referring hospital. It is clear that areas where the hospital is showing 80-90% plus of services available on C&B are getting much better reactions from GPs than those with only 10-20% of services live. Unsurprisingly, this is because in the former case the GP has every expectation of making a successful booking and, in the latter, very little success, so very little incentive to even try the system.

At the time of writing my PCT has 30% of practices who have absorbed CAB usage into most of their daily activities – but of course that means 70% have not. Even to have got this far was largely due to the incentive payments put in by the government.

There is no proper documentation of the system and little information on exactly when users should go to their local help desk or when to escalate problems to the national team.

System reliability has been patchy. This doesn’t sound that bad but what does it foretell about the launch of the other parts of the programme?

There is no way to let users know when the system goes off line – not even a simple information cascade. This is a system that should be resilient, fault tolerant, and hot swappable with real 24x7x365 availability. Well it doesn’t provide anything like this level of reliability.

What Might We Have Done?

The launch of CAB is a classic study in how conflicting pressures and drivers can seriously undermine the credibility and success of a project. In this case the pressure by the Government to be seen to deliver “change” and “improvement” outweighed the instincts of the IT Health professionals who knew that a national roll out at an early stage was not going to help build credibility or confidence in the large NPfIT programme.

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http://www.ukhis.org.uk/
This month sees the release of version 3 of the Choose and Book system. It is anticipated that its integration at local level will not be without incident. In a Report from the Streets, we are given a reflective view on the realities of C&B implementation in a London cluster with some thought provoking ideas on what might have been and what has been. The theme of education is pervasive throughout our issues of UKHIT. In this issue following the surge of interest in e-learning we provide a report on how 3D multi-media is being used in medical education, take a look at a new bio-informatics degree due to start in London in October and report on a public symposium held at City University in March.

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As an example PCTs were threatened with the loss of a star if they failed to get all practices in their respective areas to agree to offer choice (as ambiguous a phrase as can be hoped for) by the 31st December 2005.

In the real world, one would have started a project like this by developing the software and conducting extensive testing with early adopting GPs. This did happen, but the GP community had been led to believe there would be “wide spread consultation” about the software so were vocal in their complaints on consultation when the first trials of the near-complete program started.

Once all were happy with the product you would have gone on to run pilots with say 10 practices and one hospital. Again when users were happy you might go up to a PCT-wide trial, then an SHA trial, then a cluster of SHAs, a region and then national roll out. This might well take 2-3 years but this is how one builds robust software that is fit for purpose.

The CAB project effectively went from local testing to national roll out in a single bound.

In conclusion the lessons to be learnt are straightforward:

Don’t launch a product until it is ready
Ensure the required parts, e.g. ensure that a hospital has 80% plus of its specialities available before a PCT tries to get GPs using the system
Remotivating practices that have tried and given up with a product is at least three times as hard as getting them going when the required components are in place
Reliability is key in confidence building – particularly to an audience that is as sceptical about IT as the GP community is
Adequate documentation is essential in the longer term delivery of any larger IT product.

The third dimension in medical education: what do 3D multimedia and virtual environments have to offer?

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Few educators would disagree with the following statement:

Design should be directed by pedagogy not technology. Virtual environments should be constructed with a clear view of how they support learning and ensure that learning requirements are foremost.¹

Unfortunately there are no evidence-based guidelines for the instructional design of medical virtual environments or 3D multimedia. Design principles have been suggested for ‘cognitively efficient multimedia learning tools’ but these note the lack of research into 3D applications.² Without proof of educational value, a lingering suspicion remains that 3D graphics are an aesthetically pleasing, yet ultimately superfluous, toy.

Enhancing conceptual and representational knowledge

Learning how to build mental representations of three dimensional human anatomy takes time and practice:

Insufficient ability to visualise is frequently expressed by students who have difficulty identifying structures in the living body as required in clinical examination.³

3D multimedia applications allow students to explore the spatial relationship between anatomical structures. This has the potential to improve visualisation and diagnostic skills, especially when the correlation between 2D radiology scans and 3D geometry is made explicit. Animations can provide learners with a guided exploration of dynamic processes that occur over a period of time, such as anatomical development or the spread of a disease.⁴ This supports the mental construction of conceptual knowledge by focusing attention onto a topic and providing a narrative to help organise it in relation to prior knowledge. The effects of injury can also be demonstrated by manipulating a 3D model and receiving visual feedback such as the altered functioning of muscles and nerves. These types of visualisation and guidance are not possible with textbook diagrams, photographs or magnetic resonance images which show a flat, static snapshot in time.

