Call for conference participation

HC2007: Challenging boundaries

“In all affairs it’s a healthy thing to hang a question mark on the things you have long taken for granted.” — Bertrand Russell

Implementation of any programme for improving information flows in healthcare will inevitably challenge the boundaries of service provision. Given that dissatisfaction with traditional means of capturing, storing, using and communicating information, coupled with the opportunity presented by computerisation to improve these processes, has given rise to the field of health informatics, it is not surprising that application of the latter brings with it new ways of working. In learning how to use computerisation to improve clinical and managerial practice, more and more potential has been opened up. As a result, it has become possible to envisage even more new ways of working. Indeed, these are sometimes now challenging the boundaries of health informatics itself.

Everywhere we look, we see these challenges happening: the need for new types of information and new ways to use it; and the need to meet information needs without operational or physical constraints.

Almost everywhere in the world, Bertrand Russell’s question mark has already been hung on traditional healthcare and social care delivery. There is widespread agreement that the old ways are unsustainable, and radical changes have been envisaged. With this, there are great expectations that informatics will enable realisation of the hoped-for future. Can it make these ‘dreams’ come true? If so, when? What are the boundaries that must be challenged? How could they be challenged? Where have they successfully been broken down or removed? What progress has been made? Where and why did setbacks occur?

The HC2007 conference aims to focus on discussing and answering these questions.

‘Thinking outside the box’ conjures up the need to recognise the realities of existing structures and processes, to question their limitations and to probe further afield in our collaborative quest to find how to improve them.

If health informatics is to meet responsibly the challenges it now faces and to advance its role more effectively and more swiftly, it must publicise new solutions that have proven efficacious as well as creative ideas yet to be tested. You are invited, therefore, to contribute to this body of knowledge and/or submit a proposal or topic that you believe the HC2007 conference should feature in its programme.

Be creative, and challenge boundaries — including those of the HC conference programme!

We look forward to hearing, and learning, from you.
Informatics Forum chair

Glyn Hayes
Chair, BCS Health Informatics Forum www.bcshif.org
BCS Vice President, Forums
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For everyone involved in health informatics in England, the most crucial activity at the present time is obviously that of Connecting for Health. (CFH) The programme is under immense pressure because of bad publicity, delays and anxiety amongst politicians.

However, it is the view of the BCS Health Informatics Forum (BCSHIF) that it is vital nothing is done to stop or hold up the progress of CFH. We do believe CFH will deliver much of great value, even if the timescales have slipped.

However, we also believe that there needs to be a review of the content and implementation of CFH, if it is to succeed. We have thus prepared a formal BCS position paper on our view of the way forward. So that we could include extracts of this paper in Health Informatics Now, we delayed the publication of the December issue until January. The extracts are on p6, as well as at: www.bcs.org/hif/cfhdrpport

Integrating the Healthcare Enterprise (IHE)

IHE is an international organisation concerned with the communication of information between medical devices and clinicians.

IHE (UK) is the organisation which demonstrated the Conectathon at last year’s HC conference. Up until now most of its work has been within the radiology domain.

However, the work is now spreading into other medical areas, and as such it has been suggested that BCSHIF should become involved. We are currently in negotiations with the members of IHE UK, and hope to help in the development and dissemination of the standards which are being developed.

The essence of IHE work is to use existing standards and develop them to make working communications. The Conectathon will once again be demonstrated at HC2007, HC2007 Planning is now well underway for the next HC conference to be held 19-21 March in Harrogate. As usual the conference will be held in conjunction with an exhibition run by our partners, BJHC & IM.

Lord Warner will be presenting the view of the Department of Health on current policy and strategy. There will be many members of Connecting for Health present as well as a significant number of front-line NHS staff, describing their experiences of implementing systems in the real world.

Connecting for Health will have a major series of demonstrations of CFH products. Also senior members of the local service providers will be there to describe their views.

There will be a series of non-promotional presentations by the major hardware and software suppliers such as Cisco, BT, Siemens, Cerner, to allow the delegates to keep abreast of technological advances.

We are once again running the Understanding Healthcare stream. This is a nuts and bolts description of how the NHS works, how GPs and hospital clinicians do their jobs and how it is all managed. It is aimed primarily at those who work with staff in healthcare and thus need to be aware of the problems such staff face.

Last year this stream was oversubscribed as it was so popular. The programme and booking form is at www.health-informatics.org

New role

The BCS has elected me as Vice President responsible for all BCS Forums. The result is that we now need a new chair for the BCSHIF, who will be chosen sometime later this year.

What is the discipline’s core?

What is the discipline of health informatics? Professor Graham Wright, director of the Centre for Health Informatics Research and Development (CHIRAD) and Dr Peter Murray, founding fellow, CHIRAD, gave an update of their work to define the knowledge base of health informatics at the BCSHIF meeting in October. Helen Boddy reports.

When he first tried to put together a health informatics course some years ago, Graham Wright hit a problem: it was difficult to know what should be covered, given that there was no agreed definition of health informatics as a discipline. Now he is part of a team working to define the core knowledge of health informatics, which would be a useful resource for those setting up curricula, and for the industry when defining job specifications and required competencies.

This work on a cognitive definition is now being funded by the BCS and the International Medical Informatics Association (IMIA) with the aim of creating an international definition of what constitutes ‘health informatics’.

‘It will help us show that health informatics has a scientific base,’ said Graham. ‘And finally settle the arguments of what it should be called.’

The IMIA may also use the definition in its current task of formulating its own strategic plan.

The work began in early 2005 when a group of around 30 academics, practitioners and consultants from the UK, Australia, Canada and USA and from different health informatics domains got together in Otley to produce a framework matrix. They drew up a list of 239 elements or topics that made up the discipline (named ducks) that could be grouped together under 13 subject areas (named ponds) and together make up the framework matrix.

Graham, however, recognised that this matrix is ‘just one view of the world’ and that it could have gaps in it. Therefore, since the Otley meeting the team has been looking to see if the framework matrix is substantiated by other views of the world and trying to identify possible gaps.

An initial approach was to see if other groups set the same task came up with similar ponds and ducks. However, when repeated with other groups, there was insufficient time to do the same amount of work and in one case a group even produced a narrower list than that of Otley.

The team has therefore turned to published papers to validate the Otley matrix, assuming that examining authors’ words should throw up a list of quintessential health informatics topics. Graham explained that he has been experimenting with different methods of searching through research papers to come up with a list of topics, which could then be cross-referenced against the Otley matrix.

He has, for example, run different searches using various sorts of discourse analysis software and experimented using web crawlers. He has looked at how searches differ depending on whether searching keywords, MeSH headings or a combination of both. The task is complicated by the fact that the terms are contextualised but searches generally are not.

The team is currently piloting using Reference Manager to search keywords and MeSH headings in Pubmed and Scopus to provide lists of the most popular topics. They are considering whether this is the best method to capture topics. Another possibility, suggested Graham, is to ask volunteers to read through papers and define the key terms from each.

Graham and Peter have gathered together electronic copies of published papers from many sources: social citations, Pubmed and Scopus and Congress. The papers they have at their disposal are therefore not just those available on the internet, and not just peer-reviewed papers. They decided to collect papers up to ten years’ old, as terms have changed over the years.

The decision now has to be made whether all the papers collected ought to be searched, or whether a smaller sample will suffice. There is also a question of how to avoid bias. For example, some people publish extensively, often on similar subjects, and they may therefore be over-represented among research papers.

Once the validation has been completed, the matrix will go forward to a group of international experts so that an international consensus can be reached. A meeting of experts is being planned for Tennessee next year.

Project website link: www.difference-engine.net/educationsteps/documents/otley2005outputs.htm
New direction proposed for NHS programme

The English NHS Connecting for Health Agency (NHS CFH) and its main programme, the National Programme for Information Technology (NPfIT), are now about half way through their planned lives. The BCS Health Informatics Forum Strategic Panel has written a report ‘The Way Forward for NHS Health Informatics: Where should NHS Connecting for Health (NHS CFH) go from here?’ on behalf of the BCS. Below are extracts from the report: the foreword and summary of recommendations.

Foreword By Dr Glyn Hayes, chair of BCS Health Informatics Forum

The NPfIT controls the lion’s share of the NHS IT spend, but not all of it. Some of the things that the NPfIT planned to do have become, or are becoming, reality. Others are not, and some of these involve challenges that do not have easy answers. This report is a summary, and certainly not a full review of its subject. It is based on the opinions of the health informaticians within the BCS who have, between them, hundreds of years experience of implementing ICT in health. It salutes NHS CFH’s successes, and explores the less successful elements and the related external issues. It examines briefly where the NHS is headed, and assesses where NHS CFH is now. We list the strategic changes that are necessary, the detail behind our proposals, and suggest which should be a priority.

We agree with Derek Wanless, as Government Command Paper: “There is no such thing as an IT project, merely business change projects mediated by people and ICT.” This misconception has been a prime cause of large-scale IT project failure since computers first became commonplace, according to the report ‘Challenges of Complex IT Projects’ by the Royal Academy of Engineering and the BCS, April 2003. The problem has been heightened by: NPfIT’s top-down nature; the patchy reflection of NHS requirements in the procurements in 2002; and the subsequent changes in those requirements to meet the Government’s NHS reform programme. We believe this is one reason why so many NHS staff have yet to see NPfIT as a key enabler of business change and it has thus discouraged the local ownership of NPfIT implementations.

We want NPfIT to succeed – we believe that set in an appropriate and properly funded business context, informatics will make a massive contribution to safer and more appropriate patient care. We agree with Derek Wanless, as per his report ‘Securing our future health: Taking a long term view’ of April 2002, that NHS should spend about 4 per cent of turnover on informatics – but this spend must be business led, and that 4 per cent should be a guide, not a target.

We therefore consider that there is a pressing need to realign NHS CFH as a major enabler of business and service transformation. We acknowledge that NHS IT Implementation had major gaps and problems before the advent of NPfIT. We appreciate that some of the issues it faces – information governance for example – are not of its own making and predates NHS CFH, although it has inevitably raised their importance. Others – for example: the need for significant local business change; the integration of social and healthcare; and the changes in clinical data recording, quality and management it relies on – must be recognized as major challenges in their own right.

The Government has committed very significant resources for NHS informatics, which relatively little has yet been spent and less still is visible in front-line informatics. We wish to see this commitment play its proper and vital role in the new NHS. Starting from where the NHS and NHS CFH are now, our report is intended to start a constructive, urgent and open dialogue to support this goal.

Summary of key recommendations

The acronyms in brackets refer to the bodies that we consider should respond to the recommendations. These show only a minority of the recommendations are considered to be the sole responsibility of NHS CFH. The recommendations are not listed in priority order. Providing a business context for NPfIT owned at national and local level (DH & NHS). Focus on local implementations at Trust and provider unit level, e.g. hospitals, diagnostic and treatment centres, community and mental health Trusts, and practices. Providing clinical, service-specific and niche systems will encourage clinical involvement and give quicker benefits (NHS CFH, LSPs, NHS).

Paradise local NHS management that informatics is an essential part of business solutions and service transformation. Provide explicit additional funding for business change and service transformation. Embed informatics in Trust business targets with realistic target dates (DH, NHS, NHS CFH).

Adopt a truly patient-centred approach at the local health community level (DH, NHS CFH, NHS).

The strategy should be evolutionary, building on what presently works and encouraging convergence to standards over time, rather than revolutionary (DH, NHS CFH, LSPs).

Give a heterogeneous set of systems, as above, there needs to be a greater emphasis on standards to enable systems to interoperate effectively, rather than focusing on relatively few monolithic systems (NHS CFH, NHS ISB).

Establish basic informatics elements that are standard across the UK to enable coherent treatment of patients irrespective of their movement across home country borders. Ensure that other facets of the English strategy support this coherent treatment of patients (DH, NHS CFH, NHS, healthcare professionals, other health informaticians).

Put implementation of the Personal Spine Information System (PSIS) on hold (DH, NHS CFH).

Consider developing the equivalent of the Scottish this coherence (All home country health administrations and national IT programmes).

We believe that... informatics will make a massive contribution to safer and more appropriate patient care.

Fully implement GP system choice at practice level (DH, NHS CFH, LSPs).

There also needs to be an accreditation process for all new and existing systems, both against the chosen standards and functionality requirements that does not stifle innovation (NHS CFH).

Revist and reallocate roles and responsibilities of the NHS at each level (NHS CFH nationally and locally, and system suppliers. We understand this is now underway (DH, NHS, NHS CFH).

Transform NHS CFH into an open partnership with NHS management, users, the informatics community, suppliers, patients and their carers that is based on trust and respect (DH, NHS, NHS CFH).

There are major issues about the sharing of electronic patient data which need to be resolved whatever the shape of future informatics in the NHS. These must not be hijacked by technical issues, and informatics should be paramount (Patients, carers, healthcare professionals, DH, Information Commissioner).

Information sharing between care professionals should initially be by messaging using the Spine TMS service pending further work on information governance and the National Care Record Service (NHS CFH & LSPs).

Clearly define what the NHS Care Record Service (NHS CRS) is. A virtual service offering views of the distributed records available for a patient would seem appropriate (DH, NHS CFH, NHS healthcare professionals, other health informaticians).

Continue with the New NHS Network (N3), the Transaction & Messaging Service (TMS), the Personal Demographic Service (PDS), Spine Directory Services (SDS), Electronic Prescription Service (EPS), Choose & Book (C&B) and a national electronic record transfer (GP2GP) but ensure an open maintenance and enhancement process (NHS CFH & NHS).

The full report is at: www.bcs.org/hil/cfreport
As more member states join the European Union and healthcare becomes increasingly digital, is Europe on the right track in terms of cooperating on health informatics? BCS held a Thought Leadership debate to discuss the issue. Helen Boddy reports.

A better connected, healthier Europe

Healthcare informaticians from across the spectrum – the NHS, suppliers, academia, government and the EC – got together at a BCS Thought Leadership Debate on 2 October 2006, to discuss European health informatics cooperation. Two presentations were given on the subject after which delegates split into groups for further discussions.

Where are we now?

The EC started co-financing eHealth (or health informatics) research and development projects 17 years ago. At that point, the budgets were comparatively small and the initiatives were mostly pilot actions – funding was only 20 million over a four-year period. Projects that started 15 years ago as small pilots have now established themselves as definite activities. MedCom in Denmark, for example, began life as a small EC-funded pilot. EC-funding can therefore have significant results, albeit 15-20 years after being initiated.