A lack of published evaluation studies has left 3D anatomical multimedia open to criticism, especially by teachers who view electronic resources as part of a wider challenge to the tradition of dissecting human cadavers.⁵ ⁶ Even advocates of teaching anatomy without dissection have expressed scepticism:

Computerised simulations of anatomy and the body are also available, of course, but the consensus among anatomy teachers seems to be that these are not yet of sufficient quality or development in terms of pedagogic principles to be a substitute for the dead or living body.⁷

Criticising the lack of established pedagogic principles is partially justified because many early anatomy projects concentrated on the technical feasibility of 3D visualisation with little consideration given to learning. However, the situation is changing as the technology matures and a review⁸ has proposed
educational criteria for evaluating anatomy resources and including them in curricula.

Improving procedural and technical skills

A surgical training curriculum has been proposed which makes extensive use of 3D laparoscopic simulation. Students use authentic copies of surgical instruments to interact with a virtual procedure displayed on a video monitor. Some simulations aim to photo-realistically represent operations such as removal of the gallbladder, whilst others use simple geometric shapes in place of organs and tissue. For designers, gauging the correct level of realistic detail to include is a delicate balance between technical constraints and instructional benefits. For example a high fidelity 3D model might show intricate anatomical structures but be slow to appear on screen and awkward to manipulate.

Studies investigating the transfer of skills from virtual environments to the real world have shown that trainees who practice upon simulators such as the MIST VR system have improved psychomotor proficiency when performing real procedures. However, skills can decay without an individual realising they have been lost, so qualified surgeons may be advised to periodically return to a simulator to refresh their existing skills and rehearse more complex techniques.

Commercial surgical simulators are prohibitively expensive for many institutions and only allow small groups to collaborate within a single physical location. Web based simulations offer a cost effective solution and have been shown to improve student competence when performing a basic surgical procedure. Multi-user collaboration within these environments has yet to be evaluated.

Providing expert assistance and feedback

Interaction with a virtual environment does not in itself promote learning. The following theory suggests that novices learn better when they practice simulations under the initial guidance of a teacher:

1. The trainee reaches a basic level of competence on a simulated procedure with the support of an expert who provides constructive feedback and corrective remediation (scaffolding).
2. The trainee practices the procedure under conscious self-guidance.
3. The trainee internalises the process to perform the task in a habitual, automated fashion which requires minimal conscious attention. Increasingly complex tasks are performed.
4. The instructor deliberately withdraws assistance when no longer required to prevent interference with the process of automation (fading).

This framework raises the question of whether the learning benefits of expert assistance be automated. One surgical simulator has moved in this direction by using a tutorial to guide trainees through a procedure which is broken down into sequential steps of increasing difficulty. Without a study comparing human and computer assistance it is unclear whether this captures the benefits of human intervention or actually interferes with the learning process.

Conclusion

To return to the quotation at the start of this article, we do not have a “clear view” of how 3D multimedia supports learning. There is evidence that trainees can improve their real world technical and procedural skills by repeated practise in a simulated 3D environment. However, the learning benefits I have suggested for improving conceptual and representational knowledge are conjectural. Without a testable theory of instruction, the third dimension will remain a superficial add-on.

References

11. Lapism website. URL: http://www.med.umich.edu/umsc/services/lapism.htm. Last accessed: 29.03.0 A.D.
17. John N. The impact of Web3D technologies on medical education and training. Comput Appl Biosci 2005; IN PRESS.


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Electronic records form a major part of the National Programme for IT (NPfIT) in England and promise to revolutionise the way health and social care are provided. Over time, electronic prescribing and hospital bookings will be complemented by much more to benefit patients, practitioners and managers alike. Connecting for Health (CHI) is the agency responsible for the national IT infrastructure and coordinating national and local service providers to deliver on the promises.

Connecting for Health is also the theme for a series of
Sir Jonathan Michael, formerly a distinguished consultant in kidney disease, now CEO of Guy’s and St Thomas’ NHS Foundation Trust, gave a practical and policy context for the whole discussion. He suggested that contradictions exist between national standards set centrally by CfH, and the provision of care which is required to be more locally tailored. The notion that “one size fits all” is a false assumption.