The EC is now co-financing eHealth projects worth 200 million over the four-year period of the 6th Framework Programme. Funding will double in the first two years of the 7th Programme to co-finance research and development from 2007 to 2008; the programme itself will continue until 2013. One focus for eHealth projects in the 7th Framework Programme will be personalised health systems, such as close-to-body health information systems, and intelligent textiles. Two and a half years ago the EU published the European eHealth Action Plan, which provides a roadmap for the development of interoperable healthcare informatics across European member states. Since then, 22 EU member states (there are currently 25) have either initiated an eHealth policy or strategy, or set out their aims on eHealth. Activities are also happening on the ground. NHS Direct Online was quoted as an example of what eHealth can achieve.

A definite need for better connections

European cooperation, for example, could be advantageous to Europeans who move around for work, study or pleasure in terms of healthcare workers being able to quickly access patients’ details of their past medication or ongoing health problems, suggested some participants.

Interoperability will also be key to combating difficulties that will be caused by the changing demographics of the EU. As the population ages, there is a need to find innovative solutions to care. If interoperability is improved, some hospital care may be able to be moved to other environments, and even to other countries.

Cooperation could also help reduce IT costs, which are higher than might be, partially due to different countries requiring different systems.

Greater standardisation or consistency across countries would allow suppliers to provide the same solutions to different countries. Such competition between suppliers, and their ability to sell to more customers, ought to result in reduced costs.

Barriers to interoperability

The need for better cooperation is clear, but there are various obstacles to overcome before that is achieved. There are several factors that work against EU member states being successful in working together – different cultures, languages, markets. These factors have resulted in suppliers generally only being engaged at a national level to date.

National protectionism was also partly to blame for the lack of global suppliers, according to some participants. They argued that the economy should be open to health informatics systems from all countries and not restricted within the boundaries of the EU, but others were concerned about the impact that such a move would have.

A lot of European countries have programmes at the national or even sub-national level. Even in the UK, we have much to learn as there are separate programmes in each country that are not yet joined up.

More generally, participants believed the attitude of health management to IT investment is a barrier to growth in eHealth. IT programmes in general have a poor reputation due to projects running over time and cost.

Health Informaticians need to be able to convey the rationale for investment in IT, demonstrating that good care and good information go together. Healthcare executives and the public need to be convinced of the differences that IT systems can make. Successful implementations are needed to dispel the view that it is an industry that overruns and overspends on projects.

Equally, in running any programme with a wide geographical coverage, local ownership is still needed. If hospitals do not buy into a system, for example, they won’t use it and interoperability simply will just not happen.

No matter how and at what level cooperation is achieved, participants emphasised that patients must be at the centre.

Priorities for cooperation

Participants considered that one of the first steps towards achieving interoperability is to define standards, including terminology. They are vital as the industry is not uniform – there are lots of players, which produce lots of different solutions. Standards would enable businesses to grow, especially if their adoption was financially encouraged and / or mandated.

Defined standards would also enable EU-wide patient records to be created. Delegates agreed that the ultimate aim would be for an interoperable patient record but complications of confidentiality and governance would make it difficult initially. A good place to start would be to create a medication patient record, although even this would not be an easy task. One participant said that such a move alone could save thousands of lives.

Standards are an area where participants felt that the EU could make a real difference as no one stakeholder would be motivated to tackle this alone, let alone fund it. The EU however could take this on as a body and, importantly, provide the funding.

Another good starting point for European cooperation would be sharing lessons learned. Participants pointed out that currently there is a reluctance to do this when the outcomes were not favourable.

Finally, cost savings can be made in research and development costs if shared at a European level. It was suggested that “flamboyant” research and development such as in genomics, genetics, biotechnology, and even bio-surveillance for terrorism could be good areas for cooperation.

Is the EU the right level?

Although most delegates were of the view that there is a need for countries to co-operate, several delegates questioned whether the EU is the right level at which to work together. People move beyond the EU’s borders, so would it not be useful, for example, that aspects of their health record is available outside the EU? World standards would potentially mean suppliers had a larger market to target, hopefully reducing prices still further.

One viewpoint was that Europe is an important step in a scale process. If, for example, a good innovation is introduced in a small town in England, which is then adopted nationwide, it could then go Europe-wide before potentially being adopted globally. Solutions need to grow bottom up in this sort of scale process; top-down solutions are only available – one participant provocatively suggested – in dictatorships.

Others argued that there is a place for both cooperation at a European, global, and even national and local level. Certain initiatives would be most suited to certain levels. Working at a European level would have the advantage of being able to use EU institutions which do not exist at a worldwide level.

To sum up, participants believed that health informatics communities need to cooperate more closely, be that at the local, regional, national, European or global level. There is certainly a role for the EU to play. In view of Europe’s ageing population, it is imperative to decide quickly what must be done towards improving interoperability. Standards definition is the immediate priority.

Read the full report: www.bcs.org/thoughtleadership
Fearful that important pieces of historical information could be lost with the closure of the NHS Information Authority, Jean Roberts of the University of Central Lancashire took part in an initiative to set up a new National Health Informatics Collection. In this article, she explains what has been done so far and describes future plans.

Imagine my embarrassment, having spent the last few years completing a doctorate by previous publication about the development of health informatics over 30 years and then not being able to physically find some of the key documents for my Masters students in health informatics in the Lancashire School of Health and Post-Grad Medicine within the University of Central Lancashire.

The risky situation for ‘old’ but still important documents and related media has been developing over time. As people retire and public sector re-organisations occur, possible sources for documents and other media fade into the vague recollections of who worked on many projects when.

The catalyst for the establishment of the National Health Informatics Collection was the demise of the NHS Information Authority and the closure of its offices in Birmingham. We were tipped off that important material might be lost at that time, so with the willing participation of our university library team, headed by Helen Cooper, our HI course leader Bev Ellis, herself a BCS Primary Care Specialist Group stalwart, we achieved an agreement that we could have the material in Preston as long as we made it as widely available as possible.

From then on it has become quite a challenge to respond to numerous kind offers of capital content. Many times I have tried to find the boot of my car filled up on the way back with historic materials that other HI players in the domain.

Imagine my embarrassment, having worked on which projects when. From then on it has become quite a challenge to respond to numerous kind offers of capital content. Many times I have tried to find the boot of my car filled up on the way back with historic materials that other HI players in the domain.

The truth is further re-oriented we will probably again see many parallels to successful elements of the past, including Körner committees, the London Hospital System, the Experimental 3-Laboratory project, which can be compared and contextualised thanks to donations to the Collection, including some from personal donors who are, or were, key players in the domain.

However, this activity will only capture the legacy material that will set health informatics developments into context. Ways to keep the Collection inclusive, alive and growing, rather than a static archive of the past, are being explored.

Publishers of relevant material are lodging copies of new publications with the Collection or giving access to their back catalogues so we can track down previous works readily. Physical resources that we seek from donors include published books in electronic or hard copy format, journals and significant trade magazines, reports and conference proceedings.

We are encouraged by the increasing numbers of organisations which are ‘bridging’ to the Collection through their web links as recognition of our activities and to enable interested parties to reference materials not on site. Where other significant collections exist we aim to create synergy by acting as a portal for enquiries and cross-reference but not to physically incorporate such materials.