Sir Jonathan’s Trust handles 750,000 patient contacts a year. It employs 9,000 staff and consists of 1,200 beds situated at two main sites; In addition there are various clinical and non-clinical subsidiary sites which provide care for local, national and international patients. The full range of services from the major hospital is complemented by specialty centres and provides education, training and R&D.

He highlighted the fact that cancer services illustrate the potential for “network Healthcare” involving several providers and multidisciplinary teams. Travel to clinics and meetings is still a major activity in the absence of video conferencing and data/image transfer facilities. Electronic record components offer additional support. Adherence to Best Practice models of care is possible through electronic care planning and care management subsystems. Complex dosage calculations for Chemotherapy and Radiotherapy are well suited to clinical decision support functions.

Such network healthcare is also encouraged by the policy context where NHS decision-making has been decentralised to local bodies. Patients should now expect more choice and more tailored services from providers across sectors. The changes should also comply with national targets for reduced Access Times.

Technological standards are required to deliver the new ways of working. But, according to Sir Jonathan, this had been interpreted as “ruthless standardisation” from the centre by CfH. As a result, existing software packages have become “legacy systems” requiring replacement. Software has to be developed anew by a small group of providers (the Local Service Providers and subcontractors) even when the marketplace already has solutions. Solutions themselves are likely to vary with provider (District General Hospitals, teaching hospitals and specialist hospitals). However, standardisation of IT system dictates standardisation of business models and flexibility is removed from both design and implementation.

An alternative approach might make wider use of available software from diverse suppliers while also recognising some legacy systems. In addition, emphasis on standards does not necessarily preclude more flexible communications (voice, data, image, video), greater data integration, or more varied interfaces/portals to suit different applications and user groups. Overall, Sir Jonathan wondered: “could a more flexible approach by CfH utilise these solutions to deliver richer, more flexible solutions with much greater pace?”

**Setting the Record Straight.**

Mike Pringle - Professor of General Practice, University of Nottingham and GP Lead, Connecting for Health - contrasted the quality, availability and consequences of data in paper systems with the coordination and integration offered by electronic approaches.

The NHS Care Records Service (CRS) will have two components. The detailed record covers episodes of care from individual providers, while the summary record contains a subset for first line care, typically in emergency cases. Partners in direct, planned care would share features of the detailed record based primarily on role. The summary record would initially be populated with key historical data from GP systems, subject to data quality checks and network/user protection and accreditation schemes.

Service design has not been finalised as patient confidentiality remains a significant issue. Data sharing in planned care might be implicit in agreed referrals to other providers. National population opt-in, with special arrangements for sensitive diagnoses or patient groups, is part of continuing consultation for the summary record.

**NPfIT: a personal viewpoint.**

Robin Guenier - a barrister with 20 years’ experience in senior positions in IT companies, CEO of the former Central Computing and Telecommunications Agency, with current activities in a consultancy and an IT market research company and with wide interest including healthcare - drew on his experience to ward off familiar problems in IT and the public sector.

Factors contributing to failure had been raised by various Government monitoring organisations. Robin's own recipe for success had four components: clear hands-on, informed, sceptical leadership; early engagement with end users; alignment with current processes; brutal realism about time, costs and technology.

Officially, NPfIT was key to NHS modernisation and substantial efficiency savings as timetables were met. But market research had regularly suggested concerns among end-users. Doctors wanted more information and consultation. Trusts were worried about costs.

Robin had his own proposals for NPfIT. A Senior Responsible Owner (SRO), with expanded staff, should review the practicability of national integration as well as time & costs against objectives. Follow-on priorities included publishing a full business case and funding arrangements supported by a “Plan B”.

Audience discussion drew parallels with other countries and emphasised that basic principles and technologies had been around for some time. However, most comments concentrated on Sir Jonathan’s experiences as an end-user. They shared the...
frustrations of adjusting legacy systems and processes to meet
central standards and questioned the practicality of further
changes in mid stream. Later, the press also focused on Sir
Jonathan’s comments: “NHS plan is evolving but one-size-fits-
all is a fundamental flaw, says hospital chief” in Computer
Weekly1, and “Guy’s and St Thomas’ chief calls for flexibility
in NPfIT” from eHealth Insider2.

This symposium provided expert overviews and informed
discussions. Delivering an integrated and national electronic
service in the face of contradictory central policies and differing
needs between locations and provider types is clearly a complex
task.
(Viewed - 2nd March 2006)

A new full time BioMedical Informatics
degree course in London

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Introduction
A new biomedical informatics course is due to start in London.
Students can opt to study for a BSc in three years; or attend for a
further year and obtain an MSci. There is also the option of
taking a one year work-placement between years two and three.
The course is the first full-time degree course in the UK. This is
a three-institution collaboration between St. George’s, Kingston
and Royal Holloway, though students will be awarded
University of London degrees. The first three years of the course
will be run at the St. George’s medical school site in Tooting,
southwest London; in the fourth year students will have the
option of following a special interest at one of the partner
institutions.

We feel that the time is right to add a route for school
leavers to enter careers in informatics1. We believe that as IT
gets standardised and centralised across health systems, so there
will be a greater need for health informaticians able to bridge
the gap between information and communications technologists
and clinicians. This article explains the development process for
creating this course and the rationale for the structure we have
developed.

Developing a new biomedical informatics course

Identification of resources: We needed to identify the
resources required to run the course. Funding for the course has
come from the allocation of additional student numbers which
will allow us, eventually, to take up to 60 students a year on the
course. We also needed resources to provide the technology,
teaching infrastructure, learning resources, physical space and
all the learning support systems, including pastoral care, needed
to deliver such a course.

We decided to set up a course development group to build
the curriculum and other elements of the course. Without
prejudging the more detailed outputs from this group we
recognised that we needed to work with a department with
expertise in teaching computer science that also had “heavy
weight” computing capabilities that informatics students could
benefit from. We also needed to work with people with
expertise complementary to those at St. George’s. The “missing
areas” identified were: image and signal processing; bio-
informatics; information governance, security and privacy.

Course development group: The course development group
created the outline curriculum and objectives of the course. The
group contained a core group of people with expertise from the
collaborating institutions. We also invited experts and
practitioners in informatics to attend this group on a more
occasional basis.

We used the scoping document, designed to get provisional
approval to develop the course, as the terms of reference for the
course development group. We went through this document
page by page. Minutes were taken of the meeting, plus all the
participants were invited to write on their copy of the scoping
document, which we renamed the “Course Development
Document.” The course development document was then sent
round to attendees at the meeting and to industrial and academic
colleagues internationally for comments.

The principal change made during this process was adding
further modules about disease (and how it is represented in
clinical records) and professional roles within healthcare (and
the different type of records made by each group.)

Course structure: We opted to offer a four year MSci (Master
in Science) with an opt-out after three years with a BSc. We also
decided to offer a voluntary one year work placement after two
years. The first three years of the course are taught in two 15-
week semesters, with students based at St. George’s. Year four,
the MSci year, is a project-based year run at one of the partner
institutions.

Course design: The course has been designed so that the
curriculum is divided into eight subject areas. They are taught in
successive three week modules, which provide a logical learning
sequence for students. The same subject sequence is taught in
each of the first three years. The teaching is of increasing
complexity using Bruner’s spiral curriculum to reinforce
learning. Four unifying themes and ‘course-year leads’ ensure
that the modules of the course form a coherent whole.

Benchmarking the course: We wanted to look at our course in
comparison with other informatics courses around the world.
Much of the literature about informatics courses focuses on the
structure of the curriculum rather than benchmarking the
learning outcomes of the course. We have therefore developed
the first benchmarking statement for biomedical informatics2,3.
We would welcome comments on this benchmarking statement.

Supporting e-learning environment: We feel it is important
that an informatics course makes maximum use of e-learning.
We identified three elements of the e-learning environment; a
virtual learning environment (vLE); a learning objects
repository (LOR); and an electronic portfolio. We want to
deliver part of all modules via the vLE. We selected the open
source vLE MOODLE because of its flexibility and its
widespread use in schools. We plan to keep the current year’s
MOODLE accessible to that cohort of students, but to update
each module each year. The LOR uses a specialist database
package to store electronic resources. The eLearning Portfolio
provides an opportunity for students to keep a learning journal,
develop their critical thinking skills and a record of the
competencies they acquire while completing the course. We
hope to make the eLearning Portfolio available lifelong but at
least for five years after students complete the course.

**Working with the NHS:** Many of our students will work in the NHS. We have provided the opportunity within the course for the students to acquire many of the competencies defined in the NHS IM&T awards. The achievement of these awards will be recorded in students’ eLearning Portfolios and we hope that achievement of these awards will accelerate the career progression of those that join the NHS. We intend to work with the NHS to develop assessments and an approved learning structure for work placements.