Having achieved a good basis for the Collection from the founding donors, we formally launched the Collection on 6 September, gaining yet more offers for useful content from local news and trade journal references. After a short demonstration members of the NHS Health Informatics Faculty then provided ideas for increased functionality, maintaining integrity and enhancing coverage and content for the Collection over time. Their ideas included taking steps to ensure:

- users will not just be within the NHS but other care delivery agencies, their solutions and service providers and academia in all of the home countries;
- desirable content will span both the historical legacy of HI and its contemporaneous / future materials, from a UK and wider perspective;
- the Collection takes account of disability equity of access criteria including SENDA and the disability legislation;
- mechanisms to future proof content are explored, especially where the existing media become obsolete or difficult to maintain, in order to keep seminal material readily accessible, for example degraded old documents may need to be accessed through scanned electronic facsimile form, or obsolete e-media to be re-versioned forward as required (such as VHS video to CD-ROM);
- all currently available material be collected, but at some time in the future a usage review may refine the Collection or what materials may be withdrawn as no longer of significant interest, or for reasons of space or costs;
- all in all, the National H1 Collection project has captured the attention of the community and will be progressed under constant review and enhancement.

If you are a publisher, editor, webmaster or key stakeholder in this field and have (or know of) resources/links that could be added to the National Health Informatics Collection, contact Dr Jean Roberts at jroberts1@uclan.ac.uk.

Useful links
Information on how the Collection is progressing: http://nationalhealthinformaticscollection.blogspot.com
Details of the UCLAN’s health informatics initiatives: www.uclan.ac.uk
NHS Health Informatics Faculty: www.informatics.nhs.uk/news/faculty.html
Clinical engagement
a personal view

Hearing about a new system from a peer is a lot more likely to convince a clinician of its worth than a presentation from someone with another professional background, believes Sheila Bullas, secretary of BCSHIF. In this article, she gives her personal views about clinical engagement, and invites your opinions on her suggestions on encouraging clinicians to embrace new systems.

About 18 months ago, there were a lot of very senior people directly involved in the national programme telling me and the NHS generally that the systems themselves were not a problem (they were readily available) and that money and the NHS generally that the systems were not a problem (they were readily available) and that money were not available (there was sufficient money available now. If not available now, go elsewhere). Engaging with another professional background, believes Sheila Bullas, secretary of BCSHIF. In this article, she gives her personal views about clinical engagement, and invites your opinions on her suggestions on encouraging clinicians to embrace new systems.

Why should it be? It was not within the power of the people who implemented process change. Strange – for me it was the other way round. That led me to thinking that maybe gaining clinical engagement and implementing process change was not as obvious to others as it was to me. Why should it be? It was not within their knowledge or experience.

Winning over the sceptics

Most clinicians are rightly sceptical when told they will have systems that make their life and the life of their patients better and they will have them soon. They have heard it all before and many of them have heard it more than once and are still waiting for the systems they were promised in the past. They were promised in the past. They were promised many times and are still waiting for the systems that they were promised in the past. They have heard it all before and many of them have heard it more than once when they were told they will have systems that make their life and the life of their patients better and they will have them soon.

They have heard it all before and are very sceptical. They may not seem to be convinced by others, but patient safety and clinician career are dependent on understanding the full impact of any change and that includes information change. They do not have adverse effects on patient safety or the time it takes them to treat patients. They have implemented systems before where the systems really are going to be a substitute for seeing a system in operation. Peer-to-peer communications have the advantage of certain things that can be considered: shared values, shared language, an understanding of the clinical process and an assumption of common understanding of how systems will help – or at least there is a perception that they can be. Those with other professional backgrounds must do more to establish their credibility by demonstrating that they have this understanding too.

Systems demonstrations are good but no substitute for seeing a system in operation. Many a demonstration has hidden those things that the demonstrator would rather not discuss. Seeing a system in operation and discussing it with those using it shows the real system, warts and all. Most will recognise a ‘pig in a poke’ when they see one and understand that the perfect system has not yet been invented. They understand the economics of systems available to a number of organisations rather than bespoke development. Clinical engagement challenges all of us who implement systems and change. Let us respect clinicians for the highly responsible and intelligent community they are part of and rise to that challenge. There are things that already help, including: Presentations at conferences; Demonstrations by suppliers; Details on websites; Generic ‘communications materials’. Good but not good enough and often accessed only by the committed.

Doing things differently

If the analysis presented here is reasonable then different things need to be done differently. What else should be done? Here are a few suggestions of what might be done.

Enable early implementers to enter into face-to-face dialogue with clinicians and expose the good, the bad and the ugly. These sites have jobs to do and hosting visits from a large number of people is expensive, time consuming and takes people away from their job – but most who participate acknowledge the benefit.

Set up mobile units where demonstrations, hands-on use and discussions can be held with local clinicians in a clinically recognisable set up, where locals, nationals and suppliers can work through realistic processes using the systems.

Enable a body, respected by clinicians, to expose clinical governance issues arising from the use of the systems, test them and provide advice and guidance – a body that listens to clinicians, takes their concerns seriously, tests them and makes outcomes widely available.

Make the extensive tests, issues logs and progress currently provided by suppliers available to all.

Describe a local role, including responsibilities, knowledge and experience necessary: someone who will develop relationships, identify issues of concern, address them and introduce events, materials and activities at appropriate times. Support with funding and a network to help them succeed.

Make no more promises of delivery dates when it is known that these dates are impossible to meet. It is better to have later dates that can be delivered. Share uncertainties where these exist.

Please contribute to the debate: contact Chris Mayes, chris.mayes@hq.bcs.org.uk.

By Sheila Bullas, secretary of BCSHIF; associate director Information, Princess Alexandra NHS Hospital Trust; and independent consultant.

Join the debate: Professionalism in health informatics

Professionalism in health informatics will be the theme of the next issue of Health Informatics Now, out in March. There has been a lot of debate on professionalism and there are a variety of views from highly respected individuals and organisations. This important issue will be debated at the BCS Health Informatics Forum meeting in January and the key points from the debate will be reported in this newsletter.

If you want to participate, the Forum is open to all and will be on 23 January at the BCS London office, 5 Southampton Street. A buffet lunch will be held from 12.30pm with the debate beginning at 1.30pm. Advance registration is necessary. We also welcome articles and letters on the topic. We also welcome your participation on the topic of clinical engagement, which is included in this issue.

The March issue will also include news and reports from our specialist groups and we invite you to submit articles on current topics in health informatics and comments on any of the articles from this issue.

To attend the meeting, or submit articles or letters, please email Christine Mayes, BCSHIF manager: Chris.mayes@hq.bcs.org.uk.
Respect and recognition through professionalism

The Prof IT initiative, a three-year programme in which the BCS is collaborating with e-skills UK, Intellect and the National Computing Centre to develop professionalism was mentioned in the September 2006 edition of ‘Health Informatics Now’. In this article, Colin Thompson, consultant to the BCS Professionalism in IT programme, sets out the programme’s goals and its five-prong campaign.

Over the past two years considerable progress has been made by the BCS towards building a new IT profession.

The ambition is to create a profession that has a much greater business focus and that:
- attracts high quality people;
- inspires high performance;
- represents a career aspiration and opportunity for a wide spectrum of people.

The BCS Professionalism programme has two key objectives:
1. to increase professionalism by improving the ability of business and society to exploit the potential of information technology effectively and consistently;
2. to build an IT profession that is respected and valued for the contribution it makes to the exploitation and application of IT for the benefit of all government, business leaders, IT employers, IT users and customers.

The creation of a mature IT profession is about:
- putting in place the necessary infrastructure and changing the recognise and respect for IT professionalism and recognition for the importance of IT in business and the wider community.

Achieving these objectives will involve putting in place the necessary infrastructure and changing the practice and performance of individuals and organisations to ensure that the principles of professionalism are firmly embedded in standard practice.

A key building block has been to:
- clarify the structure of the profession and so illustrate typical career paths and enable the structuring of the qualifications regime to support these.
- There is agreement that the following groups will fall into the scope of the new IT profession:
  - IT practitioners;
  - Education and training providers;
  - Research and development professionals;
  - Members of other professions;
  - Professional organizations and interest groups.

The launch of the Prof IT alliance at the Prof IT conference in May 2006 signalled the intent of four industry bodies, BCS, e-skills UK, Intellect and NCC, to work together to deliver a cohesive programme to achieve the objectives of the Professionalism in IT programme. This alliance is now proposing five major campaigns concerned with changing the practice and performance of individuals and organizations.

Alliance partners will lead these campaigns and will target key stakeholders to:
- help more businesses become IT capable in terms of exploiting and managing IT;
- improve the professionalism of IT supplier organizations and thereby the performance of the IT supply chain as a whole;
- Grow the available pool of competent, professional IT practitioners both existing and future;
- Make the IT profession itself more relevant, effective;
- Ensure that the education and training sectors produce the knowledge and skills needed to support the above.

A genuine opportunity exists to:
- create a professional IT industry and the reality is that the change will happen by a very large number of individuals and organizations making a series of incremental changes.

For more information visit: www.bcs.org/professionalism or email: profit@hq.bcs.org.uk

The system allows patients to see a basic summary of their medical record at any time.

His system allows patients to see a basic summary of their medical record at any time. Patients register with their GP to access information using the internet. The system also allows patients to make new appointments or order repeat prescriptions.

Dr Hannan believes not only that this helps improve the relationship between clinician and patient, but that patients can really benefit from having complete access to their data. For example, if a patient is involved in an accident and taken to A&E, doctors there could get a complete insight into the patient’s history.

Before being piloted, the system was scrutinised by the Local Care Record Development Board at the PCT, who ensured that the system was secure, and would not break patient confidentiality. There are some issues such as third-party data and sensitive areas such as teenage contraception and security that need looking into, but on the whole feedback has been good. Dr Hannan hopes to see the system rolled out across the country as soon as possible.

PHCSG Members Only – Special Interest Group Meetings

The PHCSG Clinical Computing Special Interest Group believes that medical informatics can and should serve to strengthen the traditional values of family practice, and that it has a key role to play in improving the quality of primary care that we provide. It is a group of GPs, practice nurses, practice managers, computer professionals and other staff involved in delivering primary care who meet every two to three months at their own expense to discuss and research the application of computing to the care process. The meetings are for PHCSG members only, with the occasional invited guest and are run under Chatham House rule.

The theme of the 8-9 December conference to Dr Amir Hannan, GP, Thornley Medical Centre in Hyde for his groundbreaking work on patient record access. The prize is awarded by the PHCSG for innovation and excellence in primary care computing. Dr Amir has been piloting patient record access within his own surgery. 

Meet the Specialist Groups

Primary Health Care

Specialist groups are the grass roots of BCSHIF. Introducing the work of a group will be a regular feature in Health Informatics Now.
Low morale of the health informatics workforce and potential future skills shortages were some of the findings in a survey commissioned by ASSIST in 2006. The article below is an extract from the executive summary on the findings of this survey undertaken within the NHS in England.

The survey was designed as an interim basis for formal workforce planning for this key group of NHS staff – a group that is central to delivering a wide range of national and local service priorities, including the National Programme for Information Technology being run by the NHS Connecting for Health Agency. The survey was supported by NHS Connecting for Health (CFH) and the Information Centre for Health and Social Care.

Meetings with key senior staff within NHS CFH and the Information Centre for Health and Social Care, Skills for Health and other national organisations will take place shortly, to agree actions based on the conclusions and recommendations.

A version of this report on the survey’s findings first appeared in the British Journal of Healthcare Computing and Information Management.

The key findings of the survey include:
- The NHS informatics workforce in England is estimated at 25,000 whole time equivalents.
- The distribution of the workforce between informatics groups is: Senior managers 7 per cent; Health records staff 26 per cent; Knowledge management staff 9 per cent; ICT staff 37 per cent; Information management staff 18 per cent;
- There are significant problems with recruitment in ICT services and information management. Uncompetitive rates of pay are the main reason for this. Vacancy rates range from 12 per cent for Information managers to 4 per cent for senior managers and clinical informatics staff. Staff retention is being affected by low morale: informatics staff feel embattled, overworked and under-valued. Agenda for Change (AfC) has been contentious in many areas. Significant numbers of appeals are being lodged in all categories but particularly in ICT services, health records staff and senior managers.
- Future skills shortages are anticipated in project/programme management, information analysis and ICT and system trainers. There is strong support for establishing a formal informatics profession.
- The recommendations from the conclusions below are:

**Total numbers and make-up of the workforce**
Workforce planning measures will need to ensure that sufficient skilled staff are available to meet current and future demands. Frontline care and the delivery of key national policy objectives depend increasingly on ICT and other informatics professionals. These staff – whether or not employed directly by the NHS – will need to meet explicit technical and ethical professional standards.

**Challenges to recruitment and retention**
As different aspects of the total package are important in the recruitment of different staff, recruitment campaigns should tailor their marketing and promotional material to emphasise different aspects of the total package depending upon the category of staff being recruited.
As pay is seen as the biggest challenge to the recruitment of all types of informatics staff in the NHS, a strategy to address this challenge needs to be identified and implemented. This might include: establishment of national recruitment premia under Agenda for Change; improved marketing of the benefits of the whole package of working in the NHS; improvements in other aspects of the employment package.

**Future skill shortages**
Future skill shortages are predicted in key areas, such as:
- Project/Programme Management;
- Information analysis and ICT and system trainers.
Action should be taken as part of a robust workforce planning strategy to address these predicted shortages. Mechanisms are also needed to better anticipate the impact of policy developments on workforce capacity and capability.

**Views of the workforce towards greater professionalism**
Faster progress is needed towards the widely-supported establishment of a formal profession of health informatics. Practitioners will need a clear understanding of the responsibilities and expectations of members of a professional body, including a formal registration process with transparent and objective entry criteria. For registration to be meaningful there will need to be proper regulation of fitness to practice, behaviour and conduct.
As only a minority of survey respondents is in favour of mandatory registration and regulation, those charged with establishing the profession must also develop a clear marketing strategy to indicate the reasons for establishing the profession and for its compulsory regulation. This will need to include comprehensive details of expected membership criteria and transitional arrangements.

**Impact of Agenda for Change**
Agenda for Change (AfC) has had an adverse impact on the informatics workforce in the NHS demonstrated by the number of appeals being lodged in all categories of the workforce and the comments received about the implementation process.

The adverse impact could be mitigated now by a drive for greater consistency in the Job Evaluation process, by publicising the depth of feeling and by the ongoing review of the Knowledge and Skills Framework in support of AfC. The use of recruitment and retention premia will also alleviate the feeling of being under-valued – a feeling that is clear in some of the comments received.

**Overall self-perception of staff working in health informatics**
- The responses to the survey create the impression of an embattled group of staff within the NHS, a group with low morale who feel under-valued and unable to control their own destiny in the face of the fundamental changes taking place in the NHS.
- The following three measures would go a considerable way towards addressing these issues: The establishment of a formal professional body for health informatics staff is essential. This would immediately improve the perceived status and self-esteem. It would also accelerate the adoption of professional standards of conduct and the use of industry best practice standards with associated benefits to the NHS.

The creation of a meaningful strategic workforce plan is essential in order to shape and develop this important staff group within the NHS. This would also provide some evidence that the NHS valued this group of staff and was planning constructively for its future development.