**Informatics organizations:** We want to develop relationships with informatics organisations. We would like them to consider student membership, low student rates to conferences, student papers, access to journals and newsletters.

**Marketing and recruiting:** Marketing and recruiting are the major challenges for the course. Many people have not heard of informatics. We are working closely with our partner institutions to develop a marketing plan. Further information about the course can be found at: http://www.sgul.ac.uk/informatics/

**Summary**

We have created a new course in biomedical informatics in partnership with two partner institutions and developed e-learning resources to accompany it. We have benchmarked our course with other courses and literature. We now need to recruit the students to fill the places...

**References**


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**Review: From Patient Data to Medical Knowledge: The Principles and Practice of Health Informatics**

**Mohammad Al-Ubaydli**

*Author of The Doctor’s PDA and Smartphone Handbook: A guide to handheld healthcare*

Johann Amos Comenius was probably the inventor of the textbook. Born in 1592 the Czech educational reformer was offered the first Presidency of Harvard University and in the mid-17th century designed and used the first Latin primers. Following such august footsteps however, most educators have produced a huge output of boring and weighty textbooks.

So it is refreshing to read Dr Paul Taylor’s textbook *From Patient Data to Medical Knowledge: The Principles and Practice of Health Informatics*. He is director of the UCL postgraduate programme in health informatics, allowing him to begin the book by saying that “The best way to learn about a subject... is to write a book about it. Another good way is to teach it.”

The book is in three parts. The first covers the three “grand challenges” for health informatics of reading and writing patient records; creating (rather than just documenting) medical knowledge; and access to that medical knowledge. He explains each with clarity and brevity, but still includes the seminal papers, products and projects in medical informatics in the past.

The second part is the meat of the book, covering the principles of health informatics in seven chapters. At the risk of exposing my own ignorance, I learnt new things from every chapter, even the section on MeSH, despite my working at the National Library of Medicine.

This part includes a discussion of OpenEHR, the open source collaboration for electronic medical records systems. Developed mostly by UCL version 1.0 was released earlier this year and it is good to see it getting its fair share in the book.

The final part, “Achieving Change” must have been particularly difficult to write because Dr Taylor used examples from the UK’s Connecting for Health programme, but its lessons are still unfolding. This does make the book a topical one, and will be of interest to readers outside of the UK who want a good primer that sidesteps the jargon and politics of the Department of Health’s own documents.

The rest of the book is equally well-suited to international audiences, especially American ones as over a third of the examples are drawn from the USA.

Throughout the book are several boxes which are surprisingly interesting. My favourite is the amusing aside of how much Dr James Read, creator of the wonderful Read Codes, was paid by the NHS, and the accusations of conflicts of interest. The quoted Minutes of Evidence to the House of Commons Public Accounts Committee from 1998 are worth pursuing.

I will mention some criticisms, but only because one has to in reviews. First, it is a shame that more details were not included, which is inevitable given the constraints of the book’s size. For example, although the book discusses OpenEHR it does not include a discussion of open source software or its potential importance to the development of robust medical records systems. Second, the book for the most part avoids discussion of workflow and usability issues, especially those associated with different technologies and form factors like handheld computers. Although the book does mention Personal Digital Assistants in passing in several chapters, it does not include any entries in the index.

But here I am betraying my biases and these should not detract from the book.

So, should you buy it? Every health informatics student in the UK should buy a copy, preferably before they begin their course, as it will enthuse them for what is to come. I would give similar advice to readers outside the UK.

But I would go further as I believe the book is readable and worth reading by doctors who have no intention of pursuing a career in health informatics. Partly of course this will make a few realise their mistake and change career paths. Most importantly, however, doctors increasingly understand that information technology is making an impact on their practice, while still lacking an understanding of how to make sure that the impact is a good one. This book provides enjoyable teaching of the principles of dealing with information technology in healthcare, making it a textbook in the best traditions of Comenius.