Although it is too late now to address the unsuitability of the Agenda for Change of staff, develop a clear marketing strategy to indicate the reasons for establishing the profession and for its compulsory regulation. This will need to include comprehensive details of expected membership criteria and transitional arrangements.

**Conclusion on the state of the health informatics in the NHS**

The overall objective of this survey on which this report is based was to provide comprehensive and accurate information on the health informatics workforce in the NHS in a number of areas:
- to support future workforce planning, including capacity, capabilities and skills gaps;
- to measure the impact of Agenda for Change and progress with implementation;
- to inform the progress towards the establishment of a formal profession of health informatics.

- the survey looked at:
  - the size of the informatics workforce in the NHS;
  - staff turnover and vacancy rates;
  - managers’ views on future demand, by specialist category, and the prospects for recruitment; the outcomes of the Agenda for Change matching process.
- The survey was conducted via a web-based questionnaire throughout the first three weeks of April 2006.Over
The results of the survey provide a clearer picture on the informatics workforce in the NHS but there is still some uncertainty around total numbers. There is, however, greater clarity around the:

- Make-up of the workforce;
- Challenges to recruitment and retention;
- Future skill shortages;
- Overall self-perception of staff working in health informatics.

The full explanation of the conclusions of the findings in these specific areas is provided in the body of the report. The overall conclusions to be drawn from the findings of the survey are summarised here.

**Make-up of the workforce**

**Conclusion** – ICT staff form the largest cohort of staff working in informatics in the NHS. With the increased use of computer-based systems at the bedside and at all clinical interfaces, there will be increased dependency on software, hardware and network connections for the core businesses of the NHS.

**Conclusion** – With the increased involvement of the private sector in the implementation of the National Programme for ICT, it is highly likely that there will continue to be a mixed economy of informatics provision in the NHS and this would seem to be a higher probability in ICT than in other areas. The reason for this, it is argued, is that ICT skills are mainly generic and not specific to the NHS.

**Challenges to recruitment and retention**

**Conclusion** – There are some considerable challenges and difficulties in the retention of informatics staff. Morale is a critical factor in the retention of staff.

**Future skill shortages**

**Conclusion** – Future skill shortages are predicted in key areas, such as:

- Project/programme management;
- Information analysis and ICT and system trainers.

There is a clear rationale behind these predictions which is based upon recent policy developments within the NHS – see sections above.

**Views of the workforce towards greater professionalism**

**Conclusion** – There is a desire on behalf of the majority of respondents to move towards greater professionalisation of health informatics. The development of the profession of health informatics has been supported by national bodies (formerly the NHS Information Authority and now the Professional Development and Support division of the NHS CfH Agency) for some time.

The commissioning of this survey is in itself an excellent example of the sort of collaborative working that will be required to progress more quickly towards the formal establishment of the profession.

**Conclusion** – The survey responses also show that mandatory registration and regulation is not supported by the majority of respondents at this time. Looking ahead to the time when the profession of health informatics is formally established, it is untenable to believe that regulation could be optional.

**Impact of Agenda for Change**

**Conclusion** – A4C has had an adverse impact on the informatics workforce in the NHS, demonstrated by the number of appeals lodged in all categories of the workforce and the comments received about the implementation process.

There is a view from many respondents that those responsible for local implementation of A4C did not understand the roles of many informatics staff. There is also a view from some that informatics staff did not understand the importance of the wording of job descriptions and did not know to whom they should turn in search of advice and support.

**Conclusion** – In retrospect it is possible that part of the reason for the poor management of the implementation of A4C for informatics staff is the lack of a well-established, highly credible professional body capable of representing informatics staff. ASSIST and other bodies would argue that this is only an excuse for an unwillingness to effectively consult and negotiate on behalf of the NHS Pay Modernisation Unit. These groups would further argue that, in fact, implementation of A4C would have been even more disastrous for informatics staff were it not for the considerable work carried out by ASSIST.

Whatever the reasons for the adverse impact of A4C for informatics staff, it would probably have been handled more effectively if a formal professional body for informatics staff had already existed.

**Overall self-perception of staff working in health informatics**

**Conclusions** – The responses to Q10 of the survey create the impression of an embattled group of staff within the NHS, who have low morale and feel under-valued and unable to control their own destiny in the face of the fundamental changes taking place in the NHS.

It is not possible to accurately assess whether the perceptions of informatics staff are significantly different from other staff groups at this time of considerable publicity around financial deficits and redundancy of some clinical staff. It is possible to propose some actions that should help to address some aspects of the low morale and low self-esteem of this group of staff.

Informatics covers a wide range of job roles, responsibilities and skills. The group of staff working in informatics in the NHS will vary considerably in their work experience, vocational and academic qualifications. This heterogeneity is both a strength and also a weakness. There is strength in the cross-fertilisation and sharing of experiences that takes place in informal and more formal networking; there is a weakness in that there will continue to
A rapid increase in the number of elderly people in the UK over the next few years was predicted in a presentation to Government Ministers to ‘the Guardian’ in a front-page article on 8 November. Other forecasts, including the Government’s ‘Population Trends’, suggest that the number of people of state pensionable age will soon exceed the number of children, and that the ‘support ratio’ (working population to people of pensionable age) will drop rapidly over the next decades. Is there anything we can do to prepare for the challenges these demographic shifts will bring? Does technology have a part to play?

Some of the answers to these questions were provided in David Kelly’s talk. Like Simon Dodds, whose presentation we covered in the previous issue, David was a Healthcare IT Effectiveness Award prizewinner in 2005, so this was an update on progress since he gained first place for best use of IT in primary and community care. And like Simon’s work, although not in the most glamorous of areas, his project is an object lesson in judicious use of technology.

Tom Sharpe, chair, Northern Specialist Group.

Abstract: redesigning services for older people in West Lothian

David Kelly
West Lothian Community Health and Care Partnership

“Caring for an increasingly frail elderly population is one of the biggest challenges facing local government and healthcare services over the next 10 years. The West Lothian Council and its local NHS Health Division are pioneering a mainstream approach of partnering telecare with other support mechanisms to creatively help people stay at home within a risk-managed environment. The outcomes to date have resulted in far less bed-blocking and improved quality of life for service users. Over 1,800 older and vulnerable people are now supported in their own homes with a package of telecare technology. Approximately 10 per cent of these people have high levels of support and would have been considered for a move to institutional care in the absence of a cost-effective alternative. However, technology on its own will not produce the benefits to service users and service providers. The West Lothian experience highlights a whole system approach to the mainstreaming of telecare technology within primary and community care services.”

Talk by David Kelly

With a population of 165,000 that is rapidly ageing, and a mix of urban and semi-rural areas, West Lothian is typical of many local authorities in Scotland. When West Lothian was set up in the 1990s it inherited six rather run-down care homes, and faced the twin problems of lack of long-term hospital beds for elderly patients and shortage of resources to continue their care in the community.

The Solution

West Lothian made a successful bid to the Housing Challenge fund to modernise their care homes where appropriate and build new housing care units. The home care service was modernised into a personal care service with a number of innovations including new meal and shopping delivery services, simplified assessment procedures for referrals to social work or occupational therapy, and a focus on re-enablement for patients, leading in many cases to a reduced package of care. The service redesign used a telecare approach at three levels:

- Home safety service. People’s own homes were fitted with a home alert console with audio link, and detectors using established technology for smoke, extreme temperature, flood, and movement. Though cheap and simple, such detectors can provide a lot of information about the occupant’s behaviour and will inform a carer if a situation which needs to be investigated is developing.
- Home safety service plus. This provides additional support through detectors for falls, chairbed occupancy, wandering, and incontinence. Automated access control, reminders, and voice recognition can be added, if the elderly person’s condition calls for it.
- Housing care. The third level of support provides more sophisticated technology. This may include lifestyle monitoring, which can detect deviations from the person’s normal pattern of behaviour, a database of recommended responses to various situations, telemedicine, medication reminders and an epilepsy monitor.

It’s important to note that video surveillance is not included in any of these packages, and also that there are only 200 of the more expensive purpose-built apartments as against 1,900 ordinary homes equipped with smart technology.

Results

The results are impressive. The numbers awaiting discharge from hospital were reduced from 67 in April 2000 to 14 in October 2005 and the average length of stay in care homes was reduced from 36 months to 16 months over the same period. The costs of various types of support work out as per the table above.

Issues and conclusions

Security and confidentiality of data is an issue, but is no more sensitive an issue than it would be in the normal single shared assessment between health and social care.

West Lothian’ – for me this was not so much use of smart technology, as smart use of technology.

Ongoing evaluation of the project is important, and a high level of commitment is needed, particularly at senior management levels.

You need a strong team, and you have to invest time in taking staff, users and carers along with you. A focus on cost saving is counter-productive. In particular, telecare is not a cost-saving alternative to personal service, but sits alongside it.

Comment

It’s interesting to see how many of the points brought out in Simon Dodds’ presentation – strong leadership, looking at the whole process not just the technology, and talking to people – were echoed in David’s talk.

The original title of the talk was ‘Smart Support at Home Project in West Lothian’ – for me this was not so much of smart technology, as smart use of technology.

The full meeting report is available at: www.bcs-nmsg.org.uk

Full meeting report by Phil Paterson: phil.paterson@tiscali.co.uk

Digest by Tom Sharpe:

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Overall cost in £ per person per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technology package plus reduced number of home visits</td>
<td>8,681</td>
</tr>
<tr>
<td>Housing with care tenancy</td>
<td>16,640</td>
</tr>
<tr>
<td>Care home place</td>
<td>23,122</td>
</tr>
<tr>
<td>Long-term hospital bed</td>
<td>46,696</td>
</tr>
</tbody>
</table>
Out-of-hours patient details for emergencies

A summary of a patient’s medication information is now available to out-of-hours clinicians in Scotland. Libby Morris and William Edwards outline the scope of the Emergency Care Summary and the safeguards put in place to ensure that patient data is used appropriately.

At the end of August all households in Scotland received a leaflet entitled ‘Your Emergency Care Summary – what it means for you’. This marked the start of a campaign informing patients and practices about the Emergency Care Summary (ECS), an ambitious new project designed to provide safer medical care for patients when their GP surgery is closed. The ECS is a summary of medical information which is copied from the primary care electronic record and held in a central store, from where it can be made available to out-of-hours (OOH) clinicians. In July 2006 there were over 4.2 million ECS records in Scotland and only 22 patients had opted out. These records have been viewed. The ECS also allows patients to opt out from having their records sent to the ECS store, and if the patient informs the practice that they do not want to have an ECS then none of their data will be sent to the store. If they require care at an OOH centre their record will show ‘consent withheld’. In July 2006 there were over 4.2 million ECS records in Scotland and only 22 patients had opted out. The ECS contains demographic information and telephone numbers which are held on individual practice systems (for example, ex-directory numbers or mobile numbers will be included if they are held by the practice), as well as details of regular medication, acute prescriptions and adverse drug reactions. The information is updated twice daily, and can be viewed by clinicians working in ODH centres. This is a ‘read only’ record and no changes are made to the primary care record.

Security and consent

The ECS is protected by individual username and passwords. Audits are carried out automatically, showing who has looked at an ECS record and what information was viewed. The ECS store and the patient can ask their practice if anyone has looked at their ECS, and practices can check whether any of their own patients’ records have been viewed. This is a ‘read only’ record and no changes are made to the primary care record.

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Responses from a questionnaire conducted by the Nursing Specialist Group are being used by the executive to inform activities and decide the group’s direction. Richard Hayward, chair of the Nursing Specialist Group, examines the responses to the questionnaire, and the subsequent actions taken by the group.

The objectives are:
- to promote and support the use of information management and technology;
- to provide appropriate meetings for discussion and the exchange of ideas and developments;
- to disseminate information about current nursing applications and to encourage the publication of research and development material;
- to provide a nursing perspective on healthcare computing;
- to assist nursing, midwifery and health visiting educationalists to integrate nursing informatics into pre- and post registration curricula;
- to liaise with appropriate BCS Specialist Groups and other relevant bodies;
- to maintain international links with IMIA/NI and EFMI.

Of the respondents to the questionnaire, 21 (60%) were full members of the BCS. (It is possible to be a member of the NSG without being a full member of the BCS). This was a higher proportion than might have been expected and could be as a result of the recruitment drive that the BCS has instigated over the last 18 months. There are financial implications for the group, since the fee for membership of the NSG is waived for full members of the BCS.

Results showed that members of the group saw two main benefits from membership, with networking opportunities mentioned by 19 respondents (54.3%) and some form of communication mechanism that kept respondents up to date with current issues in health informatics highlighted by 24 (68.6%).

Examples of these mechanisms quoted were ITIN (the Group’s journal) and the website, which given the fact that few members actually accessed the website was not reflected in the number of hits received. Other perceived benefits to individuals varied, and appeared dependent on the degree of involvement with the group. Membership of the NSG for some conferred status and allowed individual voices to be heard, particularly in influencing policy at a national level. As to what extra activities the group could offer, there was a feeling the NSG could have an enhanced training role, either by running courses ourselves or promoting existing ones. The other area highlighted was the need for the professionalisation of health informaticians and raising the profile of nurses working in the field. How this was to be achieved was less clear. The overwhelming response as to how the NSG should encourage increased membership was by improving publicity. 16 respondents (45.7%) specifically mentioned increased advertising, with the suggestion that an advert in the Nursing Times as to the existence and purpose of the group could reap major rewards. Another idea was to have closer links with other interested groups (particularly the RCN) to try to get a special feature. There was also a suggestion that closer links with CIH might help increase membership.

There was a strong feeling that a change in title was appropriate, but retaining ‘nursing’ in the title was felt to be essential (77.1%). There was a fear that if nursing was removed from the title, then there would be a potential for take-over by doctors and ICT specialists.

**ITIN, the group’s journal**

There was a very positive response to ITIN, with 34 respondents (97.1%) reading all or most editions. All sections were felt to be important, with the news and original articles being most valued. There is, however, a difficulty in securing both funding and high quality copy with an academic rigor necessary for acceptance in a peer-reviewed journal.

The NSG therefore supports fully the development of Health Informatics Now. A hard copy journal that informs the membership of developments in the field is to be welcomed, and also provides members with the opportunity to contribute to the knowledge base.

**The website**

In analysing what the group should offer, there was a feeling that meetings were a useful medium for exchanging information and networking. However, 27 respondents had never attended any meetings, five had gone to every meeting held in the last three years.

There were various suggestions made for future meetings. These have been acted on by the executive, with a joint meeting held in Glasgow on the 24 November with the Scottish SG.

The suggested venues for meetings varied, but a good geographical mix was considered essential with good transport links another priority. All day meetings were felt to be the most popular, with early evening meetings also considered worthwhile. It is difficult to draw a conclusion from these responses given that respondents did not actually turn up.