UKHIT Diary

June 2006

**Nursing Informatics Congress 2006**
Date: 11-14 June 2006
Venue: Seoul, South Korea
Sponsors: IMIA - Nursing Informatics

**IEEE Symposium on Computer-Based Medical Systems**
Date: June 22-23, 2006
Venue: Salt Lake City, Utah, USA
Sponsors: the IEEE Computer Society (Technical Committee on Computational Medicine (TCCM) and the College of Engineering at Texas Tech University

**AHRO Patient Safety and Health IT Conference**
Date: 04 - 07 June 2006
Venue: Washington, D.C.

**Telemedicine and eHealth Conference**
Date: 12-14 June 2006
Venue: Tromsø, Norway
Sponsors: Norwegian Centre for Telemedicine

July 2006

**“Expanding the Scope of Health Information Systems from Hospitals to Regional Networks, to National Infrastructures, and Beyond”**
Date: 2-4 July 2006
Venue: Oeiras, Portugal
Sponsor: IMIA HIS Working Conference

**16th Annual Summer Institute in Nursing Informatics: Advancing Clinical Practice through Nursing Informatics**
Date: July 19-22, 2006
Venue: Baltimore, MD, USA
Sponsor: University of Maryland School of Nursing

August 2006

**HIC2006 - Bridging the Digital Divide: Clinicians, Consumers & Computers**
Date: 20-22 August
Venue: Sydney, Australia
Sponsors: Health Informatics Society of Australia (HISA)

**Successes and Failures in Telehealth - 6th Annual International Conference**
Date: 24 - 25 August 2006
Venue: Queensland, Australia
Sponsors: The Centre for Online Health (Univ. of Queensland)

**MIE 2006, Ubiquity: Technologies for Better Health in Aging Societies**
Dates: 27-30 August
Venue: Maastricht, Netherlands

September 2006

**“Being Heard, Being Understood”**
Dates: 8th & 9th September 2006

To have your event considered for inclusion in the UKHIT Diary, please send details as soon as they are available to Jeannette Murphy, UCL CHIME, Archway Campus, Highgate Hill, London N19 5LW or by email: j.murphy@chime.ucl.ac.uk
What is health informatics?

Health Informatics is devoted to the understanding, skills and tools that enable the sharing and use of information to deliver healthcare and promote health.

The phrase ‘Health Informatics’ is tending to replace the previous term ‘medical informatics’, reflecting a widespread concern to define an information agenda for health services which recognises the role of citizens as agents in their own care and self-care, as well as the information-handling roles of the non-medical healthcare professions. ‘Health Informatics’ is an essential and pervasive element in all healthcare activity. It is also the name of an academic discipline, developed and pursued over the past decades by a world-wide scientific community engaged in advancing and teaching about the application of information and communication technologies to healthcare - the place where health, information and computer sciences, psychology, epidemiology and engineering intersect.

UKHis is a national association for people concerned with health informatics in both of these senses, and is based on the recognition that practical and scientific concerns in this domain are interdependent and inseparable. Twenty years ago medical informatics was seen largely as the computerisation of healthcare. Today, with computers much more a part of routine daily life, there is a tendency to downplay the computers and technology in health informatics, and to stress the meanings of information in the everyday work of healthcare professionals, in communication, shared knowledge and decision-making, and in the complex social and functional needs of healthcare organizations and services. There is more scepticism (notably by the professions themselves) about guaranteed benefits from computerisation for the delivery of healthcare, and more stress (notably by politicians and managers) on technology and organization as a single agenda and on ‘culture change’ as a key item in that agenda.

The National Programme for IT (NPfIT) is the most ambitious, considered and widely supported agenda for health informatics ever officially adopted on a national basis. The scope, challenges and problems it offers for health informatics, intellectual and practical, technological and cultural, are daunting and exciting.

Aims of the UK Health Informatics Society

The UK Health Informatics Society was founded in 1986. Its purpose is to advance the knowledge and application of medical and health informatics. Its main aims are:

- In co-operation with other groups, to develop and serve an informed, interdisciplinary medical and health informatics community.
- To promote an active research and development community in medical and health informatics.
- To provide an open forum for independent, informed discussion and debate.
- To act as a voice for the professional and scientific community in the formation of information policies and strategies in the national health services.
- To advance the quality and provision of medical and health informatics education and training.

Membership is open to all, including professionals, citizens, patients, and users of healthcare and health information, who share the Society’s concerns and objectives.

Activities and services to members include:

- Publishing UK Health Informatics Today, a newsletter which keeps its membership informed of current issues in health informatics, book and software reviews, and forthcoming events.
- Organizing and sponsoring a range of open workshops, conferences and other meetings.
- Gathering and delivering advice and comment on health information policies.
- A website - with information about the Society, conference details and other useful digital resources.
- A listserv (with searchable archive) open to all members.
- Free subscription to the journal Health Informatics

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UKHiS Membership Application Form

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