**Extensive content**

**Informative, grouped well easy to track**

**Appearance: Clean Concise**

**Organisation/links very easy to use**

This highlighted the fact that there was no appetite for a web-based journal. Members liked to have, as one respondent said, ‘something to read in the bath’. This is interesting since the membership, by definition, should be computer literate and therefore potentially more amenable to new technology and differences in presentation of information.

**Group activities**

In analysing what the group should offer, there was a feeling that meetings were a useful medium for exchanging information and networking. However, 27 respondents had never attended any meetings, five had gone to every meeting held in the last three years.

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The suggested venues for meetings varied, but a good geographical mix was considered essential with good transport links another priority. All day meetings were felt to be the most popular, with early evening meetings also considered worthwhile. It is difficult to draw a conclusion from these responses given that respondents did not actually turn up.

**Demographic details**

There was a huge range of jobs represented by respondents. The commonest role was university lecturer (29%), with clinical staff representing 26%. Project managers and staff working for NHS Connecting for Health were also represented.

There is a vast amount of experience represented in the survey, with the length of service in current roles providing a wealth of knowledge:

- Less than one year 6
- 1 – 2 years 9
- 3 – 5 years 7
- 6 – 10 years 6
- Over 10 years 10

This highlights the key reason for the existence of the NSG – the enormous amount of knowledge that is greater than the individuals could disseminate on their own. The NSG also offers opportunities to influence the use of technology in healthcare both within the BCS and in the wider environment.

If you are interested in contributing to this vital work, please contact me at Richard.hayward@canterbury.ac.uk.

The results of the questionnaire have been to widen the readership of the journal by contributions to Health Informatics Now, the continued support for meetings including a successful collaboration with the Scottish SG, and an active support network for members. Join us, and help to influence the future of health informatics.
Pathway to wider adoption of telecare

Looking at key issues in gaining wider adoption of mobile technologies to support telemedicine was the subject of a presentation by Mark Ferrar from NHS Connecting for Health (CFH) to the Interactive Care Specialist Group. His presentation, given in October, is summarised by Mark Outhwaite, vice chairman of the group, who also gives an update of other activities by the group.

The Health Informatics (Interactive Care) Specialist Group brings together BCS and non-BCS members with an interest in the use of technology to support patient care at a distance from the clinician, care professional or carer. There is an increasing government policy focus (and funding) on the use of telemedicine and telecare to support patients and clients in their own home environments with the aims of:

- promoting independence;
- reducing unnecessary hospital admissions;
- better predicting risks to patient safety;
- encouraging more effective self-management of chronic conditions.

The group will be focusing on promoting a better understanding of the challenges of adopting interactive care and its impact on patients, clients, carers and care professionals. The intention is to provide a forum for sharing the lessons of adoption and implementation. In particular the group intends to explore how best to share the lessons of adoption and intention is to provide a forum for carers and care professionals. The group will be focusing on encouraging more effective self-management of chronic conditions.

**Mark Ferrar’s talk**

As one of a series of supporting events the SG was pleased to welcome Mark Ferrar from NHS Connecting for Health (CFH) in October to share his views on the pathway to wider adoption of mobile technologies to support telemedicine.

Mark has a mandate to look ahead of the current CFH implementations in order to identify some of the key issues in the exploitation of the infrastructure that CFH is laying down.

**Patient authentication**

The issue of identity management loomed large in the talk and in the subsequent discussion, in particular how an individual patient was authenticated to remote sensors in the home or on the move.

**Upcoming meetings**

The group will be following up this meeting with a series of evening sessions over the year with, for example, a major workshop in association with the DTI in February.

We also hope to make links with the Healthcare Technologies Knowledge Transfer Network (KTN) sponsored by the DTI and the DH in order to support the better mobilisation of the learning from the many projects around the country and internationally.

For more details, look at our website – www.hiicsg.bcs.org.uk – or contact Keith Clough, chairman: at kkc@int.co.uk or Mark Outhwaite: mark.outhwaite@authenticis.com.

**January 2007**

**Health Informatics Forum seminar**

23 January, 12.30pm for 1.30pm.

Debates: professionalism in health informatics.

BCS, 5 Southampton Street, London, WC2E 7HA.

To reserve your place, email christine.mayes@hq.bcs.org.uk

**ASSIST Northern Ireland Branch**

25 January.

Streaming: the referral process in health and social care.

Speaker: Dr Gillian Rankin’ Joanna McQuillan, SEBT.

**ASSIST North West Branch**

30 January, 2.30pm.

Data Security, Data Warehousing and Legacy Systems.

The Small Lecture Theatre, Conference centre Adelphi Building, University of Central Lancashire, Preston.

http://northwest.assist.org.uk/events/events.htm

**February**

**Northern Specialist Group and Interactive Care Specialist Group**

15 February, 6.15pm for 7.00pm.

Delivering CFH PACS and ensuring benefits are realised.

Manchester Conference Centre, University of Manchester Sackville Street Campus, Manchester, M1 3BB.

www.bcs-nmsg.org.uk

**ASSIST Northern Ireland Branch**

22 February.

Telecare for Children with Congenital Heart Disease and their Families.

Speaker: Dr Frank Casey, Clark Clinic, Royal Victoria Hospital.

**HIMA/ASSIST North West Spring Conference**

28 February – 2 March.

Keep Fit, Save Pounds – Is the NHS Fit for Purpose? Hilton Hotel, Blackpool.

http://northwest.assist.org.uk/events/events.htm

**March**

**ASSIST North West Branch**

9 March, 2.30pm.

18-week Patient Pathway.

Wrightington Conference Centre.

http://northwest.assist.org.uk/events/events.htm

**BCS Health Informatics Forum**


The most comprehensive health informatics event in Europe.

Harrogate, North Yorkshire.

www.health-informatics.org

**Health Informatics (Northern) Specialist Group**

22 March. 6.15pm for 7.00pm.

Decision Support in Primary Care.

Manchester Conference Centre, University of Manchester; Sackville Street Campus, Manchester, M1 3BB.

www.bcs-nmsg.org.uk

**ASSIST Northern Ireland Branch**

29 March.

The all-Ireland ‘Nestling Technologies’ SMART Homes Project.

Speaker: Rodd Bond, director Nestling Project.

**April**

**Northern Specialist Group**

3 April. 6.15pm for 7.00pm.

NHS Connecting for Health – the Clinicians’ View.

Manchester Conference Centre, University of Manchester; Sackville Street Campus, Manchester, M1 3BB.

www.bcs-nmsg.org.uk

**ASSIST North West Branch**

19 April. 2.00pm.

Electronic Prescribing and Robotic Systems.

Arrowe Park Hospital, Wirral.

http://northwest.assist.org.uk/events/events.htm

**Health Informatics Forum seminar**

24 April, 12.30pm for 1.30pm.

Electronic Prescribing and Robotic Systems.

BCS, 5 Southampton Street, London, WC2E 7HA.

To reserve your place, email christine.mayes@hq.bcs.org.uk

**May**

**ASSIST / NHS Connecting for Health**

22 May.

Annual Conference.

Theme: No one said it would be easy.

Presentation of national accolades awards; ASSIST AGM.

Leeds Town Hall.

www.bcs.org/assist

Contact: Brian Derry (ASSIST): Brian.Derry@leedsdh.nhs.uk

**June**

**Primary Health Care Specialist Group**

Summer Conference.

12-13 June.

Heythrop Park, Oxfordshire.

www.phcsg.org.uk